

# *Duke Law Magazine*

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WINTER, 1985



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*Changes at the Law School*



# *Duke Law Magazine*

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## Editor's Column

Concerns of space and timeliness continue to haunt the pages of the *Magazine*. In "About the School" two articles address the problems of physical overcrowding. Except as occasionally noted here, the problem of intellectual abundance at the school also exists and inevitably results in a selection of topics for a given issue of the *Magazine*, while other topics are deleted or deferred.

The third article in "About the School" discusses a *Law and Contemporary Problems* symposium held almost a year ago. Another concurrent symposium, on Shareholder Litigation, has gone unreported. Two conference-symposia held this fall, on Gun Control and Federal Regulation of Work, will be covered in the summer issue. This spring there will also be *L&CP* conferences on Medical Malpractice, Exactions, China Trade, and Responsibility.

The first of these spring symposia is anticipated in part in the remarks made in the congressional testimony, reprinted in the section on "Doctors and the Law," by Clark Havighurst and Patricia Danzon. Havighurst and Danzon are currently teaching a Research Tutorial on Medical Malpractice at the law school, with the aim of discovering private and legislative alternatives to present solutions in the tort system for compensation of medical injuries. Ceilings on malpractice claims could be accomplished, as Havighurst points out, by private contract or by legislative reforms such as H.R. 5400, the Alternative Medical Liability Act sponsored by Congressmen Moore and Gephardt. Danzon criticizes S. 2690 in its quasi-no-fault aspects and argues instead for the retention of a reformed fault-based malpractice system.

The same opening section of this issue gives attention to the application of federal antitrust law to physicians, in the first piece by Havighurst and the closing piece by Duke Law School graduate Mitchell Raup, class of '83. Attempted federal regulation in the provision of a very specific type of health care is the subject of the article by Brenda Hofman, a third-year student.

The next issue of the *Magazine*, in addition to reports on the conferences already mentioned, will contain an assessment of the start-up operation of the law school's Private Adjudication Center, an overview of the journals published by Duke Law School, an article on skills instruction at the school, along with two essays on legal education. The Docket section will profile a number of prominent alumni practicing in Phoenix, Arizona.

## On the Cover

The cover depicts Amy Appelbaum, a first-year student, industriously working in the official state reporter stacks in the basement of the library. Two of the articles in this issue report on the changing physical plant at the school. The first describes some of the solutions to overcrowding in the library, together with forecasts of future responses to technological changes. The second piece brings older alumni-alumnae up to date on renovations to the building made over the past several years. These alterations are in part makeshift solutions in anticipation of a more complete overhaul of the present structure.



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# DOCTORS AND THE LAW



# The Doctors' Trust: Self-Regulation and the Law\*

Clark Havighurst

It is now possible to see that the Supreme Court's decision in the 1975 *Goldfarb* case, which involved a state bar association, created more problems for physicians than it did for lawyers.<sup>1</sup> Whereas the legal profession adapted itself rather easily to the Court's ruling that the so-called learned professions are subject to the Sherman Antitrust Act, the medical profession has found that antitrust law challenges not only many of its customary practices but also its fundamental conception of itself as the guardian of the quality of medical care. The American Medical Association (AMA), reacting to this perceived threat to professional traditions, recently spearheaded a legislative campaign to obtain an exemption for the state-regulated professions from the jurisdiction of the Federal Trade Commission (FTC), the agency that, following *Goldfarb*, assumed the lead role in bringing antitrust principles to bear on the health care industry. Although the AMA proclaimed physicians' willingness to abide by basic antitrust rules as enforced by the courts, it clearly hoped for a congressional rebuke to the FTC that would signify that competitor collaboration in the professions deserves special treatment. Despite the setback received by the AMA's lobbying effort in the last days of the 97th Congress, the conflict between the traditions of the medical profession and rules of free enterprise remains on the public agenda.

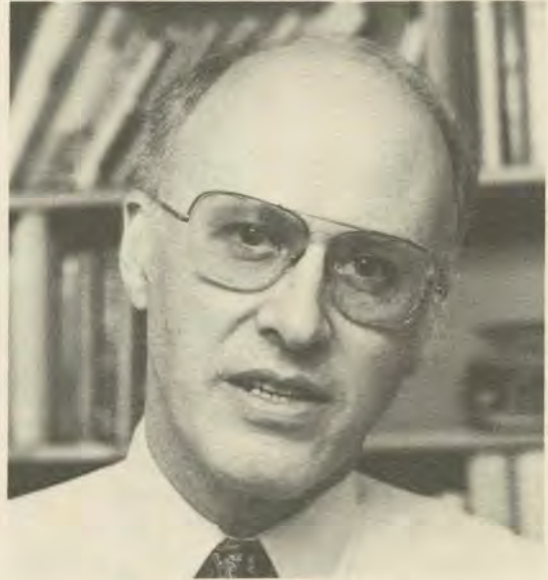
Physicians have long enjoyed considerable insulation from market forces and have collectively exercised a great deal of authority over the making of social policy with respect to how—and how much of—society's

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*Physicians have long enjoyed considerable insulation from market forces.*

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resources are employed in treating the sick. The recent history of the health care industry is largely a story of the erosion of doctors' accustomed powers, not only as a result of antitrust actions, but also through the operation of market forces (which *Goldfarb* helped to unleash) and new governmental policies (which *Goldfarb* helped to make feasible). Consideration of the conflict between emerging public policy and the sovereignty of the medical profession will demonstrate that professional self-regulation, developed by the medical profession to a high art, is facing serious challenges. This



Clark Havighurst

overview may also contribute to the needed assessment of what the public stands to gain or lose as the medical profession's dominance erodes and as market forces displace professional self-regulation as the chief mechanism of social control in the delivery of health care.

## A SOVEREIGN PROFESSION

In his recent book, *The Social Transformation of American Medicine*, sociologist Paul Starr has documented the rise of the medical profession to a position of "cultural authority, economic power, and political influence" that seems to have reached its apex, coincidentally or not, at about the time of the *Goldfarb* decision.<sup>2</sup> Starr argues that it was not inevitable that physicians would achieve the status and autonomy that they came to enjoy. Although the scientific aura surrounding medicine and the special dependency of patients on their physicians gave the medical profession significant advantages in their reach for power, hard and skillful work by dedicated professionals was necessary to raise the profession from a lowly to an exalted state.

The medical profession achieved effective control of its legal, economic, and institutional environment by espousing an ideology of medical care that knit the profession into a cohesive unit and kept decisionmaking on crucial issues largely in professional hands. Proceeding under the banner of science and patient welfare, the profession was frequently able to designate those who



effectively controlled such vital matters as state licensing policies, the nature and extent of medical training, the nature of medical specialization, the internal organization of hospitals, the politics and practices of prepaid medical service plans, and the appropriateness of payment for particular services under third party financing programs. Where it could not nominate the actual decisionmakers, the profession frequently succeeded, often with government's acquiescence or assistance, in restricting the decisionmaking scope of such potentially independent entities as medical schools, hospitals, non-physician health professionals, private health insurers, and government itself. The effect of profession-dictated limits on the discretion of these parties was to deny consumers access to agents who might represent their interests better than did physicians.

The ideology used so successfully by the medical profession in shaping the industry to its liking was rooted in a system of professional ethics restricting the individual practitioner's scope for independent action.

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### *The characterization of the medical profession in its prime as a monopoly or a cartel is probably too pejorative.*

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The history of modern medical ethics essentially began with Thomas Percival, a conservative English physician whose authoritative ethical principles, written in 1794, served as the AMA's model for its first ethical code in 1847. As a contemporary of Adam Smith, Percival faced the task of countering the free trade liberalism of his time by distinguishing medicine from "trade" and establishing the concept of a learned, self-governing profession. His principles, many of which were nothing more than rules of professional etiquette, strengthened professional solidarity, minimized competition, and launched the profession on a path quite different from that envisioned somewhat earlier by one John Gregory, a professor of medicine in Adam Smith's Edinburgh. Sociologist Jeffrey Berlant has written of Percival and Gregory:

Percival saw the forces binding the profession into a group—esprit de corps, a common academic training, and support of each other's reputations—as the source of the best in medicine. . . . Gregory challenged this central presumption and thereby also the medical profession's elitist autonomy as an independent institutional body. The domination of medical thought by men of the practicing profession, he explained, distorted the pursuit of medical knowledge and blocked the development and delivery of medical care.<sup>3</sup>

It is striking that the same fundamental issues that have been raised in medicine following the *Goldfarb* case were actively debated in the time of Adam Smith.

Though not technically inaccurate, the characteriza-

tion of the medical profession in its prime as a monopoly or a cartel is probably too pejorative and unduly demeaning to the profession's accomplishment in building a health care system that yielded a high standard of technical quality, sustained rapid scientific progress, lengthened life expectancy, and provided a great deal of free care for patients unable to pay. It is nevertheless the case that this complex system was subject, at critical points, to a degree of central control that warrants description in monopolistic terms. It is ironic that the public health movement came to criticize the health care delivery system for being a "cottage industry" and a "nonsystem," for, although the profession-dominated system did not choose to serve the objectives espoused by its public health critics, it was a system nevertheless—and an impressive one at that.

Despite its achievements, the health care system, as operated under the medical profession's domination, has one fatal flaw—its inability to control its huge appetite for consuming societal resources. Its claims on GNP rose from 4.6 percent in 1950 to 7.7 percent in 1973 to 10.5 percent today. In the last decade of slow economic growth, this toll, together with recognition of the high median income of physicians relative to other professionals, has played an important part in ending the public's willingness to let medicine's otherwise benign monopoly alone. For the moment, proposals to regulate the health care industry are being held in abeyance while more market oriented policies, aimed at breaking down monopoly power and decentralizing decision-making, are being tried.

#### ANTITRUST AND MEDICINE

Prior to the *Goldfarb* case, the medical profession enjoyed an unwritten but seemingly substantial antitrust exemption that enabled it to act in ways that would be risky today. In part, this immunity was traceable to language in the Supreme Court's 1952 opinion in *United States v. Oregon State Medical Society*, observing the ethical considerations involved in the doctor-patient relationship and opining that "forms of competition usual in the business world may be demoralizing to the ethical standards of a profession."<sup>4</sup> The context of this statement suggested that, had the proof called for it, the Court would have excused a physician boycott of a

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### *The health system... has one fatal flaw—its inability to control its huge appetite for consuming societal resources.*

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type that would normally have been a "per se" violation of the Sherman Act—that is, a practice regarded as so dangerous to competition that it is treated as unlawful even without proof of any specific harm.

Despite the broad deference to professionalism indicated by the quoted dictum, the medical profession's



de facto antitrust immunity probably owed more to constitutional limitations on the reach of federal law into local markets for professional services. Certainly, deference to medical ethics had not been apparent in the 1943 case of *AMA v. United States*, which resulted in criminal convictions of two professional associations for sponsoring boycotts aimed at enforcing ethical strictures against an early health maintenance organization (HMO).<sup>5</sup> Only the location of that offense in the District of Columbia prevented the case from serving as

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*At the margin, much health care spending is not justified by the benefits obtainable.*

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a precedent for further federal enforcement actions. In addition to clarifying that professionals are engaged in trade, the *Goldfarb* case heralded a significant relaxation of the tests for finding the requisite impact on interstate commerce.

Subsequent cases have further reduced the number of ways in which powerful physician groups can hope to escape antitrust liability. In *National Society of Professional Engineers v. United States*, the Court indicated that professionals, far from having their anticompetitive conduct evaluated under a relaxed legal standard, can only be excused, like other defendants, if their collective actions do not harm competition.<sup>6</sup> In emphasizing that the effect on competition is controlling, the Court conceded only that competition in the professions may differ in form from other competition and thus be lawful. As a further demonstration that a worthy purpose is no defense for restraining competition, a four-Justice majority in *Arizona v. Maricopa County Medical Society* found a dominant professional organization guilty of a per se price fixing violation in setting a maximum limit on fees.<sup>7</sup> Although the law is not finally settled, the Supreme Court has gone quite far toward establishing that professionals are trusted no more than other competitors to restrain trade without injuring the public.

#### CONTROL OF THE FINANCING SYSTEM

The unusual features of competition in health care have less to do with its professional character than with the prominent role played by third parties in paying for services. Private and public insurance programs that reimburse patients or providers for incurred costs dilute the incentive of consumers to shop for less expensive care and the incentive of patients and physicians to consider benefit/cost ratios in buying or ordering services. Competition under such circumstances tends to raise costs without any assurance that consumers and taxpayers really want their resources spent as they are in fact being spent. Once widespread third party payment was coupled with the inexhaustible capacity of the modern, high technology health care system to find new

ways to spend money, the system quickly gobbled up whole percentage points of GNP. Although undeniable good has come from this investment, there is some basis for suspecting that, at the margin, much health care spending is not justified by the benefits obtainable.

This resource allocation problem calls attention to defects in the way consumers are currently protected against the unpredictable costs of health care. In particular, third party payers have been quite complacent about the increased costs that their coverage induces and reluctant to take aggressive action to encourage efficient behavior by physicians. When Congress itself adopted such a passive stance toward physicians in the Medicare and Medicaid programs, it was simply reflecting deferential practices that were already well established in the private sector. Yet logic suggests that competition should have induced private third party payers to assume more control over the uses made of their funds. One explanation for the failure of these middlemen to represent consumers better and to transmit their cost concerns to practitioners appears to be that the medical profession has frequently employed its collective power to stay the competitive market's invisible hand. The profession's attempts to discipline or control the private financing system, keeping payers in a passive role, have been a primary target for antitrust enforcement.

Organized medicine at first collectively resisted medical care insurance of all kinds on the ethical ground that no one should intervene in the doctor-patient relationship. As the public increasingly demanded financial protection, however, the profession began to offer its own coverage by sponsoring Blue Shield plans. To prevent the growth of law controlled middlemen, physicians were ethically enjoined against engaging in "contract practice," and health care plans were warned, under threat of boycott, against interfering with patients' "free choice of physician."<sup>8</sup> Although the egregious tactics used by organized medicine in the early days to stamp out objectionable financing plans became less common after the *AMA* case in 1943, more subtle techniques also proved effective. For example, the record in the *Oregon State Medical Society* case revealed how the society's adoption of a Blue Shield plan, together with a partial boycott of alternative plans, forced the latter to

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*Third party payers have been quite complacent about the increased costs that their coverage induces.*

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cease their cost control efforts and to assume the passive stance that physicians preferred.<sup>9</sup> From time to time, other innovations in health care financing, including the formation of HMOs, have triggered other boycotts of varying explicitness and completeness.<sup>10</sup>

Professional domination of the financing system



took other forms as well. The FTC has threatened to challenge direct control of Blue Shield or other medical care prepayment plans by dominant medical organizations, alleging that such control insulates physicians from price competition and precludes innovation.<sup>11</sup> Some of the potential targets for antitrust attack under this FTC theory are widely viewed as valuable professional reforms that advance the cause of cost containment. Although the FTC's challenge to such reforms can be justified legally under the rule that worthy purposes do not excuse harm to the competitive process, its policy justification is somewhat harder to find. The argument has been made, however, that allowing the organized profession to assume responsibility for health care costs perpetuates its power and forecloses independent competitive initiatives.<sup>12</sup> Under this analysis, the bird in the hand of immediate cost containment is valued less than the potential benefits of competition. Although this hard line stance can be viewed as making the best the enemy of the good, profession sponsored reforms have often been responses to actual competitive threats already in being or appearing distinctly on the horizon. If it is true that the medical profession seldom reforms itself except to shore up a market position that is in danger of crumbling, then a legal rule barring dominant professional organizations from operating their own prepayment plans might facilitate more desirable change than it would prevent.

Professional boycotts against independent innovations in health care financing represent the darkest side of the medical profession's self-regulatory activities, and antitrust law has now made them largely a thing of the past. More controversial has been the use of antitrust law—in the *Maricopa County Medical Society* case, for example—to prevent dominant professional organizations from attempting to correct the system's economic faults. The conclusion that such organizations are affirmatively barred from acting to solve the cost problem is a striking demonstration that traditional conceptions of the medical profession and its role are no longer valid. Even when the leaders of such reform movements act selflessly and in the best traditions of the profession, they may still find themselves in violation of the Sherman Act because they are working from an obsolete

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monopolistic premise. The law seems now to require that solutions to cost problems be sought through competition exclusively.

**NONCOMMERCIAL PURPOSE**

Professional activities that impact less directly on the economics of health care may be less vulnerable to anti-

trust action because of a distinction that is widely supposed to exist between actions aimed at affecting the business aspects of medicine and actions intended to maintain the quality of care. To some extent, distinctions of this kind are indeed embodied in the rigorous (per se) antitrust rules governing competitor agreements related to price and in the tendency to treat less dangerous activities under the "rule of reason"—which

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*Traditional conceptions of the medical profession and its role are no longer valid.*

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requires proof of actual harm to competition. Nevertheless, distinctions based on noncommercial purpose cannot be said to be well established in the law, which insists on competition, for better or for worse, in virtually all matters. As a result of this legal uncertainty, Congress, in seeking to resolve the AMA-FTC conflict in 1982, briefly entertained proposals to confine the FTC to regulating the commercial aspects of professional practice. Although the AMA, in opposing these attempts to compromise the conflict, argued that such distinctions are spurious, similar approaches to defining professional prerogatives have appeared in later proposals.<sup>13</sup>

Existing law suggests another reason why quality related self-regulation is unlikely to suffer the same legal fate as the profession's attempts to control the commercial aspects of medicine. Such self-regulation employs techniques that, in themselves, do not or should not raise serious antitrust concerns. As described below, much self-regulation in the health care industry involves the accreditation of institutions and the certification of personnel, activities that are in themselves valuable in generating information useful to consumers and others in making purchasing, employment, and other marketplace decisions. Such collective action by competitors is therefore presumptively more helpful than harmful to competition. The presumptive lawfulness of such activities suggests that there may be no need to accord them special statutory protection, which might, after all, immunize abuse of self-regulatory powers as well as their procompetitive exercise.

**PHYSICIANS AND HOSPITALS**

In comparison with the medical profession's efforts to shape the health care financing system, self-regulatory actions with respect to hospitals are more formalized and less obviously dedicated to protecting physicians' economic interests. At the level of the individual institution, hospital medical staffs have assumed major responsibility for maintaining the quality of care. Because these physician organizations act within and are accountable to the larger hospital enterprise, a medical staff cannot be viewed as a naked conspiracy in restraint of trade. Thus, a refusal to admit a competing physician to the staff should be permissible if the hospi-



tal itself exercises the final authority, consulting its own interests rather than joining in a conspiracy with its physicians.<sup>14</sup>

As an administrative arm of the hospital, a medical staff is not, strictly speaking, a self-regulatory instrument of the medical profession as a whole. Collective actions of the profession have, however, had a substantial influence on the internal organization of hospitals. It was not inevitable that hospitals would come to be organized with a self-governing staff of independent practitioners who use the facility, without charge, as a workshop in which to treat their paying patients. Efficiency considerations might have pointed toward a quite different set of arrangements. Indeed, an M.D.-economist has recently observed how the almost total separation of a hospital's revenue centers (physician departments) from its cost centers (administrative departments) renders cost containment an almost impossible task.<sup>15</sup> An important reason why physicians are almost universally independent contractors independently organized within the hospital and why physician decision-makers are generally not accountable for costs in the hospital administrative structure is that physicians have preferred to have things so arranged. To this end, they have shaped the detailed accreditation standards of the Joint Commission on Accreditation of Hospitals. The JCAH, which is one of the most important self-regulatory bodies in the health care industry, was founded and is still dominated by physicians.

Although the JCAH is highly influential, it does not engage in regulation in the strict sense. Regulation, properly understood, involves compulsion through the imposition of binding sanctions, whereas accreditation is essentially voluntary, its significance and desirability being determined by numerous independent decision-makers and not by the accreditors themselves. Any attempt to enforce an accreditation decision, such as by an agreement to boycott an unaccredited institution, would be an antitrust violation, but a collective denial of accreditation should be subject to only limited judicial scrutiny under common law or antitrust principles and should be sustained if the action taken has some rational

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*It might be argued, however, that greater flexibility in educational approaches and greater diversity of output would serve the public better.*

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basis.<sup>16</sup> Thus, even though one might question the wisdom and motives underlying some JCAH standards, its accrediting activities are presumptively lawful. Aside from antitrust attacks on JCAH standards affecting the opportunities of nonphysician practitioners, the JCAH has not faced any serious legal challenge to its substan-

tial power.<sup>17</sup> In general, it would appear that the available grounds for antitrust or other action against accreditation standards are quite limited.

#### HEALTH CARE PERSONNEL

The medical profession has also used its self-regulatory powers to shape the personnel employed in the health care system. Accreditation of medical schools, though no longer used to restrict the supply of physicians, still serves to structure the educational process, thus promoting the uniformity of physicians entering practice from U.S. schools. Similarly, accreditation of specialty training programs operates, in conjunction with specialty boards for certifying individual specialists, to standardize specialists in each recognized field. The medical profession also participates in the design of training programs for nonphysician personnel and in providing credentials for the personnel trained. For the reasons indicated above, educational accreditation and the certification of qualified personnel are presumptively lawful professional activities.

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*It may be helpful to regard the health care marketplace as a marketplace of ideas.*

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The influence of the medical profession over the design and production of health manpower undoubtedly helps to maintain high quality standards and to ensure an easy fit between the personnel available and the needs of the system, as defined by medical interests. It might be argued, however, that greater flexibility in educational approaches and greater diversity of output would serve the public better by giving different educational theories and different types of personnel a chance to show what they can do. Because ideology can affect educational, organizational, and therapeutic choices as well as the values that providers bring to their interactions with patients, it may be helpful to regard the health care marketplace as a marketplace of ideas. First amendment traditions, as well as the values underlying a free economy, suggest the possible dangers of allowing a single educational, professional, or other philosophy to dominate a given field. They also suggest, however, that the best answer to the dominance of a particular philosophy does not lie in litigation aimed at changing that philosophy. Instead, it seems wiser to maintain a climate in which alternative accrediting and personnel credentialing systems may develop to compete with dominant ones and in which the products of different educational traditions may fairly compete for consumer favor. Antitrust law could be helpful in ensuring that such a climate exists.

It is possible that the medical profession's maintenance of its own systems for certifying medical specialists has acted to suppress the emergence of competing sources of information concerning physicians' skills and attributes. The profession's long effort to ban physician



advertising amounting to solicitation of patients—recently discontinued as a result of FTC action—had the effect of concealing from consumers the existence of significant differences among practitioners.<sup>18</sup> Professional provision of authoritative information concerning medical specialists could have the same effect if it effectively curbed the entrepreneurial urge of individual physicians to differentiate themselves from their competitors. Although the medical profession's personnel credentialing activities are undoubtedly lawful in themselves, close antitrust scrutiny of the details and interrelationships of the various programs might reveal that competition in the production and dissemination of valuable information has been restrained.<sup>19</sup>

#### PROFESSIONAL STANDARDS

A particular coup of the medical profession has been its success in establishing and maintaining professional norms and standards as the chief determinants of spending for health care services.<sup>20</sup> Third party payers' complaisance toward physicians has generally taken the form of a willingness to pay any claim that is not demonstrably unjustified under prevailing professional standards. Thus, professional fees are reimbursed if "usual and customary," and costly treatment decisions are questioned only if the prescriptions fall outside professional norms. Such acceptance of professional norms and standards as guides for spending embodies the rather large assumption that the medical profession knows best what value society should place on particular health services; a similar assumption also underlies the use, in the law of medical malpractice, of customary practice as the benchmark for assessing professional negligence. But, because professional norms and standards have emerged in a market with weak cost constraints, widespread reliance on them may be inefficient. Surprisingly few standard medical practices have ever been scientifically shown to be superior in all relevant respects to other possible methods.

Professional self-regulation has played a central role in developing professional standards and establishing their authority. By creating local physician committees

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to evaluate the reasonableness of fees and the quality and appropriateness of care in specific cases, the medical profession has effectively pre-empted decision-making responsibilities that the various payers might have assumed independently, choosing their own physician arbiters. It is likely, however, that, as the health

care industry becomes more competitive, decision-making on such crucial subjects will become more decentralized. Because HMOs appear to have some freedom within the constraint of malpractice law to establish their own practice patterns, they represent one way in which departures from dominant professional norms and standards have begun to occur. In view of the unreliability of customary practice as a guide to efficient behavior, HMOs and other organized health plans should be allowed some freedom to contract with their

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subscribers to provide a standard of care that departs from prevailing norms.

Professional peer review of the reasonableness of fees raises obvious antitrust issues. In a 1982 decision, the Supreme Court held that the McCarran-Ferguson Act's antitrust exemption for the business of insurance does not extend to profession sponsored bodies engaged in reviewing fees for insurers, and the *Maricopa County Medical Society* case prohibited the promulgation of maximum fees.<sup>21</sup> On the other hand, the FTC has allowed local peer review committees to review fee disputes between insurers and physicians on an ad hoc basis as long as insurers are free to adopt other approaches to solving their cost problems.<sup>22</sup>

Peer review of the appropriateness of care (and thus its eligibility for reimbursement) is also open to antitrust challenge. A strict reading of the antitrust laws, along the lines of *Maricopa County*, would invalidate the promulgation by a dominant professional organization of practice standards that effectively limit the output of medical services. In this case, however, federal legislation specifically authorizes "peer review organizations" (PROs) and requires them not only to review Medicare and Medicaid claims but also to make their "facilities and resources" available to private payers.<sup>23</sup> Nevertheless, this statute does not clearly authorize PROs to accept delegation of insurers' responsibility for generally defining the coverage of their health plans. For this reason, dominant professional organizations should probably be advised to confine themselves to providing administrative services and advice on request and to avoid assuming responsibility for economic decisions of the kind that antitrust law requires be made on a decentralized basis.



## CONCLUSION

The federal appeals court in the 1943 AMA case said of the medical society defendants, "Appellants are not law enforcement agencies ... and although persons who reason superficially concerning such matters may find justification for extra-legal action to secure what seems to them desirable ends, this is not the American way of life."<sup>24</sup> Antitrust law today appears to do no more than to embody this stricture against coercive extragovernmental action and to require powerful professional organizations to refrain from dictating, as government regulators might do, the pricing or clinical practices of physicians, the reimbursement and other policies of private financing plans, the nature of personnel and other system inputs, or the kinds of information that consumers may receive. In accordance with "the American way of life," however, the medical profession remains free to express its authoritative views, however influential they may be, on quality of care and other matters. In particular, the accrediting of hospitals and training programs and the credentialing of health care personnel, if undertaken under the proper auspices, are not only unobjectionable practices but can be positive contributions to the quality of care and the efficient operation of the health care marketplace.

There is no question that more vigorous enforcement of the antitrust law poses unfamiliar hazards to professional groups and requires a rethinking of the medical profession's position in the larger scheme of things. But even though decisionmaking responsibilities are shifting away from the organized profession, the finest aspects of medicine's traditions are not likely to be impaired. One should expect the medical profession, even faced with new necessities, to continue to stand for the highest professional standards and to assist the nation in resolving the difficult ethical dilemmas and practical trade-offs with which medical care inevitably abounds.

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19. *See* note 16 above.
20. Havighurst, *Decentralizing Decision Making: Private Contract versus Professional Norms*, in *Market Reforms in Health Care* 22 (J. Meyer ed. 1983).
21. *Union Labor Life Ins. Co. v. Pireno*, 102 S. Ct. 3002 (1982).
22. "Peer Review Plan for Resolving Fee-Related Disputes," FTC Advisory Opinion to Iowa Dental Association, 99 FTC 648 (1982).
23. 42 U.S.C.A. § 1320(c)-1320(c)(12) (West Supp. 1982).
24. *AMA v. United States*, 130 F.2d 223, 249 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943).



# Testimony before the Committee on Labor and Human Resources, U.S. Senate, July 10, 1984, Patricia M. Danzon

I am a Ph.D. economist, specializing in the application of economics to evaluate public policy, particularly health policy. I have worked on health policy at the Rand Corporation, at the Hoover Institution at Stanford University, and now at the Center for Health Policy at Duke University, where I also teach economics and health policy. For the last few years, the major focus of my research has been medical malpractice. The medical malpractice system we have today is designed to perform two functions: deterrence of medical negligence and compensation of its victims. As an economist, my concern is with the efficiency or cost-effectiveness of this system, from a social standpoint. In order to understand how the malpractice system actually operates in practice, to distinguish fact from allegation, and to evaluate proposals for reform, I have undertaken several detailed empirical studies of the disposition of malpractice claims, the determinants of claim frequency and severity, the effects of the tort reforms enacted in response to the last crisis, the causes of that crisis, and the operation of malpractice insurance markets. My findings are the subject of a forthcoming book on public policy towards medical malpractice.

Today I would like to make five points:

1. The malpractice system is costly and imperfect but these defects are often exaggerated.

2. The cost of malpractice—the real social cost of the injuries due to medical negligence—is many times



Patricia M. Danzon

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*The malpractice system is costly and imperfect but these defects are often exaggerated.*

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greater than the more visible costs of malpractice insurance premiums and wasteful defensive practices. Therefore in considering reform, we should be at least as concerned about the deterrence of malpractice as about the cost of malpractice claims.

3. The current negligence or fault-based approach is worth retaining as a system of quality control—a deterrent to malpractice.

4. The malpractice system can be made more efficient by several specific reforms, which I shall discuss.

5. A no-fault approach such as that embodied in S.2690 could be a disaster. Restructuring the medical liability system solely to provide more extensive compensation is not worthwhile. Compensation can be achieved more efficiently and more equitably through existing insurance programs. Let me now elaborate on each of these points.

## 1. DEFECTS OF THE MALPRACTICE SYSTEM ARE EXAGGERATED

*Malpractice Insurance.* The allegation that malpractice insurance is a major factor driving the high and rising cost of health care is exaggerated. Between 1975 and 1982 malpractice insurance premiums rose roughly 73%, while the cost of physicians' services rose 92% and the cost of a hospital room rose 130%. Overall, malpractice insurance premiums account for around 1% of the \$350 billion health care bill. For physicians, malpractice insurance premiums average around 3% of their gross income, ranging from 1-2% for general practitioners to 5-6% for high-risk surgical specialties. These percentages have increased only slightly since 1970.

The recent round of increases in malpractice insurance rates follows several years of little or no increase.



There is currently no lack of availability of insurance except in states where rates are heavily regulated to levels insurance carriers deem inadequate for the risks involved. Similarly, the availability crisis of the mid-sev-

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*The medical malpractice system we have today is designed to perform two functions: deterrence of medical negligence and compensation of its victims.*

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enties was largely the result of regulation. Price controls in any market discourage supply and lead to shortages. The only difference in insurance markets is that the resulting shortage is called an availability crisis.

*Defensive Medicine.* Defensive medicine is rarely precisely defined and has never been reliably estimated. I shall define as defensive medicine any waste of resources (net excess of costs over benefits) that results from physicians changing their practice patterns in response to the threat of liability. There is no doubt that many tests and treatments are performed which are not cost-effective—the costs exceed the expected benefits. But most of this is not defensive medicine. It is the result of the incentives for overutilization built into our traditional fee-for-service system of health insurance. Prospective payment or capitation-based reimbursement for health care, which reverse the financial incentives facing providers, would do far more to eliminate excessive utilization than would abolition of liability for malpractice.

On the other hand, some physician behavior that is correctly ascribed to the liability threat is not pure waste. Spending more time with patients, referring difficult cases—these are precisely the types of increased care which the malpractice system is intended to encourage.

*An erratic lottery?* The allegation that the tort system is an erratic lottery is exaggerated. My analysis of the disposition of malpractice claims shows that the courts and the settlement process follow the legal precepts of negligence law to a fair degree. Over 90% of claims are settled out of court. Two-thirds are closed within two years of filing. On average, claims settle for 74% of their potential verdict (the expected award, had the plaintiff pursued the case to verdict and won). Some of the tort reforms enacted in response to the last crisis have indeed made a difference. In particular, caps on awards and mandatory reduction of awards by the amount of collateral benefits have significantly reduced verdicts and settlements in states that enacted such changes. In general, one obtains a very biased perception of

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*Restructuring the medical liability system solely to provide more extensive compensation is not worthwhile.*

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the malpractice system as a whole from the few highly publicized but atypical cases that win huge jury verdicts. These cases are litigated precisely because they involve unusually difficult issues and severe loss.

**2. THE REAL COST OF MALPRACTICE**

The visible costs of the malpractice system—insurance premiums, defensive practices—are small compared to the less visible but far larger costs of malpractice—the injuries that occur due to medical negligence. A 1974 study by the California Hospital Association and California Medical Association showed that roughly one in 126 hospital admissions results in an injury due to medical negligence.<sup>1</sup> I estimate that at most one in 10 of these injured patients filed a claim, and at most one in 25 received compensation

through the tort system. A rough estimate of the cost of these injuries is \$24 billion, or 10 times the cost of malpractice insurance premiums. It is surely worth incurring some expense to reduce this incidence of injury due to negligence.

**3. MALPRACTICE AS A SYSTEM OF QUALITY CONTROL**

Unfortunately we cannot measure the deterrence benefits of the malpractice system—the injuries that are avoided because the threat of liability makes physicians and hospitals more careful. But one can make some rough calculations of the amount of deterrence necessary to justify the additional costs of litigating over fault. Ignoring defensive medicine, I estimate that if the incidence of negligent injury would be at least 4% higher, were it not for the threat of liability, the malpractice system pays for itself. The extra costs of litigation are offset by the savings in injuries prevented. Even if we triple the estimate of cost to allow for defensive medicine, only a 12% reduction in the incidence of negligent injury is required to justify the tort system. If such estimates do not strike you as implausible, the fault-based approach is worth retaining.

It is often argued that the malpractice system does not and cannot deter because what is called malpractice is typically error of judgment that would not be avoided by being more careful. This claim is belied by

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*The current negligence or fault-based approach is worth retaining as a system of quality control.*

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the evidence. The California study concluded that problems of performance, rather than purely judgmental issues, were overwhelmingly responsible for the medical injuries that occur in hospitals. Similarly, improper performance is the most common allegation in malpractice claims.



Admittedly there are other mechanisms of quality control—licensure and accreditation, peer review, etc. They serve a useful function. But they cannot monitor every

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*Prospective payment or capitation-based reimbursement for health care... would do far more to eliminate excessive utilization than would abolition of liability for malpractice.*

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patient-physician encounter. The advantage of the tort system is that it provides a continual, ongoing system of "regulation by incentives." And it does not rely on enforcement by the medical profession which, like any other profession, is notoriously reluctant to police its own members. To illustrate, in California in 1976, there were 1,500 paid malpractice claims, but only six disciplinary actions for incompetence or gross negligence.

#### 4. REFORMS

The tort system could be improved by the following reforms:

*Awards* (i) Scheduled awards for economic loss only. Awards for damages should be restructured to resemble more closely the insurance people buy voluntarily. After all, in its compensation function, the tort system is simply a form of compulsory insurance, which we are all required to buy when we buy health care. When faced with the choice—and the bill—most of us do not buy insurance against pain and suffering. The tort system should provide compensation for loss of earning capacity (after tax) and for reasonable medical expenses, rehabilitation, and other monetary costs. Pain, suffering, and other nonmonetary losses are very real losses, but money cannot

replace them. That is precisely why most of us do not choose to insure against them, and the tort system should not force us to.

Payments should be based on a schedule, as in workers' compensation, not determined on an individual, case by case basis. Individualizing awards encourages expenditure on litigation, is inefficient insurance, and adds nothing to deterrence. Payment according to a schedule, based on age and injury severity, is superior to the single ceiling or cap which some states have enacted. Such a uniform limit tends to hit hardest the young, severely injured plaintiff, who has the largest economic loss.

Note that although reforms of this type are usually advocated as part of a no-fault system, that is not a necessary connection. These changes make sense on grounds of economic efficiency, while retaining the fault-based liability rule. A federal model

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*The advantage of the tort system is that it provides a continual, ongoing system of "regulation by incentives."*

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bill proposing such changes for all branches of tort law, not just medical malpractice, could contribute to overriding the constitutional objections to limiting awards solely for the victims of medical malpractice.

(ii) No reduction in the tort award on account of other, collateral sources of insurance coverage. But all private health and disability insurers should have rights to seek reimbursement (subrogation) for expenses they incur. Payments under public programs—Social Security Disability Insurance, Medicare, and Medicaid—should be reduced by the amount of the tort award. This would eliminate double compensation while transferring the cost of the injuries to the parties responsible. Such "internalization" of costs is essential for deterrence.

(iii) Periodic payment for permanent injuries, through an annuity or trust fund set up by the defendant at time of settlement. This should revert to the defendant (or his insurer) in the event of early death of the plaintiff, minus reasonable payment to his estate. Note that although the payment should be periodic, the amount should be determined at time of settlement. Periodic payments that are contingent on expenses actually incurred create inefficient incentives to delay rehabilitation and to incur unnecessary expenses.

(iv) An uninsurable fine on the physician or hospital, in cases of severe injury due to gross negligence. This uninsurable fine would replace punitive damage awards. The fine should be paid to the state and used to defray the public costs of the courts.

*Statute of limitations.* I advocate a short statute of limitations—say, three years for adults, ten years for minors—running from the time of the injury, not from its discovery. (Such a statute is also often called a statute of repose.) The reason is that with rapidly changing technologies, volatile legal rules and social standards, a long statute of limitations exposes physicians to a severe risk of retroactive application of standards that were not relevant at the time care was delivered to the patient. Such retroactive application of new standards serves no useful deterrent function, is inequitable, is inefficient

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*Awards for damages should be restructured to resemble more closely the insurance people buy voluntarily.*

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insurance, and has contributed very significantly to the cost of malpractice insurance and to disruptions in malpractice insurance markets.

*Standard of Care.* The standard to which the physician is held is the "customary practice of physicians in



good standing." Unfortunately, customary practice is not necessarily efficient practice because of incentives created by excessive health insurance and fee-for-service reimbursement. There is movement underway

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*A long statute of limitations exposes physicians to a severe risk of retroactive application of standards that were not relevant at the time care was delivered to the patient.*

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towards more cost-effective modes of health care delivery, as the private sector and the public programs experiment with HMOs, prospective payment, preferred provider networks, etc. If these efforts are to succeed in eliminating inefficient practice patterns, they must not be held to the customary norms of traditional fee-for-service medicine. If a physician can show that performing—or omitting—a procedure is justified after weighing the costs, the risks, and the benefits, this should be recognized as a defense against a malpractice claim.

*Contracting out.* The tort system mandates a rule of liability, a standard of compensation, and a system of dispute resolution that may well exceed what patients would be willing to pay for, if given the choice. If physicians, hospitals, insurers, and patients enter into contracts that provide for alternative standards of compensation or methods of dispute resolution, such contracts should be honored by the courts, as explicit evidence of the preferences of the parties involved. Some private contracting already exists—for example, some HMO contracts provide for binding arbitration. However, federal legislation explicitly authorizing and establishing guidelines for valid contracts would encourage contracting

out, by resolving the ambiguity as to their legal status.

**5. NO-FAULT COULD BE A DISASTER**

A comprehensive no-fault approach to compensation for medical injury would degenerate into an extremely costly and inefficient system of national health and disability insurance. It would be a disaster.

The quasi-no-fault bill currently before Congress (the Alternative Medical Liability Act, S.2690) has some of the same problems, if to a lesser degree. Under this bill, a defendant could foreclose a civil action by offering to settle, on a no-fault basis, for the amount of the plaintiff's monetary loss and reasonable legal fees, less compensation payable from collateral sources.

If malpractice defendants or their insurers routinely made settlement offers on a no-fault basis, as the bill intends, any patient who suffers an

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*Federal legislation explicitly authorizing and establishing guidelines for valid contracts would encourage contracting out.*

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adverse health outcome could file a claim, whether or not negligence had occurred. The number of claims filed could increase at least fifty-fold. This estimate of the potential increase, based on the California data on medical injuries, makes no allowance for invalid claims, i.e., claims involving incomplete cure despite the best possible medical care. In fact, I suspect that defendants would frequently not offer to settle but would incur the expense of litigation in order to stop the potential avalanche of claims that would occur if settlement were automatic. Thus whether the bill would in fact deliver the promised benefits of fairer and more prompt settlement for more people is far from certain.

Several of the goals of S.2690 could be better achieved by the tort

reforms outlined above. As I argued earlier, eliminating payment for non-monetary loss need not be tied to a no-fault liability rule, nor should it be confined to cases that settle out of court, as S.2690 proposes. Scheduled awards for monetary loss would not only eliminate wasteful compensation, but would also reduce incentives for litigation and delay, and reduce insurance risk. Prompt settlement could be further encouraged by requiring that the defendant pay pre-judgment interest at prevailing market rates, from the date of filing to settlement.

While the benefits of a quasi-no-fault bill are uncertain at best, S.2690 would add costs in at least three important ways.

First, the proposal to pay future expenses as they accrue is an open invitation for plaintiff delay in rehabilitation and for litigation over what constitutes reasonable expense.

Second, waste due to defensive medicine may well increase. Even if the stigma of fault is removed, the physician or hospital still incurs an expense in settling a claim and therefore has an incentive to avoid high-risk patients or procedures. Physicians' incentives to avoid high-risk situations would be greatest in the case of uninsured and underinsured patients—those with chronic problems, newborns, the poor and the elderly who have exhausted their

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*Social Security Disability Insurance, Medicare, and Medicaid already provide a very substantial safety net for those without adequate private insurance.*

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Medicare coverage—because the defendant pays only for monetary loss not covered by other insurance.

Finally, if the quasi-no-fault system operated as intended, it would effectively act as a form of national catas-



trophic health and disability insurance. This is not the place to discuss the merits of a national catastrophic insurance program. Suffice it to say that if we opt for such a system, it should be operated and funded as a separate program, not as an add-on to the medical liability system. In fact, Social Security Disability Insurance, Medicare, and Medicaid already provide a very substantial safety net for those without adequate private insurance. If our concern is compensation, we would do better to close the holes in this net of programs

which serve everyone, rather than devise an expensive add-on program confined to the victims of medical injury.

In conclusion, I believe that the fault-based malpractice system, reformed along the lines I have sug-

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*The extra costs of litigation  
are offset by the savings in  
injuries prevented.*

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gested, is worth retaining as a deterrent to medical negligence. For purposes of additional compensation, we already have extensive private and public health and disability insurance programs. If this security net has gaps, they should be closed, but not partially patched through the medical liability system.

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1. Report on the Medical Insurance Feasibility Study, California Medical Association and California Hospital Association, Sutter Publications, Inc. (1977).



# Testimony before the Committee on Labor and Human Resources, U.S. Senate, July 10, 1984, Clark C. Havighurst

Mr. Chairman, my name is Clark C. Havighurst. I am a professor of law at Duke University with academic interests in antitrust law and economic regulation of business. Since the late 1960s, I have directed the Program on Legal Issues in Health Care at Duke and have studied and written about health care issues. Many of my writings have advanced the view that we have relied too heavily on government and not enough on the competitive marketplace to guide health care developments. I have also written about alternatives to traditional tort law mechanisms for compensating victims of medical accidents and ensuring the quality of care.

In these remarks, I want to consider the problem of medical malpractice from the general perspective of national health policy. By viewing the problem in this fashion and not in isolation, I hope to call attention to a new way in which it might be attacked. Specifically, I wish to argue that the new competitiveness of the health care industry—fostered through such federal policies as encouragement of prepaid health plans and aggressive antitrust enforcement—has opened exciting possibilities for private, as opposed to judicial and legislative, reform of the rules that govern liability for injuries suffered by patients in the course of medical treatment. Although law professors and economists have frequently suggested that health care providers and consumers should enter into contracts creating

rights and remedies that differ substantially from those established by courts and legislatures, this way of attacking the problem has remained largely an academic idea. The time has now come, it seems to me, for the health care industry, and ultimately the courts, to recognize that tort law as laid down by courts and legislatures is not necessarily the final word. Instead, tort law should be seen as governing only in the absence of a negotiated arrangement. Although questions may be raised about the enforceability of particular contracts altering patients' rights, it seems to me that courts should be generally receptive to private parties' efforts to escape the burdens imposed upon them by existing law.

In this statement, I will first show how changed industry conditions have made it feasible and acceptable to contemplate private initiatives to

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*Courts should have an open mind when they are asked to enforce a private contract that purports to alter the liability rules prevailing between health care providers and their patients.*

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redefine rights and responsibilities associated with medical accidents. Then I will summarize some reasons for thinking that the legal system has not found the best, or even a satisfactory, way to protect consumers against the risk of injury and to motivate providers to provide care of appropriate quality. Finally, I will suggest some ways in which health care providers and consumers might improve upon the legal system's effort.

Courts should certainly hesitate before enforcing a liability-limiting contract that a patient—usually with the benefit of hindsight following some injury—later regrets having entered into. Nevertheless, they should avoid being too hard to convince that such a contract was fairly negotiated and served the interests of consumers as well as providers. Because the new competitive environment gives consumers new opportunities for informed choice of health plans and providers and new help in bargaining with provider interests, the need for judicial vigilance against provider overreaching is lessened. I have argued in a recent article that courts should have an open mind when they are asked to enforce a private contract that purports to alter the liability rules prevailing between health care providers and their patients. Havighurst, "Decentralized Decision Making: Private Contract Versus Professional Norms," in J. Meyer, ed., *Market Reforms in Health Care* ch. 2 (American Enterprise Institute for Public Policy Research, 1983). A copy of this



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*Courts should be generally receptive to private parties' efforts to escape the burdens imposed upon them by existing law.*

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article has been submitted for the hearing record.

**I. THE APPEARANCE OF COMPETITION IN THE HEALTH CARE INDUSTRY HAS CREATED NEW OPPORTUNITIES FOR CONSUMERS TO ESCAPE THE LEGAL SYSTEM'S MONOPOLY OVER THE MAKING AND ADMINISTRATION OF LIABILITY RULES.**

More than anything else, the appearance of active competition in the health care sector is the circumstance that makes it possible now to contemplate private solutions to the problems posed by tort law for medical care providers and their patients. In the era when the current law of medical malpractice took shape, consumers were seen as having no real options in the marketplace and no capacity to exercise choice. It was therefore natural for the law to prescribe duties and for courts to be suspicious of attempts to set aside the law's prescriptions. Under the old assumptions, it was also natural for the law to look to the medical community for standards of care and to enforce professional norms of conduct without questioning their appropriateness or cost-effectiveness. Under the old circumstances, tort law was essentially prescriptive and regulatory, imposing substantial sanctions for departures from accepted processes whenever a bad result occurred.

The old situation was, of course, essentially monopolistic. Health care was generally thought of as the product of a unitary "system" in which consumers had little choice,

professionals set their own standards, third-party payers unquestioningly supported professional habits, and tort law rigorously enforced adherence to the system's norms. Recently, however, profound changes have begun to occur both in the structure of the industry and in our ways of thinking about health care. As we have begun to recognize that we live in an era of limits, even for medical care, alternatives to the previously dominant style and methods of practice have begun to seem acceptable. Although it is still hard to acknowledge it explicitly, we are gradually accepting the fact that we can't have it all, that the highest quality is not necessarily worth its high cost, and that trade-offs must be made. The belief that the same high standards should prevail everywhere, though still widely professed, is more and more seen as unrealistic, and emphasis is being placed instead on raising standards where they are unacceptably low. Decisionmaking is being decentralized, thus opening up innovation possibilities that were previously foreclosed.

In these new circumstances, there is less reason to assume that there is one right way to treat patients. It should also appear that there may be more than one right way to redress medical injuries. Now that we have accepted alternatives to the dominant system of medical care, it seems a logical next step to look to HMOs and competitive medical plans of other kinds to offer consumers alternatives to the dominant legal system. Indeed, the key benefit of deregulat-

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*As we have begun to recognize that we live in an era of limits... alternatives to the previously dominant style and methods of practice have begun to seem acceptable.*

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ing the health care industry, which more than compensates for the accompanying problems, is that it offers consumers a chance finally to escape the burdens of professional monopoly—not only the physicians' monopoly over the making of costly medical decisions but also the lawyers' monopoly over the costly business of making and administering rules governing liability for medical injury.

**II. THE EXISTING LEGAL SYSTEM IS VERY COSTLY, PROVIDES POOR PROTECTION FOR PATIENTS, AND MAY DISTORT INDUSTRY PERFORMANCE.**

There are not many good things that can be said about the existing legal system for handling medical malpractice. Its most apparent virtue is that it gives patients an opportunity they would otherwise lack to call doctors and hospitals to account for harms they cause through poor practice, and it is at least arguable that the availability of this powerful grievance mechanism causes health care providers to be more careful than they would otherwise be and more attentive to their patients as human beings. Although the coming of competition has given consumers more opportunities for choice and effective complaint than they previously enjoyed, there may still be a need for some public forum in which a patient can pursue his grievance to a decisive result and can see a meaningful sanction imposed on a negligent provider. Almost certainly, the reluctance of legislatures to make substantial changes in the law of medical malpractice has been attributable to a sense that patients should not be deprived of this basic right to seek redress for the serious harms that providers do, sometimes through culpable neglect.

Everything else that can be said about the law governing medical malpractice is negative. The following brief specification of the legal system's faults, summarizing what others have observed, adds up to a powerful indictment. Although these objections may not justify legisla-



tion repealing or greatly restricting patients' right to sue, they certainly suggest that both providers and patients could benefit substantially by entering into private contracts creating liability rules which differ from the rules created and administered by the legal system.

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*The key benefit of deregulating the health care industry... is that it offers consumers a chance finally to escape the burdens of professional monopoly.*

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(1) *Very high legal and administrative costs.* Judging negligence in the provision of medical care is often very difficult and expensive. As a result, much of the money paid as malpractice insurance premiums is absorbed, not in paying claims, but in deciding whether a particular loss should be shifted. Estimates of the portion of the premiums paid into the system that eventually goes to injured persons go no higher than 40 percent, meaning that at least 60 percent of the premiums collected go to pay lawyers and insurers for operating the system. (Costs of operating the courts are an additional and hardly negligible factor.) It might easily be judged that these high operating costs are not justified by any benefits the system yields in overcoming economic hardships and enforcing good medical practice. A system of compensation that was simpler to administer—that did not, for example, require a determination of fault in every case—could benefit many more injured patients without costing any more. Patients and providers might see an opportunity to cut out the lawyers and to use the savings to cover more injuries, to reduce fees or premiums, or to improve quality.

(2) *High psychic costs.* The emotional toll taken on both providers

and patients is unmeasurable but is very high. The acrimony of trials, the tensions introduced into doctor-patient relationships, and the burdens on patients awaiting adjudication of their claims have been remarked by many others. Many, though perhaps not all, individual providers and patients will see substantial value in escaping from such a system into one with fewer adversarial features.

(3) *The haphazard incidence of compensation.* Many injured patients go uncompensated even when their injuries were actually caused by negligence; a few patients are compensated extravagantly. A review of the numerous reasons why some potential lawsuits are brought while many others are not leaves the impression that the system is not serving any clear function well. Instead, like lightning, it seems to strike almost at random. There would seem to be a great deal of room for improving patients' financial security by increasing the number of patients compensated while reducing the level of payment to more closely approximate real economic losses.

(4) *Perverse incentives.* Although the tort system is expensive to administer, there is always the possibility that its cost is justified by the behavior it induces. But there is good reason to believe that the liability system, whatever good it does, also promotes a great deal of uneconomic and undesirable behavior. Although "defensive medicine" is difficult to define and identify, unnecessary testing and overutilization of health care resources do occur and seem in some degree to reflect providers' desire to be protected against accusations of negligence. Moreover, tort law enforces a standard of care drawn primarily from customary practice—did the doctor do what other doctors would do? Unfortunately, this standard of care is almost certainly an inefficient standard because it is derived by observing a market in which third-party payers unquestioningly foot the bills and physicians seek not only absolute safety for their patients but also protection against lawsuits for themselves. By

using customary practice as a reference point for imposing liability, the legal system appears to restrict opportunities for even the most responsible economizing, thus forcing the public to bear unnecessarily high health care costs. Private agreements altering liability rules would seem to have great potential for improving the climate for efficient behavior.

**III. THERE ARE NUMEROUS WAYS IN WHICH PRIVATE CONTRACTS BETWEEN PROVIDERS AND PATIENTS COULD IMPROVE UPON THE EXISTING LEGAL SYSTEM.**

Although the foregoing defects in the existing legal system are hard to compare to any benefits that the system may have in raising the quality of care to appropriate levels, they certainly provide a solid basis for thinking that there is room for improvement. Because legislative changes are inhibited by interest-group politics and uncertainty about precisely what to do, private avenues of change are worth exploring. Providers and consumers interacting in a competitive market would appear to have an excellent opportunity to negotiate new arrangements that, by avoiding heavy legal and administrative costs and lifting the heavy penalties on responsible cost containment, could benefit everyone directly concerned. Only trial lawyers would have reason for complaint. Even patients who later suffer some injury that would have entitled them to a huge award

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*There may still be a need for some public forum in which a patient can pursue his grievance to a decisive result and can see a meaningful sanction imposed on a negligent provider.*

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may be seen as beneficiaries of the earlier decision to rule out such recoveries.

The following paragraphs suggest some specific ways in which private health care plans and individual hospitals and physicians might agree with consumers on a different set of

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*At least 60 percent of the premiums collected go to pay lawyers and insurers for operating the system.*

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rules governing what happens when a patient suffers an injury in the course of treatment:

(1) *Changing the forum.* HMOs in California have already been allowed to require arbitration of claims for medical malpractice. Such arbitration agreements may be entered into before an injury occurs, and plaintiffs have been held bound by arbitration clauses negotiated by their employers on their behalf even when they did not actually know that their right to a jury trial had been restricted. In such cases, it appeared to be important that the employee also had the option (through "dual choice") of choosing another form of financial protection which would have maintained his traditional legal rights. In addition to arbitration clauses, one can also imagine provisions that would limit the bringing of malpractice suits that have not been previously approved by a screening panel of some kind. Such methods for foreclosing frivolous claims are similar to those adopted in some state legislation and would provide some protection to providers without preventing clearly meritorious actions.

(2) *Limiting recoveries.* Just as some states have sought to limit malpractice recoveries, private parties might do the same. Although the agreement might set a flat dollar limit, it would probably be preferable to provide that a plaintiff could recover his full economic losses but

not for pain and suffering or amounts reimbursed from collateral sources; a possible variation might provide an additional amount out of which the patient could pay his attorney's fees. Even though such limitations on recoveries might appear to benefit only the provider and not the patient, the lesser exposure to liability risks might well translate into lower fees and health plan premiums.

(3) *Altering the standard of care.* Because malpractice law appears to require that physicians adhere to customary practice in their community, opportunities for responsible economizing are restricted. As a result, a health plan or provider might wish to specify by contract a commitment to abide by a different standard. For example, an HMO might contract to be bound, not by community standards, but by the standards of other HMOs. Alternatively, the HMO's subscriber contract might preserve a

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*The system is not serving any clear function well.*

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right to depart from customary standards in good faith where medical literature supported the HMO's judgment and its subscribers were consulted on the decision to adopt different methods. Avoidance of dubious claims might also be accomplished by contracting to limit liability to those cases in which gross negligence or an intentional act or omission could be proved.

(4) *No-fault alternatives.* As a substitute for patients' rights under the tort system, a provider or organized health plan might provide for automatic compensation for certain designated compensable events. Some years ago Dr. Laurence Tancredi and I proposed such a no-fault system that would be financed through provider-purchased insurance. See Havighurst & Tancredi, "'Medical Adversity Insurance'—A No-Fault Approach to Medical Malpractice and Quality Assurance," 613 *Insurance Law Journal* 69 (February, 1974); see

also Havighurst, "'Medical Adversity Insurance'—Has Its Time Come?," 1975 *Duke Law Journal* 1233. A study by a commission appointed by the American Bar Association confirmed the desirability and feasibility of such a compensation system. ABA Commission on Medical Professional Liability, *Designated Compensable Event System: A Feasibility Study* (1979). Although a compensation system along these lines could be created by statute, it might also be implemented by private contract. In addition to protecting patients, such a no-fault compensation system preserves strong incentives to avoid adverse outcomes.

(5) *The Moore-Gephardt (O'Connell) strategy.* Private contracts might also provide for limitations on malpractice claims that are similar to those currently embodied in H.R. 5400, the Alternative Medical Liability Act introduced by Congressmen Moore and Gephardt. This proposal, embodying ideas first advanced by Professor Jeffrey O'Connell, would permit a provider to foreclose a lawsuit for medical injury by tendering the patient's net economic loss. See O'Connell, "Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses," 77 *Northwestern University Law Review* 589 (1982). Whatever the desirability of legislation implementing this promising idea, it is worth recognizing that it might also be implemented privately.

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*In addition to arbitration clauses, one can also imagine provisions that would limit the bringing of malpractice suits that have not been previously approved by a screening panel.*

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(6) *Exculpatory clauses.* The most extreme form of private agreement altering patients' rights to compensation for medical negligence is an exculpatory clause, by which the patient entirely surrenders his right to sue. Although clauses of this type have been struck down by the courts from time to time, a case can be made for enforcing them. See Epstein, "Medical Malpractice: The Case for Contract," 1 *American Bar Foundation Research Journal* 95 (1976). In any event, it should be clear that judicial resistance to enforcing contracts of this extreme type does not control the enforceability of agreements of other kinds.

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*The new competitiveness of the health care industry makes private solutions to this problem thinkable for the first time.*

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Mr. Chairman, these remarks are meant only to highlight some new possibilities for relieving the serious burdens that are imposed on patients and providers alike by medical malpractice and the legal system's cur-

rent methods for dealing with it. The new competitiveness of the health care industry makes private solutions to this problem thinkable for the first time. I am currently in the process of organizing a major national conference to be held next winter at which we hope to explore the private sector's potential role in solving these difficult problems. I hope that members of Congress, while continuing to consider the federal government's role in addressing these issues, will share my hopefulness about initiatives in the private sector. Any encouragement that this committee can give to such initiatives would be highly beneficial.



# The "Squeal Rule": Unconstitutional Burden on Minors' Decisions About Contraception

*Brenda Hofman\**

Since the landmark case of *Skinner v. Oklahoma*, 316 U.S. 535 (1942), the United States Supreme Court has had continuing occasions to consider the rights of individuals arising out of sexual activity, and the extent to which these rights may be permissibly infringed by state and federal government. The individual's right to make personal decisions regarding abortion and contraception free from government intrusion derives from a broad and fundamental right of privacy, which the Court has consistently recognized in these contexts.

Over time, individual privacy interests have become broader in response to changes in moral climate. Lawmakers have resisted these changes by systematically responding with regulations designed to increase parental authority and curb sexual autonomy in an attempt to maintain traditional values. In response, the Supreme Court has struggled over the last decade to carve out a standard for parental consent and notification requirements that reflects the delicate balance between the sanctity of parental guidance and the fundamental nature of the right to privacy.

The latest of these regulatory "missions" into the "vexed and hotly controverted area of morality and prudence"<sup>1</sup> involves regulations promulgated by the Department of Health and Human Services ("DHHS") on January 26, 1983, mandating parental notification when unemancipated minors seek prescriptions for contraceptives from federally funded family planning clinics. Popularly known as the "Squeal Rule," the regulation was designed to promote parental involvement in the minor's contraceptive decision.

On January 26, 1983, the DHHS, pursuant to its authority under Title X of the Public Health Service Act, amended the regulations governing the family planning services program. The new rules, which have generated "a great whirlwind of public controversy," contain three main provisions: (1) federally funded family planning facilities must notify the parent or guardian of an unemancipated minor receiving prescription contraceptives within ten days of their provision; (2) the facilities must comply with any existing state laws requiring



*Brenda Hofman*

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*The "Squeal Rule"... was designed to promote parental involvement in the minor's contraceptive decision.*

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parental notification or consent for the provision of contraceptive services to minors; and (3) in order to satisfy the low-income test for eligibility to receive services on a confidential basis, minors must now be evaluated on the basis of their parents' resources.

Even before the regulation was published in final form, institutional family planning recipients of Title X funds filed actions in federal district courts in four states to enjoin their enforcement. On February 8, 1983, federal courts in New York and the District of Columbia issued injunctions prohibiting the enforcement of the



regulation on the grounds that by *mandating*, rather than unobtrusively encouraging family involvement, the regulation contravened the clear congressional intent underlying Title X to halt the epidemic of teenage pregnancies, and was therefore promulgated in excess of DHHS' delegated authority.

*State of New York v. Schweiker*<sup>2</sup> and *Planned Parenthood Federation of America v. Schweiker*,<sup>3</sup> decided on the same day, articulated the judiciary's disapproval of the DHHS regulation a mere two weeks after its promulgation. Although the regulation was designed "to implement [the] 1981 amendment to Title X<sup>4</sup> to encourage, to the extent practical, family participation in the provision of [family planning] services," both courts reasoned that the mandatory notification requirement would actually undermine the legislative goal of Title X to "stem the increase in unwanted births and pregnancies," especially among teens.

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According to the courts, statistical evidence and logic indicated that the regulation's intrusive notification requirements would *deter* adolescents from using the Title X clinics. Unfortunately, while the "squeal rule" and its counterparts would certainly result in a significant decrease in contraceptive use by teenagers, it would not be likely to deter their sexual activity. Most adolescents denied access to Title X services would be unable to obtain adequate sources of contraceptive care because of the prohibitively high cost of obtaining prescription contraceptives from a private physician,<sup>5</sup> and because nonprescription contraceptives, which may be obtained relatively inexpensively from a drugstore, are "significantly less effective than prescription contraceptives."<sup>6</sup>

The courts thus concluded that the deterrent effect of the regulations would yield an inevitable result: a significant increase in teenage pregnancies, precisely the problem sought to be avoided by Congress through its Title X policies. This finding was supported by overwhelming evidence estimating the number of additional pregnancies, abortions, and births that would occur among adolescents due to changes in contraceptive use which were expected to result from the regulation:

In one year, an additional 33,000 adolescents aged 17 or younger would become pregnant, resulting in 14,000 abortions, 9,000 out-of-wedlock births, and 4,000 miscarriages. The long term adverse social and economic effects of births to women in this young age-group, especially of unintended and out-of-wedlock births and of early, forced marriages, have been well documented.<sup>7</sup>

Because the only courts to consider the DHHS regulation thus far have invalidated it on statutory grounds (i.e., as promulgated in contravention of its authorizing statute and thus in contravention of the DHHS's delegated authority), no court has yet had the opportunity to address the constitutional issues which are concededly raised by the regulation. The constitutional questions, however, are far from moot because a reauthorized squeal rule withstanding statutory challenge would be subject to constitutional review.

The remainder of this essay will consider the constitutional implications of the "squeal rule." Despite extensive judicial and legislative treatment of the separate issues of parental notification and consent, minors' privacy rights, and government benefits, the "squeal rule" urges a unique consideration of the constitutional questions which necessarily arise when all of these areas *overlap* and interact.

#### A. THE RIGHT TO PRIVACY

It is well settled that a right of privacy and certain zones of personal privacy are protected under the Constitution. Individual freedom to make personal decisions regarding contraception is firmly established in the history of the right of privacy.

The irony that pervades the Supreme Court's line of cases recognizing the individual right to make contraceptive decisions, however, is its steadfast reluctance to acknowledge the right to engage in sexual activity which gives rise to these decisions in the first place. Logic dictates that the decision to engage in sexual activity precedes and is therefore implied in the decision to use a contraceptive. Thus, in *The Constitutional Status of Marriage, Kinship and Sexual Privacy*, 81 Mich. L. Rev. 463, 530 (1983), Hunter argues that "if there is a constitutional right to *prevent* conception there must be a right to cause conception."

The only clear guidelines the Court has offered to determine whether certain sexual activity is constitutionally protected require that the activity either occur in the context of the marital relationship or have procreative possibilities which give rise to a potential mother-child relationship. However, the fact that the Court has recognized a fundamental right to use contraceptives which facilitate *non-procreative* sexual activity implies that the procreative prerequisite for constitutional protection of ordinary heterosexual intercourse is invalid.

Assuming a constitutionally protected right to make certain personal decisions regarding one's sexual activity, it is necessary to determine whether this right applies with equal force to minors. The Supreme Court has consistently recognized that "a child, merely on account of his minority, is not beyond the protection of the Constitution."<sup>8</sup> More specifically, the Court has expressly held that "the right to privacy in connection with decisions affecting procreation extends to minors as well as to adults."<sup>9</sup>

While recognizing a minor's general right to consti-



tutional protection, however, the Court has nevertheless concluded in a variety of contexts that "the constitutional rights of children cannot be equated with those of adults." Broader restrictions on the rights of minors are generally justified as a means of protecting a minor against her own immaturity and imprudence.

## B. BURDENING THE RIGHT OF PRIVACY

By burdening a minor's decision to seek contraception free from unjustified government interference, the kind of mandatory parental notification requirement imposed by the squeal rule infringes the minor's constitutional right of privacy. The nature of the right of privacy implicated by such interference is two-fold: (1) The right to obtain and use contraceptives, and (2) the derivative right to engage in non-marital sexual activity, despite majoritarian morality.

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*The deterrent effect of the regulations would yield... a significant increase in teenage pregnancies.*

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The DHHS regulation at issue burdens a minor's right of privacy in two important ways. First, by imposing a mandatory parental notification/consent requirement on a minor's decision to obtain contraceptives from Title X clinics, and thus, on her decision to engage in sexual activity, the squeal rule unconstitutionally burdens the minor's right to make such personal decisions on her own.

Second, by requiring the minor to forfeit her constitutional right to make those decisions individually without parental involvement as a condition to receive the federally funded benefits of Title X, the DHHS regulation impermissibly burdens the right of privacy by attaching unconstitutional conditions to its exercise.

### 1. PARENTAL INVOLVEMENT IN THE DECISION-MAKING PROCESS

DHHS defended its current regulations in part on the grounds that there is no interference with the minor's personal decision because notification is required only *after* contraceptives have been obtained; the minor is not required, therefore, to include her parents in the actual decisionmaking process.<sup>10</sup> DHHS further argued that "[t]he parental notification requirement does not prevent a parent or guardian who receives a notice from refusing to become involved in any way in decisions about a child's sexual activities . . . [i]t merely provides the opportunity for participation if the parent elects to become involved." See Brief for the DHHS at 25-26, *Planned Parenthood Federation of America v. Heckler*.

These arguments are defective for two reasons. First, the temporal distinction attempted by DHHS ignores the reality that the mere *threat* of unwelcome parental involvement in the minor's contraceptive decision is likely to have a significant deterrent effect on minors' use of Title X clinics. Second, by conditioning active parental involvement on the parent's choice to initiate discussion with his or her minor child, rather than on the teenager's preference, the regulation effectively undermines the minor's ability to choose to remain independent in the whole process.

## 2. UNCONSTITUTIONAL CONDITIONS

The squeal rule further infringes on the minor's right of privacy by conditioning her access to federally funded contraceptive services upon the forfeiture of her corresponding right to make contraceptive decisions independently. DHHS maintained that the right of access to contraceptives is unimpaired because Title X services remain readily available to those who are willing to tolerate the attached condition of parental notification.

It is well established that the decision whether or not to subsidize constitutionally protected activity "is a question for Congress to answer, not a matter of constitutional entitlement."<sup>11</sup> Once Congress chooses to fund such activity, however, "it may not impose conditions which require the relinquishment of constitutional rights."<sup>12</sup> In implementing Title X, Congress has chosen to subsidize the constitutionally protected activity of obtaining contraceptive care. Having done so, it must ensure that the subsidy is distributed in a constitutionally permissible way. By attaching certain "conditions" to eligibility for federally funded benefits, however, the DHHS regulation in effect exerts a coercive pressure on the teenager to choose between receiving contraceptives on the government's terms, or exercising her constitutional right to make a private decision—at the expense of those benefits. As such, the regulations seem to fall within that category of restrictions prohibited by the Supreme Court for penalizing the exercise of a constitutional right.

## C. STATE INTERESTS

### 1. PROTECTING THE WELFARE OF MINORS

The State's interest in protecting the welfare of its young people is well-recognized. The protective notion of the State as *parens patriae* is based in large part upon the doctrine of capacity which assumes that minors are unable fully to understand and consent to the consequences of certain decisions. In the interest of protecting a minor against her own immature and imprudent decisions, the State may impose considerable restraints.

As presently drafted, the DHHS regulation is unconstitutionally overbroad insofar as it seeks to protect minors from their own immature decisions. In the recognition that some minors are mature enough to understand the nature and implications of their deci-



sions, courts have evolved a "mature minor exception" to traditional judicial deference to parental authority. This exception has developed most notably in relation to parental consent requirements for medical treatment of minors.<sup>13</sup> Under the "mature minor exception," a minor may obtain medical care without parental consent if she can convince a court that she is sufficiently mature to act in her own best interests, and thus to make an independent judgment to consent to treatment. A judicial determination of maturity provides an alternative authorization for a minor to engage in a desired activity, even in the absence of parental consent. A finding of maturity on the part of the acting minor is consistent with the State's interest in eliminating the dangers incident to immature decision-making.

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### *A right of privacy and certain zones of personal privacy are protected under the Constitution.*

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This distinction between mature and immature minors is found in the Supreme Court's treatment of the right of privacy. Indeed, each of the Court's abortion decisions involving minors carefully limits the right of privacy according to the maturity of the parties seeking to forego parental involvement.

Despite these judicially recognized differences based on maturity, the DHHS regulation fails to distinguish between mature and immature minors. Rather, it applies generally to "unemancipated minors," which is further defined as "individual[s] . . . age 17 or under and . . . not, with respect to factors other than age, emancipated under State law." It is well-settled that, to withstand constitutional scrutiny, a burdensome regulation "must be narrowly drawn to express only the legitimate State interests at stake."<sup>14</sup> To the extent the regulation protects minors from their own immature decisions, the regulation applies *overbroadly* to many older unemancipated minors between the ages of 16-17<sup>15</sup> who regularly use contraceptive services and are likely to fall within the mature minor exception. The regulation operates as a blanket presumption of immaturity in contravention of the Court's insistence on a case-by-case determination of maturity.

The State may also claim that its interest in protecting the welfare of its minors is considerably enhanced, given the serious nature of the contraceptive decision and the potential risks associated with teenage pregnancy and abortion. To allow the serious importance of the decision itself to justify greater state interference, however, suggests that the State has a corresponding interest in "maximizing the probability that the decision [will] be made correctly."<sup>16</sup> This view is problematic because many of the reasons underlying greater state

interference are precisely the same reasons which make the decision so fundamental to the individual's freedom of choice. To permit these same concerns to justify the imposition of state-mandated standards of correctness, therefore, is to undermine the very essence of the right of privacy which guarantees individual autonomy to make personal decisions regarding procreative choices.

Even if this interest is regarded as a valid one, it is not immediately obvious that DHHS has made the correct choice by mandating parental involvement. In light of the statistical likelihood of increased pregnancy and abortion among teenagers under the current DHHS regulation, one might reasonably argue that sexually active minors who seek contraceptive protection are doing more to protect their own welfare than the State. Thus, the regulation appears inconsistently related to its goal of protecting the welfare of its minors.

## 2. INTERESTS RELATED TO PARENTAL INVOLVEMENT

Parental notification requirements reflect a state interest in ensuring that all the principal family players take part in the child's contraceptive decision-making process. The DHHS regulation, therefore, might be justified as an effort to engage sexually active minors and their parents in a meaningful dialogue in the interests of (1) encouraging a carefully reasoned decision by the minor through the contribution of parental experience, knowledge, and guidance, or (2) promoting positive family communication in general.

The extent to which state-mandated notification actually serves either goal of promoting intra-family communication or improving the quality of the minor's decisional framework, however, is questionable. In keeping with congressional intent that Title X services be provided to prevent unwanted adolescent pregnancies, a primary purpose of Title X clinics is to educate patients, particularly minors, about birth control methods, and the responsibilities and consequences of being sexually active.<sup>17</sup> Given the reality that many minors will not discuss their contraceptive decision with their parents or other adult figures, these practices are designed to ensure that the minor's decision is reasonably well-informed and poses no significant health risks. It seems unlikely, in most cases, that lay parental input can materially supplement expert medical information.

Proponents of family participation argue, however, that decisions involving teenage sexual activity, contraception, abortion, and pregnancy involve additional factors "much more profound than a mere medical judgment"<sup>18</sup> which a parent is best suited to address. While there may be some merit to this argument, it is premised on an assumption that parents will always respond rationally and in a helpful manner to the news of the child's sexuality. In reality, parents do not always respond in a manner that may contribute constructively to the minor's decision. Moreover, by requiring notification of parents only *after* the child has carried out her decision to obtain contraceptives (and, in many



instances, after she has become sexually active), the rule draws parents abruptly into the picture without establishing a framework in which to begin a useful dialogue. Finally, the fact that the minor has already chosen not to consult her parents may be symptomatic of a deeper schism between the parent and child that may make helpful parental input unlikely. Seen in this context, the squeal rule does not seem to bear a necessary or even a substantial relationship to the promotion of meaningful parent-child communication.

### 3. HEALTH INTERESTS

The State has its own interest in protecting the health of its citizens. Governmental attempts to regulate the use and distribution of contraceptives typically reflect a concern with regulating the consumption or use of hazardous substances.

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*[The regulation] is premised on an assumption that parents will always respond rationally and in a helpful manner.*

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It may be argued that the notification requirement furthers this interest—either by restricting the use of hazardous substances, or by minimizing the risks incident to their use through parental involvement. However, although the State's interest in protecting the health of its citizens may be compelling, the notification requirement does not further this interest.

First of all, the ability of lay parents to ensure the proper use of contraceptives beyond the instruction supplied by the clinics is significantly limited. Moreover, by restricting the availability of affordable contraceptive care, mandatory notification increases the risks incident to sexual activity without protection.

The mortality risk associated with teenage use of prescription contraceptives is extremely low. In fact, the estimated risk of death from use of virtually every method of birth control by teenagers is significantly lower than the same risk from unintended pregnancy which may result from no method. Contrary to popular myth, the Pill, which is prescribed to 95% of the mature minors who choose a prescription contraceptive at Title X clinics, carries the lowest risk of death of all contraceptives among non-smoking teenagers.

Besides posing only negligible health risks, some oral contraceptives have recently been found to carry significant health benefits, particularly among females who have not yet borne children.<sup>19</sup> Also, because the Pill has the lowest rate of failure of any method, it prevents against the risks associated with pregnancy. Because contraceptive failure rates tend to be higher

among teens and low-income women generally, it is especially important for highly effective methods to be affordably accessible to these groups.

Teenage pregnancy and childbirth, by contrast, pose significant risks to the physical and psychological health of the mother, including "a higher percentage of pregnancy and childbirth complications; a higher incidence of low birth weight babies; a higher frequency of developmental disabilities; higher infant mortality and morbidity."<sup>20</sup> Moreover, because almost 96% of unmarried adolescents who give birth choose to keep their babies, the emotional, social, and economic implications of teenage pregnancy are often far-reaching.

Thus, by restricting the availability of prescription contraceptives which are not only non-hazardous, but arguably beneficial, and by increasing the likelihood of teenage pregnancy with its attendant harms, the DHHS regulation may actually defeat the State's interest in the health of sexually active women.

### CONCLUSION

The constitutionality of mandatory parental notification as a condition to the distribution of contraceptives to unemancipated minors remains an open question in the Supreme Court. While the minor's interest in obtaining affordable and effective contraceptive services seems to override any concurrent concerns of the State, the Court has until now been reluctant to construe the privacy rights of minors too broadly. The "Squeal Rule," however, does little to keep these privacy interests in check. Rather, by sweeping too broadly in applying to mature as well as immature minors, and by failing to anticipate the inevitable consequences of its operation, the "Squeal Rule" undermines its own goals and any recognizable goals of society.

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*\*Third year student, Duke University School of Law. An amplified version of this piece appears as a Note in the Dec. 1984 issue of Duke Law Journal.*

1. Planned Parenthood Fed'n of America v. Heckler, 712 F.2d 650, 665 (D.C. Cir. 1983) (Bork, J., dissenting).

2. 557 F. Supp. 354 (S.D.N.Y. 1983).

3. 559 F. Supp. 658 (D.D.C. 1983).

4. Title X of the Public Health Service Act was created by Congress in 1970 to establish a system of federally funded public and nonprofit private family planning projects. In 1978 the title was amended to clarify the congressional intent that services be provided to adolescents for the prevention of unwanted pregnancies.

5. The average first-year costs of prescription methods of contraception obtained through a private physician, including both the costs of supplies and medical care, are as follows: pill—\$172; diaphragm—\$160; IUD—\$130. Excluding the possibility of subsequent office visits, the yearly costs after the first year taper off to approximately \$107, \$66, and \$95 respectively. Alan Guttmacher Institute: *Evaluating the Health Risks and Benefits of Birth Control* 21 (1983). Adolescent patients receiving the same supplies and services from family planning clinics, by contrast, pay nothing if they qualify as low income patients, or only a minimal fee, if not. It is not surprising, therefore, that 60% of adolescents surveyed preferred the clinic "because a doctor is too expensive." Planned Parenthood Fed'n of America v. Schweiker, 559 F. Supp. at 666, n.14.

6. Planned Parenthood Fed'n of America v. Schweiker, 559 F. Supp. at 666.

7. Torres, Forest & Eisman, *Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services* 291 (citing, *inter alia*,



Fustenberg, *The Social Consequences of Teenage Parenthood*, 8 Family Planning Persp. 148 (1976); Moore & Caldwell, *The Effect of Government Policies on Out-of-Wedlock Sex and Pregnancy*, 9 Family Planning Persp. 164 (1977); Baldwin & Cain, *The Children of Teenage Parents*, 12 Family Planning Persp. 34 (1980).

8. For a survey of the Supreme Court's "ad hoc adjudication of the various constitutional rights extended to minors," see generally Note, *The Minor's Right of Privacy: Limitations on State Action after Danforth and Carey*, 77 Colum. L. Rev. 1216, 1220 n.28 (1977).

9. *Carey v. Population Services Int'l*, 431 U.S. 678, 693 (1977).

10. DHHS contended that the notification requirement did not necessarily ensure parental involvement, but rather "provides [only] the opportunity for participation if the parent elects to become involved." Brief for DHHS at p. 26 (emphasis added). Even if one concedes this temporal distinction in the actual decision-making process, it acknowledges only a short-lived right of privacy. Contraceptive care commonly requires a continuing relationship with the physician in order to obtain prescription refills or to ensure that the diaphragm or IUD does not need refitting or replacing. Thus, even if a teenage girl can physically obtain some method of contraceptive not subject to her parent's approval during her first visit to the clinic, her parents' subsequent disapproval after being notified may significantly inhibit the likelihood of a second visit.

11. *Harris v. McRae*, 448 U.S. 297, 318 (1980).

12. *Id.* at 337 (Brennan, J., dissenting). See also *Sherbert v. Verner*, 374 U.S. 398, 406 (1963).

13. It has been suggested that sexual activity, accompanied by an awareness of the importance of contraception, may in itself be a sign of sufficient maturity to make contraceptive decisions.

One can well argue that an adolescent old enough to make the decision to be sexually active . . . , and who is then responsible enough to seek professional assistance for his or her problem, is ipso facto mature enough to consent to his own health care.

Hofmann, *Consent and Confidentiality and Their Legal and Ethical Implications for Adolescent Medicine*, in *Medical Care of the Adolescent* 42, 51 (J. Gallagher, F. Heald & D. Garrell eds. 3d ed. 1976). On the other hand, the opposite conclusion may nevertheless justify judicial consent as a protective measure in the minor's best interests:

The sexually active 15-year old is given access to birth control not out of recognition of his or her mature judgment. Indeed, the less equipped a particular individual is for the burdens of parenthood, the stronger the argument against denying access to contraceptives when we cannot deny access to sex.

F. Zimring, *The Changing Legal World of Adolescence* 62-63 (1982).

14. *Roe v. Wade*, 410 U.S. 113, 155 (1973).

15. In a representative sampling of unemancipated family planning patients, 46% were 17 years old, 30% were 16 years old, 17% were 15 years old and 7% were 14 years old or younger. Torres, Forest & Eisman, *Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services*, 12 Family Planning Persp. 284, 289-90 (1980).

16. *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 103 (1976) (Stevens, J., dissenting).

17. The practices of a publicly operated family planning clinic in Lansing, Michigan, may serve as an illustration. Before contraceptives are dispensed, minors must participate in at least one weekly "rap session" conducted by the center's counseling staff. The sessions deal with factual issues about birth control methods, and are intended to stimulate discussion about non-medical aspects of teenage sexuality as well. A complete medical history of the minor is required in order to detect medical problems which might be aggravated by a particular contraceptive. If, after a physical exam, no medical problems appear, a three-month supply of oral contraceptives will ordinarily be provided, if this is the patient's preference. If the patient returns for an additional supply of pills, another physical exam will be made and the physician will inquire about any contraindicative symptoms. A physician always makes the final evaluation about whether a minor should receive a particular contraceptive.

18. *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 104 (1976) (Stevens, J., dissenting).

19. The Pill has been conclusively linked to the prevention of benign breast disease. It is estimated that as many as 235 per 100,000 Pill users avoid hospitalization for benign breast disease yearly. Additionally, there is accumulating evidence that the Pill provides protection against ovarian and endometrial (lining of the womb) cancers. This benefit may have particular applicability to young Pill users since the Pill's protection against these two forms of cancer seems to increase with duration of use and seems to be greatest among females who have not yet borne children.

20. 42 U.S.C. § 3002(a)(5) (1978) (Congressional findings). The emotional and psychological effects of pregnancy and abortion have been shown to be considerably more traumatic in teenagers than in adults. See generally Wallerstein, Kurtz & Bar-Din, *Psychological Sequelae of Therapeutic Abortion in Young Unmarried Women*, 27 Arch. Gen. Psychiatry 828 (1972). One early 1970's study indicated that almost 25% of all female minors who try to commit suicide do so because they are pregnant or at least fear that they are. Teicher, *A Solution to the Chronic Problem of Living: Adolescent Attempted Suicide* in *Current Issues in Adolescent Psychiatry* 129, 136 (J. Schooler ed. 1973).



# Medicaid Boycotts by Health Care Providers: A *Noerr-Pennington* Defense<sup>†</sup>

Mitchell D. Raup\*

In recent years, as health care costs have risen faster than state resources, a widening gap has appeared between the market price of health services and the price that state Medicaid programs will pay. In an effort to obtain higher fees, physicians and other health care providers in several states have threatened to boycott Medicaid programs. Such boycotts have been challenged under state and federal antitrust law, but until last year the antitrust issues involved in a Medicaid boycott had not been fully litigated. In February 1983, the Federal Trade Commission affirmed an administrative law judge's decision that the Michigan State Medical Society violated section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45 (1976), by conspiring to boycott patients financed by Michigan Medicaid.<sup>1</sup> The Commission held that the Medical Society's actions unreasonably restrained trade, and it rejected the Society's *Noerr-Pennington* defense. This article argues that *Michigan State Medical Society* was wrongly decided, and that a boycott by physicians aimed solely at influencing the amount that a state will pay for the health care it buys for Medicaid patients is not, and should not be, a violation of the federal antitrust laws.

The article will first briefly describe the economics of Medicaid pricing and the motivation for a Medicaid boycott. It will then analyze the bases and limits of the *Noerr-Pennington* doctrine. After a discussion of the legal basis of the FTC's decision in *Michigan State Medical Society*, the article will discuss some policy considerations that militate

against application of the antitrust laws to Medicaid boycotts.

## I. THE MEDICAID BOYCOTT PROBLEM

### A. MEDICAID RATE SETTING: EXAMPLES FROM THE NURSING HOME INDUSTRY

The price that a state Medicaid program will pay for a given health service is set by a political process, not by the market. Most Medicaid rates are lower than the market price, and the increasing frequency of complaints by both consumers and providers indicates that the price gap is causing serious problems. One such problem that has received considerable attention is the inability of Medicaid patients in many states to find nursing homes that will accept them at the Medicaid rate, which is often substantially less than the market rate.

State Medicaid programs are not required to pay market rates for the services they purchase. One court has decided that federal regulations require Medicaid to pay less than market rates. In *DeGregorio v*

*O'Bannon*, 500 F. Supp. 541 (E.D. Pa. 1980), a group of potential Medicaid patients who had been unable to find nursing home beds in Pennsylvania sued the state, seeking to compel an increase in the Medicaid rate. The plaintiffs relied on a federal regulation requiring the states to encourage provider participation in Medicaid by setting a rate "sufficient to enlist enough providers so that services under the plan are available to [Medicaid] recipients at least to the extent that those services are available to the general population."<sup>2</sup> The court denied the plaintiffs relief, finding that the regulation does not mean what it says. First, construing the entire scheme of federal Medicaid regulation, the court held that Medicaid rates must be based on cost, not price. Therefore, a "state plan which relied, to any significant extent, on price-competition and prevailing market conditions in setting nursing home reimbursement rates, would conflict with Congress's consistent desire to set rates on a reasonable cost-related basis." Second, the court noted that the state could "encourage" provider participation by means other than raising rates: It could require nursing homes to accept Medicaid patients at the current rate.

The *O'Bannon* court's suggested approach has been followed in several states with varying degrees of success. In Minnesota a nursing home that accepts Medicaid patients may not charge its private patients more than the Medicaid rate. Massachusetts and Connecticut have enacted laws prohibiting nursing homes from "discriminating" against Medicaid patients. New Jersey has gone a

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*When conventional lobbying is ineffective, provider groups sometimes seek to dramatize their bargaining power by threatening a group boycott.*

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step further: It requires all nursing homes to reserve a certain number of beds for Medicaid patients as a condition of operating in the state.

### B. THE ECONOMICS OF MEDICAID RATE SETTING

Even in states that have not adopted coercive laws like those discussed above, Medicaid programs can buy health care services for less than the market price because they have market power. The market power of a large buyer is called monopsony power, and in many ways is analogous to monopoly power.<sup>3</sup> A monopolist uses his power to raise the price of a product he sells; at the monopoly price he sells less, but his total profits are greater than those a competitive seller could earn. Conversely, a monopsonist uses his power to lower the price he pays for a product or service he buys. The monopsonist, however, usually is not free to choose the most advantageous combination of price and quantity. His needs are predetermined; he must offer a price high enough to purchase the quantity he needs. If the price he offers is too low, too many of his suppliers will leave the market.

Thus, there is a limit to the state's power to exploit health care providers. State monopsony is not, however, harmless. The state *can* exploit providers by paying less than the competitive price. Rather than go out of business, a provider will continue to deal with Medicaid if he is paid enough to cover his costs plus a market rate of return on recoverable capital. He thereby can be denied any return on the unrecoverable or "sunk" costs of establishing his business. In the health care industry, sunk costs are often high. Professional training requires a large investment in time and money. A hospital or nursing home has a high initial cost and a lower salvage value. The greater the unrecoverable investment, the more vulnerable the provider is to exploitation by the state.

Ultimately, monopsony is self-defeating. Unless providers selling to Medicaid can make a normal profit,

no new capital will be invested in health care facilities for Medicaid patients. Thus, the state will someday have to raise its price in order to maintain a source of supply. The state budget process, however, usually looks only to short-run problems, and in the short run monopsonistic rate setting benefits the state. It is, in effect, a tax on providers for the benefit of taxpayers who would otherwise bear the full burden of buying health care for the poor. Providers can legitimately object that monopsony is not an equitable way to finance Medicaid programs.

### C. THE PROVIDERS' RESPONSE: POLITICAL ACTION AND MEDICAID BOYCOTTS

It is apparent that many providers, acting in their individual self-interest, have decided not to deal with Medicaid patients at current reimbursement rates. In sufficient numbers, such refusals will force the states to increase Medicaid rates, but before that time comes, providers may have legitimate complaints about the current rates. The providers' response in many states has been to unite to bring political pressure to bear on state legislatures and agencies. When conventional lobbying is ineffective, provider groups sometimes seek to dramatize their bargaining power by threatening a group boycott.

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*Although Medicaid patients are clearly injured by the boycott, the real target of the boycott is the state.*

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Such a boycott could be characterized either as a refusal to deal with the state Medicaid program or as a refusal to deal with patients financed by Medicaid. The former characterization more accurately describes the economic realities: The state is in the role of purchaser of health care for the poor, deciding which services it

will buy and what it will pay for them. The providers, dissatisfied with the state's policies, refuse to accept Medicaid reimbursement in return for their services. Medicaid patients, against whom the providers have no grievance, are turned away as a result. The refusal to deal with Medicaid thus takes on some of the characteristics of a secondary boycott, because it may induce Medicaid beneficiaries and their political allies to bring pressure on the state to change its policies. Although this strategy may play a part in Medicaid boycotts, such boycotts are not viewed properly for antitrust purposes as concerted refusals to deal with individual patients. The providers remain willing to treat any patient who can pay, and presumably will continue to treat some needy patients for free in keeping with the health care industry's tradition of community service. Therefore, although Medicaid patients are clearly injured by the boycott, the real target of the boycott is the state.

How the boycott is characterized may make a difference in a debate over the moral legitimacy of the boycott, but it is not relevant to the antitrust issues involved. In either case, the boycott is a concerted attempt by competitors to raise prices by refusing to deal except at an agreed-upon price, and price fixing has long been a per se violation of the Sherman Act. The issue in an antitrust challenge to a Medicaid boycott is not whether the boycott unreasonably restrains trade, but whether the antitrust laws apply to boycotts of this kind. If the boycott violates the antitrust laws, the United States may seek to enjoin it or bring a criminal prosecution. A state may sue for treble damages for injury to its economic interest in the Medicaid program or as *parens patriae* on behalf of its citizens. In addition, there may be private plaintiffs who have standing to sue the boycotters for treble damages. At a minimum, a private plaintiff must show that he has been "injured in his business or property" by the boycott. At least one court has held that a Medicaid-eligible patient who is denied Medicaid-funded care because of a boy-



cott, and therefore must pay for the health care that the state would otherwise have paid for, has been so injured and has standing to pursue an antitrust action.<sup>4</sup>

The magnitude of treble damages for injuries caused by a Medicaid boycott is potentially very great. It therefore is important that the issue of *Noerr-Pennington* protection for such a boycott be resolved. The FTC's brief treatment of the issue in *Michigan State Medical Society* is not likely to be the last word on the subject. The sections that follow analyze the *Noerr-Pennington* doctrine and apply it to the Medicaid boycott situation.

## II. THE MEANING OF NOERR-PENNINGTON

In *Eastern Railroad Presidents Conference v. Noerr Motor Freight*, 365 U.S. 127 (1961), the Supreme Court held that an agreement among competing railroads to advocate, through advertising and lobbying, "the adoption and retention of laws and law enforcement practices destructive of the trucking business" did not violate the Sherman Act. The Court did not, however, hold that the defendants' conduct was political speech protected by the first amendment, finding it unnecessary to decide that question. The Court adopted as a "basic construction of the Sherman Act . . . that no violation of the Act can be predicated upon mere attempts to influence the passage or enforcement of laws." The Sherman Act was intended to regulate "business activity," not "political activity," so the defendants' anticompetitive purpose and unethical practices were irrelevant: The Act simply did not apply. The Court buttressed its conclusion by noting that a contrary construction probably would invade first amendment rights and "deprive the government of a valuable source of information," but it did not pursue these arguments.

Four years later, in *United Mine Workers v. Pennington*, 381 U.S. 657 (1965), the Court reaffirmed its construction of the Sherman Act, holding that cooperative efforts by large mine owners and a labor union to

persuade the Secretary of Labor to raise the minimum wage applicable to companies selling coal to the Tennessee Valley Authority did not violate the Sherman Act. The defendants' later efforts to convince the TVA, a federal agency, to buy coal only from companies paying the wage so imposed also did not violate the Sherman Act. First amendment rights were not mentioned in the opinion. The defendants' efforts to influence public officials were not illegal because "the Sherman Act was not intended to bar concerted action of this kind."

The Court's decision in *California Motor Transport Co. v. Trucking*

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### *The Sherman Act was intended to regulate "business activity," not "political activity."*

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*Unlimited*, 404 U.S. 508 (1972), reinterpreted the theoretical basis of the *Noerr* doctrine, characterizing it for the first time as an *immunity* from the antitrust laws. Immunity for political action is required, the Court said, by the first amendment rights of association and petition. An apparent corollary to this proposition is that anticompetitive conduct that is not protected by the first amendment is not immune, and that the antitrust laws were intended to reach such conduct regardless of its political nature. The defendants in *Trucking Unlimited* had adopted a policy of opposing, with or without reasonable grounds, all new license applications by potential competitors in California. The Court characterized this policy as abuse of the judicial and administrative processes and held that "actions of that kind cannot acquire immunity by seeking refuge under the umbrella of 'political expression.'"

*Noerr, Pennington*, and *Trucking Unlimited* are the only Supreme Court cases that deal directly with the issue of antitrust liability for political

action, and unfortunately they create a conflict in the *Noerr* doctrine that has yet to be resolved. Is political activity beyond the scope of the Sherman Act's prohibition of conspiracies in restraint of trade, as *Noerr* holds, or does the Sherman Act reach such activities subject to the overriding protection of the first amendment, as *Trucking Unlimited* implies? Because *Trucking Unlimited* is the more recent case, it must be viewed as controlling to the extent that it conflicts with *Noerr*: The *Trucking Unlimited* opinion does not make clear, however, that the defendants' activities were unprotected by the *Noerr* doctrine *because* they were not protected by the first amendment. The Court pointed out that, by obstructing and delaying their competitors' license applications, the defendants really were attempting not to influence public officials, but to "interfere directly with the business relationships of a competitor." In *Noerr* the Court said that such direct interference in the guise of political activity is a "mere sham," and could violate the Sherman Act. So interpreted, *Trucking Unlimited* is consistent with *Noerr*.

The Supreme Court's most recent discussion of *Noerr* supports the view that the Sherman Act does not apply to political activity, although it emphasizes that first amendment considerations influenced the Court's construction of the Act. In *NAACP v. Claiborne Hardware Co.*, 458 U.S. 886 (1982), the Court held that the first amendment prohibited Mississippi from imposing tort liability on the organizers of a nonviolent boycott of white-owned businesses by black citizens demanding an end to de jure segregation in Port Gibson, Mississippi, in 1966. Antitrust issues were not involved; therefore, *Noerr* was not directly on point. However, Justice Stevens cited *Noerr* as an example of how far the Court is willing to go to avoid penalizing attempts to influence government. He noted that the defendants' conduct in *Noerr* was anticompetitive both in purpose and effect and yet did not violate the Sherman Act. He emphasized that the



*Noerr* Court was careful not to lightly impute to Congress an intent to invade first amendment freedoms, but he made it clear that *Noerr*'s holding is based on statutory construction, not first amendment analysis. This distinction is important because the statutory construction approach gives much broader protection for concerted political activity by competitors than the first amendment would require. In *Cow Palace, Ltd. v. Associated Milk Producers*, 390 F. Supp. 696 (D. Colo. 1975), for example, a group of milk producers allegedly had used bribes and illegal campaign contributions to promote an increase in the level of federal price support for milk. The defendants claimed protection under the *Noerr* doctrine; the plaintiffs responded that *Noerr* did not apply because the defendants' conduct clearly was not protected by the first amendment. Finding that the defendants' activities were "efforts to persuade the Department of Agriculture to take specific action of a regulatory nature," the court rejected the plaintiffs' argument:

Some conduct may not be the subject of a Sherman Act suit even though it is *not* protected by the First Amendment. Whether this is truly a matter of "exemption" or simply a threshold question of the limits of the Sherman Act, it is clear that activities which Congress did not intend to be regulated or proscribed by the antitrust laws are not brought within such laws *merely* because the activities are outside First Amendment protections or even because they may be illegal under statutes *other* than the Sherman Act.<sup>5</sup>

The *Cow Palace* court's interpretation of the *Noerr* doctrine is sound, and it is the standard by which antitrust challenges to Medicaid boycotts should be judged. This approach would appear to protect a Medicaid boycott from antitrust scrutiny because such a boycott is indeed aimed at influencing government and therefore is beyond the scope of the Sherman Act. It should be noted that as a construction of the Sherman Act, the *Noerr* doctrine is solely a rule of

federal antitrust law and does not restrict the operation of any other body of law. Medicaid boycotts can be unreasonable, anticompetitive, and injurious to innocent third parties. As such, they may be actionable under state tort or antitrust law, or a state legislature may prohibit them by specific statute. They do not, however, violate the Sherman Act.

Despite its support in the Supreme Court case law, the statutory construction approach to the *Noerr* doctrine has not been well received in the lower federal courts.

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*Medicaid boycotts can be unreasonable, anti-competitive, and injurious to innocent third parties... [and thus prohibited.] They do not, however, violate the Sherman Act.*

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Applying principles of first amendment analysis, the lower courts have created two major exceptions to the *Noerr* rule. One denies *Noerr* protection to attempts to influence government by "improper means," including group boycotts. The other denies protection to attempts to influence government acting in a "commercial" capacity, as a buyer of goods or services in the market. The FTC's decision in *Michigan State Medical Society* relied to some extent on both exceptions. The next part of this article analyzes the Commission's decision and argues that it is inconsistent with the Supreme Court decisions.

### III. MICHIGAN STATE MEDICAL SOCIETY AND THE PURPORTED EXCEPTIONS TO THE *NOERR* RULE

In *Michigan State Medical Society* the Federal Trade Commission found that Michigan physicians had threatened two separate boycotts: one against Blue Cross and Blue Shield of Michigan and the other against Mich-

igan Medicaid. In both cases the Medical Society collected "proxies" from individual physicians, authorizing the Society to decide at any time that the physician would no longer participate in the target programs. The Society succeeded in collecting a large number of proxies, which gave its negotiators the ability to declare a boycott at a moment's notice. This power gave the doctors new negotiating strength; merely by "waving the proxies in the face of the legislature," the Society was able to extract concessions on Medicaid pricing, and similar concessions were granted by Blue Cross.

The Commission considered the legality of the two boycotts in the same discussion and found them both to be unreasonable restraints of trade in violation of the FTC Act. Because the Society's tactics and objectives with respect to Medicaid and Blue Cross were identical, it seems natural for the Commission to treat the two boycotts in the same way, but this equation obscures an important distinction: Blue Cross is a private insurer, and Medicaid is operated by the state. The Commission assumed that the Sherman Act applies to boycotts against the state to the same extent it applies to boycotts against private parties. By making this assumption, the Commission ignored the threshold question of the applicability of the Sherman Act to political activities.

Having assumed that the Medicaid boycott in question was within the scope of the Sherman Act, the Commission treated the *Noerr* doctrine as an affirmative defense, to be confronted only after an antitrust violation has been found. Although it conceded that the *Noerr* doctrine was "originally premised on an interpretation of the scope of the Sherman Act," the Commission argued that "the Court in *California Motor Transport* made clear that the doctrine also is grounded in First Amendment principles." Thus, the Commission framed the *Noerr* issue in this manner: Did the Medicaid boycott "exceed the bounds of legitimate political influence or lobbying



activities"? It decided that the doctors' threat of a boycott was not protected political speech and that "subjecting the practices to antitrust scrutiny [would] not chill exercise of First Amendment rights," and therefore denied *Noerr* protection. The Commission admitted that the doctors were attempting to influence government action, but held that the coercive way in which they exerted their influence—the group boycott—put them outside the scope of the *Noerr* doctrine.

#### A. IS THERE A "COERCION" EXCEPTION TO THE NOERR DOCTRINE?

Courts confronted with attempts to influence government by means that they consider corrupt, coercive, or otherwise reprehensible sometimes have been reluctant to apply the *Noerr* doctrine. Some have argued that coercive conduct never is protected by the doctrine, and others have proposed that such conduct is protected only when it has an appropriate political motivation. This section will examine these lines of reasoning and argue that they are not well supported in Supreme Court case law, at least as applied to Medicaid boycotts.

##### 1. "Coercion," Abuse of Process, and the Sham Exception

*Sacramento Coca-Cola Bottling Co. v. Chauffeurs, Teamsters and Helpers Local 150*, 440 F.2d 1096 (9th Cir. 1971), is often cited for the proposition that the *Noerr* doctrine does not protect "threats and other coercive measures" used to influence government. The case involved an allegation by a local Coca-Cola distributor that a labor union had used threats and coercion to persuade officials of the California State Fair to forbid the sale of Coca-Cola at the 1966 fair. The complaint alleged that this conduct violated the antitrust laws and the secondary-boycott provisions of the Labor Management Relations Act. The trial court, relying on the *Noerr* doctrine, granted summary judgment for the defendants on the antitrust claim; the Ninth Circuit reversed. The court

of appeals first reviewed *Noerr* and *Pennington*, holding that the "basic thrust of these decisions is political" and is based on the first amendment right to petition and the "chilling effect" that antitrust enforcement could have on that right. The court concluded that "it does not seem to this Court that the doctrines of *Noerr* and *Pennington* were intended to protect those who employ illegal means to influence their representatives in government. . . . There is no room for such tactics in a democratic system."<sup>6</sup>

#### *Merely by "waving the proxies in the face of the legislature," the Society was able to extract concessions on Medicaid pricing.*

The *Sacramento* court's reasoning leaves much to be desired. The court did not say why the alleged "coercion" was illegal, nor why "illegal" means of exerting political influence should be regulated by the antitrust laws while "legal" means should not. It offered neither authority nor argument to support its conclusion that *Noerr* protects only conduct favored "in a democratic system." Most importantly, it did not explain the apparent conflict between its holding and the cases it purported to apply. In *Noerr* the Court said that the defendants had "deliberately deceived the public and public officials," but "that deception, reprehensible as it is, can be of no consequence so far as the Sherman Act is concerned." In *Pennington* the Court reversed an appellate court decision that interpreted *Noerr* as applying only to conduct unaccompanied by a purpose to violate a statute, stating simply that "[j]oint efforts to influence public officials do not violate the antitrust laws."

One year after *Sacramento* was decided, the Supreme Court decided

*Trucking Unlimited*. As previously noted, the *Trucking Unlimited* Court stated the *Noerr* doctrine in first amendment terms, although it based its holding on the "sham" exception announced in *Noerr*. The Court held that the defendant had abused the judicial and regulatory processes by forcing its competitors to defend repetitive and baseless claims. This fits the *Noerr* Court's definition of a sham: a direct attack on a competitor in the guise of an attempt to influence government. The *Trucking Unlimited* Court's "abuse of process" theme has been followed in several cases. For example, in *Israel v. Baxter Labs, Inc.*, 466 F.2d 272 (D.C. Cir. 1972), the defendants allegedly gave false information to the FDA in an effort to "preclude, not induce, fair FDA consideration of the safety and efficacy of plaintiffs' drug."<sup>7</sup> The court refused to accord the conduct *Noerr* protection. Liking the case before it to *Trucking Unlimited*, the *Israel* court argued that the real purpose of the defendants' action was to foreclose the plaintiff's effective access to the administrative agency. Although *Israel* reached the same result as *Sacramento* in denying *Noerr* protection for unsavory "lobbying" activities, the *Israel* court based its ruling on the sham exception rather than on a more general "coercion" exception. This approach is consistent with Supreme Court case law and therefore should be preferred over the *Sacramento* rule as a means of condemning corruption of the political process.

Even under a rule that would deny *Noerr* protection for coercive or illegal conduct, the status of Medicaid boycotts is unclear. Such a boycott probably is not "illegal" unless it violates the Sherman Act. Defendants presumably do not lose their antitrust exemption by violating the antitrust laws. A boycott could, however, be viewed as "coercive" or a "threat." *Sacramento* does not define these terms, but it implies that the defendants' conduct may have been more akin to threats of physical violence than to a refusal to deal. Arguably, therefore, a boycott aimed at influ-



encing public opinion and legislative action could be protected under *Sacramento* even if it brought substantial pressure to bear on public officials. Under the better analysis of *Israel*, a Medicaid boycott clearly would be protected, because it is actually intended to influence government and therefore is no sham.

## 2. "Coercion" and Political Boycotts

The few cases that have examined economically motivated political boycotts under the *Noerr* doctrine have applied neither *Sacramento* nor *Israel*. Instead, they have attempted to reconcile *Noerr* with the first amendment case law on political conduct and symbolic speech, with conflicting results. Two cases closely analogous to the Medicaid boycott problem arose out of the gasoline shortage of July 1979. At that time, more than 3000 members of an association of gasoline dealers in Pennsylvania and Delaware closed their stations for three days in an effort to dramatize their complaint that federal gasoline price controls did not allow them a high enough profit margin. Their effort succeeded, and the Department of Energy raised the permissible retail price of gasoline. Following the shutdown, antitrust actions were filed in federal district courts in Delaware and Pennsylvania, and the courts reached opposite conclusions on the issue of *Noerr* protection for the dealers' efforts to influence government. These cases, which are likely to be cited in a future antitrust action involving Medicaid or similar boycotts, both use first amendment analysis to resolve the *Noerr* question.

In *Crown Central Petroleum Corp. v. Waldman*, 486 F. Supp. 759 (M.D. Pa. 1980),<sup>8</sup> a gas station franchisor sought an injunction against one of its franchisees, barring the dealer from participating in another shutdown. The court granted the dealer's summary judgment motion, holding that the shutdown was protected by the *Noerr* doctrine. The court characterized the shutdown as a boycott and found that it had re-

strained trade. Although the motive for the boycott was political, the court held that the boycott was "conduct beyond pure speech used to petition the government." Noting that the *Noerr* opinion extends protection to conduct only "insofar as those activities comprised mere solicitation of governmental action," the court framed the issue as whether the defendant's conduct was political speech protected by the first amendment. Ordinarily, the imprecise calculus of first amendment law would require a balancing of the govern-

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## "Lobbying"... may all too often include bid rigging, misrepresentation, and bribery.

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ment's interest in regulating anticompetitive conduct against the defendant's interest in uninhibited political expression. However, the *Crown Central* court held that *Noerr* already had struck this balance in favor of political speech. All that remained for the court to decide was whether the conduct in question had sufficient political content to be called speech. The court found that it did, because (1) the closings were not the dealers' normal conduct, (2) they were intended to influence government, (3) the dealers could reasonably believe that the public would be aware of the political motivation of the boycott, and (4) the boycott was the dealers' only effective means of arousing public sentiment.

In *Osborn v. Pennsylvania-Delaware Service Station Dealers Association*, 499 F. Supp. 553 (D. Del. 1980), an antitrust class action against the dealers' association, another court applied the same case law to the same facts and arrived at the opposite result. After reviewing the balancing test referred to above, the court concluded that "a boycott, along with its communicative component, has a coercive economic effect

which ordinarily may be regulated without serious jeopardy to First Amendment interests." The court stated that there was no evidence that the defendants lacked other effective means of making their views known. The defendants' motion to dismiss was denied.

The inconsistency between *Crown Central* and *Osborn* illustrates a practical problem with using first amendment analysis to determine the limits of the *Noerr* doctrine. In assessing the value of the political speech involved, courts must decide if the speaker has less restrictive but equally effective means of expressing his opinion. This determination is necessarily subjective. There are always alternative strategies for influencing government, and the speaker presumably has chosen the strategy that he thinks will be most effective. In *Michigan State Medical Society* the Commission decided that prohibiting a boycott would not prevent the Medical Society from "effectively exercising its First Amendment rights." The *Osborn* court reached the same conclusion with respect to the service station dealers' association. In *Crown Central* the court found that the dealers' association had no effective way to speak except through a boycott. The two gas station cases cannot be reconciled; the best conclusion is that neither is asking the right question. The issue under *Noerr* is not whether the first amendment protects boycotts aimed at influencing government, but whether the Sherman Act prohibits them.

In perhaps the most famous political boycott case, *Missouri v. National Organization for Women*, 620 F.2d 1301 (8th Cir. 1980),<sup>9</sup> the Eighth Circuit framed the *Noerr* issue as a threshold question. The case involved a boycott organized by NOW that sought to direct the lucrative convention trade only to states that had ratified the Equal Rights Amendment. The *NOW* opinion relies heavily on the argument that the boycott was motivated by social and political concerns, as opposed to economic self-interest. This contention is debat-



able—economic equality is a major goal of NOW—but it does tend to lessen the precedential value of *NOW* in cases involving “commercially motivated” political action. Yet the majority’s interpretation of *Noerr* is likely to be influential in boycott cases until the Supreme Court addresses the question.

The State of Missouri’s principal contention in its appeal was that *NOW*’s use of a boycott rendered the *Noerr* doctrine inapplicable, because *Noerr* protects only “mere . . . solicitation of governmental action,” and an economic boycott is more than “mere solicitation.” The Eighth Circuit answered this argument by likening the boycott to the slanderous publicity campaign engaged in by the *Noerr* defendants. In both situations, the court said, “the ultimate object is legislation, and the intermediate goal is inflicting economic injury with the hope of achieving that ultimate objective.” Thus, neither the injury to Missouri businesses nor the restraint of trade caused by the boycott justified denying *Noerr* protection to *NOW*’s boycott.

*NOW* is significant not only for its holding, but for its interpretation of the theoretical bases of the *Noerr* doctrine. In dismissing the antitrust action against *NOW*, the court did not hold that *NOW*’s conduct was protected by the first amendment, but rather that “the Sherman Act does not cover *NOW*’s boycott activities.”<sup>10</sup> *NOW* is the first federal appellate decision in more than a decade to so embrace the statutory construction approach to the *Noerr* doctrine. Unless later cases distinguish *NOW* as a “social issue” case, this holding justifies the final rejection of the “coercion” exception to the *Noerr* doctrine. *NOW* also justifies rejection of the unpredictable first amendment analysis of boycotts used in the *Crown Central* and *Osborn* cases. To date, however, few courts have taken advantage of the *NOW* decision’s potential for unraveling the tangled web of *Noerr* law.

The FTC in *Michigan State Medical Society* distinguished *NOW*, stating that “the non-commercial, non-

competitive relationship of the parties served as the primary reason for the court’s conclusion that the anti-trust laws were not applicable.” This is not a fair reading of *NOW*. Although the *NOW* court pointed out that the boycotters’ principal purpose in appealing to the legislature was social change, not economic gain, the court held that the facts of *Noerr* “cannot be analytically distinguished [from the facts of *NOW*] insofar as is relevant to the applicability of the Sherman Act.” *Noerr*, of course, involved a conspiracy between competitors to

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### *How Medicaid rates are set affects aspects of state health care policy far more important than the income of providers.*

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achieve a purely commercial goal through legislation.

After concluding that *Noerr* did not protect the Michigan State Medical Society’s means of influencing government, the Commission noted an alternative basis for its holding: *Noerr* would not protect *any* concerted lobbying effort by physicians on the issue of Medicaid prices, because the proper level of those prices is a commercial, not a political issue. The Commission thus invoked the so-called “commercial activities” exception to the *Noerr* doctrine, which has been hotly debated in the courts for many years. Although the Commission did not rely on this exception, this Article discusses it in the next section.

#### **B. IS THERE A “COMMERCIAL ACTIVITIES” EXCEPTION TO THE NOERR DOCTRINE?**

Due to an understandable reluctance to endorse the kind of conduct for which defendants often seek the protection of the *Noerr* doctrine, some courts have created an exception to the *Noerr* doctrine that denies

protection for attempts to influence government decisions that are purely commercial, as opposed to policy-making. In 1982 government purchased about twenty-one percent of the gross national product. Some government purchases are made to further specific policy objectives, such as commodity purchases required by price support programs; some have no policy content, such as purchase of office supplies; and some, such as affirmative-action hiring of minority contractors for planned construction, are a mixture of the two. The “commercial activities” cases attempt to sort these situations out and apply the antitrust laws to attempts to influence government purchasing decisions that do not affect policy.

The principal case recognizing a commercial activities exception to the *Noerr* doctrine is *Whitten v. Paddock Pool Builders, Inc.*, 424 F.2d 25 (1st Cir. 1970). The parties in *Whitten* were competing manufacturers of prefabricated gutter systems for large swimming pools purchased primarily by state and local government agencies acting under competitive bidding statutes. Before soliciting bids for construction of a swimming pool, the agency (often a school board) typically hires an architect to produce plans and specifications for the pool. The defendants attempted, with considerable success, to convince architects to specify their products to the exclusion of the plaintiff’s products, and the plaintiff alleged that such conduct violated the Sherman Act. The trial court granted summary judgment for the defendants based on the *Noerr* doctrine. The First Circuit reversed, holding that “the immunity for efforts to influence public officials . . . does not extend to efforts to sell products to public officials acting under competitive bidding statutes.” The court based its holding on two conclusions. First, the court held that *Noerr* protects only efforts to influence “the passage or enforcement of laws,” which the court interpreted to mean “some significant policy determination” and not “purely commercial dealings.” Second, the court noted that the first



amendment does not protect commercial speech to the extent that it does political speech. *Whitten* and its progeny share with the previously discussed "coercion" cases an important underlying concern: the fear that if antitrust law does not regulate private firms' efforts to influence government, political corruption may go unpunished. "Lobbying" such as the selling effort in the *Whitten* case may all too often include bid rigging, misrepresentation, and bribery. The Supreme Court cases protect even corrupt lobbying in the "political" arena, but the *Whitten* court was unwilling to extend the same protection to transactions in the "commercial" world, in which the government buys and sells products in the market. On one level the *Whitten* court's argument is convincing. *Noerr* is based on the principle that the Sherman Act regulates business activity, not political activity, and efforts by businessmen to make money by selling to the government certainly look like business activity. Nonetheless, there are serious logical and practical problems with construing the Sherman Act to regulate some, but not all, efforts to influence government. The underlying philosophy of the *Noerr* case is that the political process can accommodate even underhanded expressions of economic self-interest, and that the political arena therefore need not be regulated in the same way as the competitive market. *Noerr* should be applied in that spirit without regard to whether the government is making policy or merely paying its bills.

The *Whitten* court's distinction between political and commercial speech has been weakened by subsequent decisions. Supreme Court decisions since *Whitten* have greatly expanded the first amendment protection accorded commercial speech. In *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748 (1976), the Court refused to follow the commercial speech cases cited in *Whitten* and recognized a first amendment right to advertise. "[T]he free flow of commercial information," the Court

said, "is indispensable to the proper allocation of resources in a free enterprise system." Significantly, the Court advanced a very similar argument in *Noerr*: "A construction of the Sherman Act that would disqualify people from taking a public position on matters in which they are financially interested would thus deprive the government of a valuable source of information. . . ." It therefore can be argued, contrary to the *Whitten* court's view, that both antitrust and

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### *The states have the power to prohibit Medicaid boycotts by specific legislation.*

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first amendment policies favor the kind of persuasion engaged in by the *Whitten* defendants.

The *Whitten* court's first conclusion, that the *Noerr* doctrine applies only to attempts to influence "significant policy determinations," is also unsupported by Supreme Court case law. In *Pennington* large coal companies attempted to convince the TVA not to buy coal from small coal companies on the spot market, although spot market coal was cheaper because minimum-wage restrictions did not apply. It would be difficult to imagine a more commercial activity than government procurement of coal. There is no suggestion that the TVA had "policy" discretion to favor one seller over another by buying at above the market price. Because the Court had no difficulty in finding the defendants' acts to be within the *Noerr* doctrine, *Pennington* must be viewed as an implicit rejection of the commercial activities exception.

Perhaps the most fundamental objection to the *Whitten* rule is that it cannot effectively be limited to commercial situations without taking the defendants' intent into consideration, which the Supreme Court repeatedly has refused to do. However, Medicaid boycotts probably would merit *Noerr* protection even if the commercial activities exception were applied.

The commercial activities exception denies protection to attempts to influence *market decisions*, in which the government acts as a buyer like any other buyer in the market, as opposed to *political decisions*, in which the government makes policy. The *Whitten* court expressly limited its holding to efforts to influence officials acting under competitive bidding statutes in which the legislature has "decreed that government purchases will be made according to strictly economic criteria." Although subsequent cases have extended the exception to situations not involving competitive bidding, it has never been extended to attempts to influence a decision found to have a significant policy content. To make this determination, courts consider the extent and nature of the discretion vested in the governmental entity whose decision the defendants seek to influence.

A boycott of Medicaid patients by health care providers could have at least three goals: to arouse public support for an increase in Medicaid payments, to convince the state legislature to appropriate more money for the Medicaid program, and to persuade the state agency that administers the program to change its reimbursement policies. The first two purposes are not different from those of the *Noerr* defendants: to influence the passage of laws. The attempt to influence the administrative agency requires more analysis, because it can be argued that the agency acts in a purely commercial capacity, purchasing health care for the state in accordance with policies set entirely by the legislature.

In fact, Medicaid agencies have substantial policy discretion. The rates they set must conform to federal statutes and regulations that are far from specific and embody conflicting policy goals. In general, "payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population."<sup>11</sup> They must, however, be "consistent with efficiency, econ-



omy, and quality of care."<sup>12</sup> Clearly, reasonable minds can differ as to what price these standards require for a given service. How Medicaid rates are set affects aspects of state health care policy far more important than the income of providers, including the relative availability of different services and the overall quality of care available to the poor. Attempts to influence such decisions certainly would be protected by the *Noerr* rule, even as analyzed in *Whitten*.

The decisions made by Medicaid agencies are different from those considered in *Whitten* in a more fundamental way: They actively reject the market price in favor of a price determined by political processes. Federal cost-containment regulations require the agencies to set the lowest price that will elicit the desired quantity of services, although the market price may be much higher than the Medicaid rate. One court recently held that a "state plan which relied, to any significant extent, on price-competition and prevailing market conditions in setting nursing home reimbursement rates, would conflict with Congress's consistent desire to set rates on a reasonable cost-related basis."<sup>13</sup> This method of government purchasing could hardly be less similar to the competitive bidding described in *Whitten*. The policy implications of a government decision to purchase health care in this way are discussed in the next part.

#### IV. SHOULD MEDICAID BOYCOTTS BE PERMITTED?

This article has argued that the antitrust laws do not prohibit health care providers from joining together and refusing to deal with a state Medicaid program that will not pay the fees the providers demand. This is not to say that Medicaid boycotts are a good thing, or that they always must be lawful. Medicaid boycotts in some cases may be motivated by sheer greed, and in every case they directly injure innocent people—the poor and the sick—who have no control over Medicaid pricing. There are, however, strong arguments in

favor of the providers' right to strike in self-defense against unfair state pricing policies. These arguments should be sufficient, at a minimum, to make courts reluctant to impose the harsh penalties of the antitrust laws on a Medicaid boycott.

The states have the power to prohibit Medicaid boycotts by specific legislation. Doctors, along with other health care professionals, enjoy a

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*When rate-setting policy... is set by a political process, affected interest groups... have a legitimate claim to uninhibited political expression.*

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privileged position as state-licensed monopolists. A state may impose duties as a condition of enjoying this privilege. When New Jersey enacted regulations requiring all licensed nursing homes to accept and care for Medicaid patients at the Medicaid rate, the nursing homes challenged the regulations as an unconstitutional taking of private property for public use without just compensation in violation of the fifth and fourteenth amendments. The New Jersey Supreme Court upheld the regulations, holding that because Medicaid provides for reimbursement of nursing homes at a "reasonable" rate, the regulations could not be said to require taking without just compensation.<sup>14</sup>

States also have the power to set Medicaid rates at a level that denies providers a fair profit. Whether or not a state should adopt such a policy is a political question of the first magnitude. Its resolution will affect the distribution of wealth between providers and taxpayers and also will affect the quality of care that Medicaid patients receive.<sup>15</sup> When rate-setting policy, as well as individual Medicaid rates, is set by a political process, affected interest groups such

as health care providers have a legitimate claim to uninhibited political expression. The first amendment may well require the states to allow something like collective bargaining over Medicaid rates.

However this issue is resolved, the federal antitrust laws have no place in the debate between providers and the states. The antitrust laws seek to preserve the free market, in which prices are set by competition and the interplay of supply and demand. When government follows the same rules as other actors in the market, as it does under competitive bidding statutes, it legitimately can demand that the private parties with whom it deals obey the antitrust laws. But when government chooses to exercise its monopsony power, to set prices by legislative fiat, it abandons the free market in favor of the political process. As the Supreme Court observed in *Noerr*; the antitrust laws are designed to regulate business activity, not political activity. If a state elects to buy health care for the poor by means of a political process, then the sellers of health care should be allowed to respond by bringing political pressure to bear. A Medicaid boycott is such a political response, and the antitrust laws should not be construed to prohibit it.

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1. Michigan State Medical Soc'y, [1979-1983 Transfer Binder] Trade Reg. Rep. (CCH) ¶ 21,991 (Feb. 17, 1983).



2. 42 C.F.R. § 447.204 (1982). States are not required to have a Medicaid program, but if they do, they must comply with federal regulations as a condition of receiving federal funds.

3. G. Stigler, *The Theory of Price* 87, 205 (3d ed. 1966).

4. See *DeGregorio v. Segal*, 443 F. Supp. 1257, 1263-64 (E.D. Pa. 1978).

5. 390 F. Supp. at 702.

6. 440 F.2d at 1099.

7. See also *Walker Process Equip., Inc. v. Food Mach. & Chem. Corp.*, 382 U.S. 172, 176 (1965) (maintaining patent obtained by fraud on Patent Office can violate § 2 of Sherman Act); *Trans Kentucky T.R.R. v. Louisville & N.R.R.*, 1983-2 Trade Cas. (CCH) ¶ 65,476, 68,308 (E.D. Ky. 1983) (knowing submission of false information to agency not protected by *Noerr*).

8. *Rev'd on other grounds*, 634 F.2d 127 (3d Cir. 1980).

9. *Cert. denied*, 449 U.S. 842 (1980).

10. 620 F.2d at 1319. In its discussion of the state law claims against NOW, the court did find that the boycott was entitled to first amendment protection, but this holding was not part of its Sherman Act analysis. *Id.* at 1318-19.

11. 42 C.F.R. § 477.204 (1982).

12. 42 U.S.C. § 1396a(a)(30) (Supp. V 1981); see 42 C.F.R. § 447.250 (1982).

13. *DeGregorio v. O'Bannon*, 500 F. Supp. 541, 547 (E.D. Pa. 1980).

14. *In re Review of Health Care Admin.*, 83 N.J. 67, 415 A.2d 4147 (1980).

15. In *Michigan State Medical Soc'y*, the doctors presented evidence that low levels of Medicaid reimbursement tend to leave the poor with few alternatives to the so-called "Medicaid Mills" — low priced, low-quality clinics serving only state-supported patients.



# ABOUT THE SCHOOL



*A Conference Report***Police Discretion in Law Enforcement**

*The patrol car with two veteran police officers inside cruises through a rundown commercial section of a large city. It is the middle of a weekday afternoon, but the bars and movie theaters along the street are occupied by a variety of neighborhood residents. As the officers pass one of the dimly lit bars, a man emerges waving his arms to motion the policemen to stop. As he approaches the patrol car the police observe that he stumbles as if mildly intoxicated. The man, unshaven and appearing somewhat disheveled, reports that he has just been robbed by another man in the bar.*

*The police accompany the man back into the bar to identify and confront the accused robber. The accused man insists that the perceived victim actually lost the money betting on a pool game a few minutes earlier. The police find no other witnesses to the alleged robbery among the patrons of the bar. The policemen question the victim about the accused robber's explanation but he adamantly insists that he was robbed, although he is not certain how it happened. The officers are faced with the decision of whether or not to make the arrest based on the complaint of the man whose credibility is highly suspect.*

*At the same time in another section of the city, two officers respond to a domestic disturbance call. They arrive to find a husband and wife in a heated argument over an automobile in the driveway of their modest suburban home. The wife says her husband has struck her during the dispute. The police officers must choose the appropriate action to take from among several alternatives, ranging from lecturing the couple and leaving to arresting the husband.*

These two brief scenarios illustrate incidents in which the police find themselves in situations calling for the exercise of discretion. The responses of the police in these two situations may depend upon numerous factors including their training, police department policy, personal familiarity with the suspects, and, perhaps, intuition. Should police departments encourage the use of discretion by police officers or should the departments develop structured guidelines in an attempt to "standardize" the behavior of police officers? Should police officers study the results of experimental studies indicating the consequences of police actions in a wide range of situations or avoid this knowledge because it will produce discriminatory responses by the police? These and many other similar questions were addressed at a Conference on Police Discretion held at Duke on February 17 and 18, 1984.

The purpose of the Police Discretion conference was to bring together a distinguished group of lawyers, judges, and academicians to review, discuss, and exchange ideas on nine articles authored by conference participants; these articles will form the nucleus of an

upcoming issue of *Law and Contemporary Problems* on police discretion. The conference was hosted by Dean Paul D. Carrington and Duke professors Beale, Christie, Everett, Mosteller, and Pye. Former Duke Law professor Ronald Allen, professor of law at the University of Iowa, served as chairman of the conference.

In addition to the authors of the articles, the conference participants included: The Honorable Gerald B. Tjoflat of the United States Court of Appeals, Eleventh Circuit; the Honorable Kenneth W. Starr of the United States Court of Appeals, District of Columbia Circuit; the Honorable Frank W. Bullock, Jr., of the United States District Court, Middle District of North Carolina; Mr. Wade Barber, Jr., District Attorney for Orange County, North Carolina; and Mr. Peter Gilchrist, District Attorney for Mecklenberg County, North Carolina.

The diversity of the topics of the papers discussed at the first session of the conference is indicative of the broad scope of issues raised in the consideration of police discretion. Professor H. Richard Uviller of the Columbia University School of Law presented the results of his research on *The Unworthy Victim: Police Discre-*



*tion in the Credibility Call.* Professor Uviller, a former prosecutor in New York County, New York, for fourteen years, recently spent six months accompanying police officers on patrol in the lower East Side of Manhattan. His purpose was to observe how the police interpreted the constitutional limitations placed on them and how they applied these constraints in their daily activities. Although he collected no quantitative data during his research, he was able to observe the actions of the police from a perspective few persons conducting empirical research ever experience.

He concluded that, for the officers, one of the most troubling aspects of their work was whether the credibility of the victim was a relevant consideration in the decision to arrest on a complaint. Professor Uviller came away from the experiment with the opinion that the police do not believe that the credibility of the victim is a consideration in the decision to arrest. It is only when the police officers have strong suspicions regarding the truth of the complaint that they may hesitate to arrest. Some of the conference participants proposed that the moral worthiness of the victim guided the discretion of the police more than any other single factor. All of the participants believed this was undesirable.

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***By analyzing problematic situations and their outcomes police officers can be better trained to handle the discretionary acts that are required of them.***

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Professor David H. Bayley of the University of Denver's Graduate School of International Studies reported on research he and Professor Egon Bittors of Brandeis University conducted on how police officers learn the skills of policing. Most police officers contend that because the daily situations experienced in their job are too diverse to be reduced to simple principles, training of the nature given in police academies is largely irrelevant. Bayley and Bittors take issue with this "experience is the only teacher" view of policing as a craft and attempt to demonstrate that scientific analysis of police experience can be translated into a form of guidance for training police officers. Professor Bayley described a system in which the experience gained by officers is broken down into three categories: goals, tactics, and presence. He contends that by analyzing problematic situations and their outcomes police officers can be better trained to handle the discretionary acts that are required of them.

The desirability of conducting scientific experiments in police discretion was the topic of a presentation by Lawrence W. Sherman of the Police Foundation in Washington, D.C. Sherman points out that "[t]he police lack reliable knowledge about the effects of their discre-

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***There are four different senses of discretion: (1) discretion as wisdom; (2) discretion as managerial authority; (3) discretion as personal input; and (4) discretion as power.***

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tionary actions on suspects, victims, witnesses, and potential criminals." Scientific research that reveals the results of police discretion is becoming more common. A 1983 study in Minneapolis points out the usefulness and dangers of this type of research. Police officers in Minneapolis gave up the use of discretion in making arrest decisions in cases of simple domestic assault. The officers followed a random number formula to "decide" whether to (1) arrest the suspect, (2) order the suspect to leave, or (3) just talk to the suspect and then leave. Although the sample group was so small (150 cases) that the results were not statistically valid, the results indicated that those arrested were only half as likely to repeat their violence during the six month followup period. The research also concluded that arrest had virtually the same deterrent effects for people of different races and different economic and education levels.

The suggestion that research of this nature was desirable troubled several of the participants. The potential for misuse of data, indicating that for some crimes there is a significant difference between the responses of people of different races or economic levels, is obvious. Exercise of police discretion based on scientific analysis indicating such differences violates due process and equal protection rights in the view of several commentators. Despite those dangers, Sherman concluded that the police will be better off with the knowledge and that misuse of experimental data can be remedied.

Professor Albert J. Reiss, Jr., of the Yale University Department of Sociology compared two models of policing in his presentation on *The Consequences of Compliance and Deterrence Models of Policing for the Exercise of Police Discretion*. Reiss examined the traditional dual function of police forces: first, as agents for punishing those who commit crimes in order to deter others; and second, as the major actors in the effort to

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***More scientific analysis of police actions will soon be available.... How these data will be incorporated into police training and evaluation is unclear.***

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obtain voluntary compliance with the law. His general thesis was that a greater emphasis on the compliance model of law enforcement in the evaluation of police discretion will lead to an improvement in the operation of the criminal justice system.

Professor Gregory Howard Williams of the University of Iowa College of Law concluded the first day's session with his presentation on the issue of whether police have the authority to develop rules and guidelines limiting discretion. His paper, entitled *Police Rule-making Revisited: Some New Thoughts on an Old Problem*, evaluated the arguments concerning the constitutional and statutory basis for police rulemaking articulated in the writings of Professors Kenneth Culp Davis and Ronald Allen.<sup>1</sup>

The topics of the second session covered a wide range of subjects. The first presentation was by David Linnan of the law firm of O'Melveny & Myers on *Police Discretion in a Confidential European Administrative State: The Police of Baden-Wuerttemberg in the Federal Republic of Germany*. Linnan's paper outlined the contrast between the Germans' use of sanctions against police and the application by the courts in this country of the exclusionary rule.

A paper from a different perspective was presented by Abraham Goldstein, Professor of Law at Yale University. Professor Goldstein examined the provisions of the federal *Victim and Witness Protection Act of 1982* that provide for increasing the participation of the victims of "serious" criminal acts. The Act, among other things, provides for consultation with the victim by the prosecutor at four designated stages of the criminal process: (1) dismissal; (2) release of the accused pending judicial proceedings; (3) plea negotiations; and (4) pretrial diversion program. The guidelines promulgated under the Act add five additional stages where consultation is required.

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*One of the most troubling aspects of [police] work was whether the credibility of the victim was... relevant ... in the decision to arrest.*

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Although the prosecutors are not required to accept the victim's views, Goldstein believes prosecutors are likely to be influenced. He feels the critical question is whether, given the prosecutors' discretion, hearing the victim's views will not only make the victim feel better but make the criminal justice system work more effectively.

A controversial view of discretion in law enforcement was proposed by Harold E. Pepinsky, Professor of Forensic Studies and East Asian Languages and Cultures at Indiana University, in his article entitled *Better Living*

*Through Police Discretion*. Pepinsky contended that, practically by definition, law enforcement entails overwhelming class bias because a class-blind law enforcement system is impossible to construct. He asserted that the solution to this injustice is to increase the discretion given to the police while at the same time developing a system of accountability. Participants at the conference expressed disagreement with the concept that a class-blind law enforcement system was impossible to achieve. The concept proposed by Pepinsky, that rules

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*Scientific research that reveals the results of police discretion is becoming more common.*

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to curtail discretion and therefore eliminate biased enforcement of the law were undesirable, was the subject of considerable dissent.

Professor George Fletcher of the Columbia University of Law concluded the conference program with his insights on some of the basic disputes about police discretion. Fletcher analyzed four theoretical constructs of discretion in his discussion, entitled *Some Unwise Reflections About Discretion*. Fletcher's discussion returned the participants from a detailed discussion of the issues of police discretion to a more generalized review of what discretion means in a variety of contexts. Fletcher's conclusion was that there are four different senses of discretion: (1) discretion as wisdom; (2) discretion as managerial authority; (3) discretion as personal input; and (4) discretion as power. What police discretion consists of depends on many factors, not the least of which is one's perspective. One of Fletcher's concerns is that the different meanings of discretion cause us to lose the capacity to appreciate the distinctions.

Whether or not one believes that police officers need to exercise greater discretion in carrying out their duties, it cannot be denied that more scientific analysis of police actions will soon be available. As the law enforcement agencies of the nation come to depend more on computerized networks to assist with law enforcement activities, the data for empirical studies on the results of discretionary acts by police officers will become more readily available. How these data will be incorporated into police training and evaluation is unclear. Whatever the outcome, the research and exchange of ideas concerning police discretion presented at the conference will certainly contribute to the ability of policymakers to make educated choices on the discretion of law enforcement programs.

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1. See K. Davis, *Police Discretion* (1975), and Allen, *The Police and Substantive Rulemaking: Reconciling Principle and Expediency*, 125 U. Pa. L. Rev. 62 (1976).



# The Duke Law Library: Its Changing Role

*Richard A. Danner*

*Director of the Law Library and Associate Professor of Legal Research*

**L**ike the law school it serves, the Duke Law Library could choose any of several dates to mark its beginnings. Some law books undoubtedly were included in the general library collection of Trinity College when Braxton Craven began lecturing on legal subjects in the mid-1850's. At the beginning of the twentieth century, separate space was created for law students in the general library, and by 1908 the law collection was large enough to justify publication of a slim pamphlet under the title: "Catalog of the Law Library of Trinity College."

The collection remained modest in size, however, until shortly before the library moved to its own quarters in the new law building of Duke University in 1930. A determined effort over two years had tripled the size of the collection, and when classes began in the new building in September, over 12,000 volumes were on the shelves. In an early history of the library and its services, William R. Roalfe, who had become law librarian in July of 1930, noted that the total was "well above the minimum required by the Association of American Law Schools."<sup>1</sup>

*View from the Mezzanine*







*Lexis Terminal*

Today that collection has grown to over 340,000 volumes and their equivalents in microform, and is overcrowding the space allocated for it in the law building opened in 1963. In addition to the growth of the collection, the fifty plus years of the law library's history as an independent library have been characterized by an accelerating rate of change in the nature of the library services offered to faculty, students, and others. Presently, as we consider our transformation into an "information society," and as information is published and stored in a variety of new forms, it can be argued that adaptation to change is overtaking growth as the driving force in law and other research libraries.<sup>2</sup>

#### CHANGING SERVICES AND OPERATIONS

In particular, we may be experiencing fundamental changes in the ways a library supports instruction and research, and in the ways library funding is allocated and spent. In the past, library budgets have grown in order to acquire materials for locally-held collections. As the collections grew larger and more complex, increased budgets were needed to provide larger staffs to organize the materials and to assist patrons in using them. A library's prestige rested almost exclusively on the size of its holdings of bound, hard copy material.

There is no doubt that the hard copy research collection will continue to be significant in marking the quality of the law library of the future. However, it is equally certain that other, less easily quantifiable measures will begin to play a greater role than they have in the past. One reason for this is the continued growth in

volume and cost of printed legal materials, and of materials from other disciplines needed for legal research. It is no longer realistic for even the largest law library to assume that it can rely solely on its own collection to meet its patrons' every need. This realization has led to various forms of cooperation among law libraries, and to increased reliance on data that is stored electronically at central locations outside the library, accessed through local terminals, and transformed into printed form on site for the user. It is forecast that more and more information will be available only in electronic or some other non-print format.

This means that, in the future, greater proportions of library budgets will be spent to provide *access* to information stored elsewhere, rather than for the *acquisition* of permanent local copies. Purchase of books, journals, and other traditionally published materials will not stop, but, increasingly, material will be made available in a variety of new formats and ways involving computers, telecommunications hookups, network participation, new forms of document delivery, and new types of information services. It has been suggested that soon the library acquisitions budget will be better named the "Acquisitions and Access Budget."

#### CHANGE AT DUKE

How will these changes affect the Duke Law Library? At Duke, as well as in most other law libraries, the materials of legal research already are found in a shifting mixture of paper, microform, and electronically stored data. Even the processes through which the



traditional material is acquired and cataloged are heavily dependent on automation.

The heart of the library remains its collection, currently ranked as the 23d largest in the country. During his tenure as librarian between 1930 and 1946, William Roalfe labored to create the basis of an outstanding retrospective collection in Anglo-American law, and in materials from foreign jurisdictions, particularly Western Europe. As befits a national law school, and a school supporting the research of renowned legal scholars, the collection today remains deep in primary source American materials, and boasts extensive current and retrospective collections of treatises in law and related subjects, and of legal periodicals. The holdings in English, Canadian, other commonwealth, and European materials are strong, as are those in international law and the laws of selected other foreign jurisdictions. The separate collection of U.S. federal government publications was recently given an "excellent" rating in an inspection by the Government Printing Office depository program.

Although the heavily-used primary source materials continue to be collected in hard copy (and often in multiple copies to meet student needs), increasing reliance is placed on their availability in other forms. In some cases, the collection has been augmented by acquisition in microform of materials that are either unavailable in paper or too costly in price or required space for hard copy purchase to be considered. Among these are the Records and Briefs of the U.S. Supreme Court and other courts, Supreme Court oral arguments,

several comprehensive sets of congressional materials, out-of-print treatises and journal runs, compiled legislative histories, and a variety of state and federal government publications. Microform also provides back-up copies for material collected in hard copy, is used to preserve newspapers and other difficult-to-preserve material, and substitutes for little-used items available in both formats. The microform collection is supported by a variety of readers and reader/printers, and is accessed through comprehensive and detailed indexes.

The accelerating development of full-text computer-assisted legal research (CALR) systems, such as LEXIS and WESTLAW, has created not only a new approach to legal research, but provides immediate access to resources that both duplicate and complement the library's printed resources. Duke students and faculty have both systems available in the law library. At the very least, knowing that a case or other document is available through a CALR terminal prevents the frustration caused by lost or missing library volumes. It also means that newly decided cases are available sooner than ever, and creates access to federal agency decisions and documents previously difficult to obtain and maintain in printed form.

Computer-stored text also greatly enhances the library's ability to quickly deliver non-legal material that is too little-used and too expensive to be acquired in hard copy. Mead Data Central's NEXIS system, available through the LEXIS terminal, provides the full text of newspapers such as the *New York Times* and *Washington Post*, as well as the text of news magazines, and



*Reference Room*





*Reading Room*

journals and newsletters in politics, economics, and business. Other services, such as Lockheed Corporation's DIALOG system, offer more limited full-text contents, but provide fast and comprehensive on-line indexing of published journals and scholarly material, enabling researchers to quickly identify material they need, whether it is held locally or must be borrowed from another library.

Much borrowing of books or articles from other libraries is itself facilitated by the computer and the library's participation in the interlibrary loan network of OCLC, the On-line Computer Library Center. OCLC provides an on-line database of cataloging records for over ten million titles that is used by Duke and 6,000 other libraries to prepare their local catalog records. Presently, nearly all the law library's orders for new books are placed through a University-wide automated system. Upon receipt, the books are cataloged and processed using the OCLC system. Catalog cards now are produced using OCLC; in the future, the standard card catalog likely will be replaced by easy to use terminals accessing records of the library's holdings. In the fall of 1984, initial testing began on an on-line system linking the catalogs of the libraries at Duke, the University of North Carolina at Chapel Hill, and North Carolina State University. When the system is completed, law library users will have computerized access not only to the law library's holdings but also to those of other campus and area libraries as well.

Now, as always, the library remains a central focus of law school life. Members of the staff are normally on

duty from 8 a.m. to 12 midnight, and after-hours student access is available. During legal writing periods and before exams, many students use the library throughout the night.

The library staff currently includes eight professional librarians, a clerical staff of thirteen, and a number of student assistants. All members of the professional staff hold masters degrees in librarianship and four have law degrees as well. In addition to providing reference and research assistance to faculty and students, the law-trained staff participates in the instructional program with courses in basic legal bibliography and other training in legal research techniques. The director and the assistant librarian also offer courses in the regular law school curriculum.

In recent years the staff has published a series of subject research guides, a newsletter, and other publications that in 1984 were honored with the American Association of Law Libraries' Law Library Publications Award. Members of the staff have edited and contributed bibliographies for issues of *Law and Contemporary Problems*, and have contributed monographs and journal articles to the literature of law librarianship. Presently, AALL's quarterly journal, *Law Library Journal*, is edited at Duke. In addition to writing activities, staff members are active in the affairs of AALL and its Southeastern Chapter. In November, the staff helped organize a Duke conference on international legal materials in conjunction with the University's Center for International Studies.

As well as providing reference and instructional



services for students, the staff provides a variety of direct programs for faculty, including preparation of research bibliographies, and maintenance of on-going notification services to keep faculty aware of new publications and other developments in their fields of interest. While the public service staff is highly visible to students and faculty, the technical services librarians, who are responsible for cataloging, acquisitions, serials control, and local automated systems, perform the less visible but essential tasks of organizing and maintaining the quality of the collection.

The library also serves local area attorneys with its open collections and reference assistance, and assists lawyers throughout the state with a photocopying and mailing service.

### FUTURE DIRECTIONS

Changes in information forms and in library services make this an exciting time for libraries, and a time that is filled with opportunity. As with any period of transition, however, today's library faces a number of conflicting pressures.

At Duke, the primary problem is one of adequate space for library collections and for users of the resources. In 1985, the library's area in the present building is overcrowded and is not configured to meet the current needs of faculty and students. The most obvious shortcomings of the present facility are seen in the cramped study areas. Almost as apparent are the tightly packed book stacks on each of the library's four levels.

Within the confines of the present library, we have

worked to improve those situations. During the past two years we have doubled our stock of large individual study carrels. Yet, as the collection grows, the space available for new seating declines. Without additional contiguous space, more material will have to be stored outside the library. In January 1984, a small movable shelving unit, designed to hold about 15,000 volumes, was installed in a former classroom near the student locker-room. Although such facilities can be useful for storage of less-used and superseded materials, they do limit access to the materials stored therein. Access problems will be multiplied if more frequently used holdings must be stored away from the library in the future.

The combined impacts of a growing research collection and heavy student use of the library for research and study have created the need for more library space at Duke. Unless more of the library's holdings are to be removed from open stacks and placed in storage, an addition to the building is necessary. Traditionally, library additions have emphasized expansion space for growth in the hard copy book collection. In the late twentieth century the law library's book and serials collections will continue to grow, and to fill available space on library shelves. Yet acquisition of non-book materials will also increase, both to supplement and to replace hard copy resources. Growing collections of information captured in microform and in various electronic formats will require new methods of storage and new means of access. Because the exact configuration of the library in the year 2000 cannot be forecast with certainty, current library space planning should stress



*Study Table*





Mezzanine

flexibility and the capability for adjustments to changing information technology and to the resulting changes in services demanded by the library's clientele.

Certain continuing needs can be specified, however. They include:

1. *More Individual Study Spaces.* Even with the recent purchase of 100 large study carrels, the law library can provide carrel seating for only about one-quarter of the student body. Most new law libraries, such as that at the University of Minnesota, can seat over 50 percent of their students in carrels; Stanford has carrel seating for nearly three-quarters of its students. In addition to being greater in number, the library's carrels should be equipped to allow students to hook up portable computers and terminals, and microform readers.

2. *Conference Rooms.* With the emphasis in the curriculum on first year writing projects and on upper class research tutorials and seminars, students need space for small group cooperative work within the library. Presently, discussion groups can function only by disturbing other students involved in quiet study.

3. *Computer Facilities.* Full-text legal research systems such as LEXIS and WESTLAW will be used more frequently by more students in the future, as will other

information services available through publicly accessible computer terminals. The traditional card catalog of the library's holdings is likely to be replaced (at least in part) by an on-line computer catalog, providing faster and easier access to the holdings of this and other libraries. Personal microcomputers will be used for individual computer-assisted instruction and for other student purposes. Future space planning must take into account the need for more workspaces equipped to provide access to electronically stored information.

4. *Microform.* The law library has long made substantial investments in collecting material in microfiche or film. Yet, despite the size and quality of the collection, the microform holdings are not adequately housed. Future planning requires space for a growing collection, as well as for reading and copying stations better designed to encourage and simplify use of the materials. Special regimes of temperature and humidity control should be established to ensure the long life of the collection.

5. *Other User Needs.* Student use of the library is heavy throughout each 24-hour period, and the facilities designed 25 years ago are clearly overtaxed. Planning for the future could provide more copying machines on different levels of the building, adequate space for student word processing, facilities for handicapped students, and internal elevators.

The major needs are relatively easy to define. Others depend on how advances in technology affect legal education and research, and on the law school's own choices among priorities. As the possibilities increase for local storage of electronic data, library space may be needed for equipment to access, manipulate, and store optical disks and other machine-readable data in-house. Space for an expanded audio and video collection may be needed if the use of such material increases in the curriculum. Controlled space for the library's rare books collection may be seen as desirable, as may a separate faculty library.

In many ways the library is the most visible of the various attributes that determine the quality of a law school and its programs. Duke has a tradition of excellence in law library service, extending from William Roalfe through his successors to the current staff. Its collection of traditional legal materials is extensive, as is its provision of modern information retrieval services. The future, however, depends not only on the continuance of a longstanding commitment to library excellence on the part of the law school administration and faculty, but on careful planning and on the development of new facilities capable of meeting the changing needs of faculty and students in the years ahead.

1 Roalfe, *The Duke University Law Library: An Account of Its Development*, 35 *Law Libr. J.* 41, 42 (1942).

2 This shift in emphasis is explored in DeGennaro, *From Growth to Change, From Acquisitions to Access: The Research Library of the Future*, *Library Issues*, March 1983, at [3].



# Building Alterations

In 1962, with a faculty numbering 11 and a student body of 230, the Duke University School of Law moved from its gothic home on the West Campus to a new brick structure which stood near several undergraduate science buildings on a wooded Science Drive. This move was the culmination of nearly ten years of careful planning and aggressive fundraising. The idea for a new building came in 1951, when Dean Joseph H. McClain, Jr., convinced University Trustees that the facility, which had seemed so adequate in 1930, could no longer accommodate the 130 students and 100,000 library volumes it housed. With a \$250,000 commitment from the Trustees and subsequent funding from the Duke Endowment the idea for a new building slowly became a reality. When the building was completed at a cost of \$1,668,000, it boasted a total 101,924 square feet of floor space and an interior design which made provisions for the many functions a law school serves. With spacious lecture rooms, ample office space, and a library with room to spare, then Dean Elvis R. Latty, who had been instrumental in seeing the building through to completion, declared:

The new building and the generous space available should give us full opportunity for the development of the law school's potential.

Twenty-three years later, the law school's 35 person faculty and student body of 556 are making due in clearly cramped quarters. Each summer, the building endures its own brand of "space wars," as professors, visiting lecturers, placement officials, support staff, and student groups all jockey for a little more of its dwindling room. However, with the creativity and persistence of Dean Carrington and the Faculty Committee on Buildings and Grounds, the law school's many constituents continue to make do.

The past few years have seen a variety of changes that have relieved space pressures in several areas. The basement area, once used primarily for storage and locker space, now houses all of the journal offices, and a new, smaller court room. After removing the Duke Bar Association office and the videotape room from the basement, the Dean expanded the offices of *Law and Contemporary Problems* and *The Alaska Law Review*. The television lounge became a locker room, and the



*New Small Court Room*





*New Seminar Room*



*New Picnic Grounds*

former locker room became a new food services area and lounge. This improvement greatly reduced congestion in the Brown Lounge, the former Green Lounge, which is scheduled to undergo another facelift sometime next year. The former *Duke Law Journal* offices are now occupied by Professor Hutchinson as well as the Assistant Dean for Alumni Affairs and Development and the fledgling Private Adjudication Center. The *Duke Law Journal* currently occupies space adjoining a new smaller moot court room in the basement.

On the main floor, the famous "fishbowl" area behind the reception and mail desk, which was once used for a student lounge and weekly student-faculty coffee hours, is now occupied by two staff members and Professors James D. Cox and Melvin G. Shimm. The Dean's Office and the corridor which runs from the entrance area to the back stairs have been renovated and recarpeted.

Change is still more evident, however, on the second floor of the law school. Classrooms 213 and 214 have been renovated in recent years and now provide comfortable, functional seating, tiered rows of desks, and carpeting. The atmosphere of the rooms is further enhanced by the addition of various works of art. Room 213 houses three prints, including Nissan Engel's "Pegasus" and two screen prints of stone figures from the Mayan Period, as well as a red broché given to Dean Carrington by the government of the People's Republic of China while on a recent visit there. The former works were given to the law school by alumnus Ralph Lamberson of the Class of 1942. The Latty Moot Court Room was refurbished and reduced in size to provide for a new seminar room and three small conference rooms, which also function as work areas for the Duke Bar Association, the Moot Court Board, and the Dean's Advisory Council. The area once occupied by the World Rule of Law Center is now predominantly a general faculty office area. Former seminar rooms 201 and 220 serve as office space for the law school support staff. Work room 204 is now the Larson Conference Room. This room is adorned by another Engel work contributed by Mr. Lamberson. The halls of the second floor classroom area include several four-person study tables where students can lunch before class or confer while studying.

The faculty lounge, in the far righthand corner of the second floor office area, is the faculty's number one "getaway" place during school hours. This modest but functional space contains one of the law school's true art treasures: a calligraphy done on the occasion of the 70th anniversary of the "Xin-hai Revolution," the 1911 revolution led by Dr. Sun Yat-sen which overthrew the Qing Dynasty. It was presented to the law school by student Shi Xi-min of Beijing, China in 1982, with the compliments of Chang Xu, the Chief Justice of the Supreme People's Court of Beijing.

The grounds and facade of the law school have remained virtually unchanged over the past twenty-five



years. In the rear of the law school, a volleyball net and sand playing surface are a testament to the continued interest in the pastime by students anxious for a quick, albeit competitive, change of pace. A small picnic area with benches and tables has been carved out of the pine forest on the west side of the building. This area is frequently used by students for eating lunch or for outdoor meetings.

With volumes growing in number daily and more students in search of study space, the library remains the most vivid example of overcrowding and the creative use of space at the law school. Built to hold 275,000 volumes, it now houses 340,000. Constant reorganization of the main floor has made room for additional study carrels and work tables. The basement areas are now filled with open carrels, as well as books. The former typing room on the basement level is now a conference room/photocopier room combination. Several of the adjacent closed carrels are now used for typing areas. Within the library's cramped confines, one can find various art works, the most prominent of

which is located in the entrance hall. The piece, entitled "The Bystanders," is a standing wood carving created by Frank Smullen. It was given to the law school by Dean Carrington.

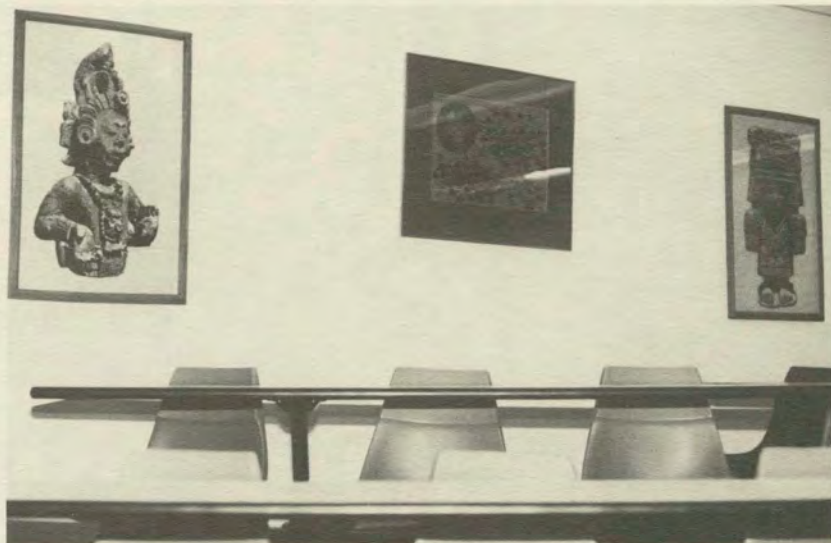


*The Bystanders*



*Faculty Lounge*

*Room 213*





# THE DOCKET



*Book Review*

# Legal Reasoning

## Martin Golding

*Legal Reasoning* (Alfred A. Knopf, 1984)

In *Legal Reasoning*, Martin Golding inquires into "the 'logic' of judicial decisionmaking." The book analyzes the kinds of arguments judges give "frequently in written form, in support of the decisions they render." Golding's book applies to judicial opinions the methods of formal logic in a manner which would be unfamiliar to most law students and practitioners. Golding's approach is, however, well-suited to the book's purpose. The book is intended for use in law-related undergraduate philosophy courses.

Golding has divided each chapter into a 'text' section, which provides the author's analysis of one or more aspects of legal reasoning, and a related 'materials' section, consisting of excerpts from judicial opinions, and scholarly essays, together with questions for in-class discussion and writing assignments. While most of the judicial opinions in the book stand for outdated propositions of law, the opinions all offer "good illustrations of significant facets of legal reasoning." The book's dual structure maximizes its educational value, first introducing students to the nature of legal arguments, then offering students an opportunity to examine for themselves the arguments contained in actual opinions. As a supplemental benefit, *Legal Reasoning* also acquaints undergraduates with the concept of tort, the principle of *stare decisis*, the distinction between questions of law and of fact, and also provides a short but useful explanation of standard legal citation form.

In Chapter I, "The Study of Legal Reasoning," Golding meets criticisms that the study of judicial reasoning is

pointless—because the real reasons for judges' decisions are often absent from their opinions, making judicial opinions nothing more than rationalizations. To do so, Golding draws a distinction between "explanatory" and "justifying" reasons for a decision. Golding offers the non-legal example of a professor who fails a student's term paper because the student has been particularly obnoxious during class. The professor returns the paper, however, with a detailed list of criticisms (poor organization, unsupported conclusions, etc.). If the student takes the case before a faculty review committee, the committee will not focus on the "real" reasons for the failing grade but rather on whether the professor's criticisms of the paper were valid, and thus a sufficient justification for the failure.

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*Golding draws a distinction between "explanatory" and "justifying" reasons for a decision.*

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Factors of personal psychology and personal prejudice may be the underlying (explanatory) reasons why a judge reaches a particular decision in a given case, but in a judicial opinion, the judge must provide reasons which show the decision to be the correct one. Legal reasoning is thus the essence of our legal system. Reasoned decisions are "attempts at rational persuasion,"

efforts to convince losing parties and society at large that the judge has not acted arbitrarily, that his exercise of authority has been legitimate. Moreover, because judicial opinions state which facts in a given case were legally significant, they enable individuals who were not parties to the case to plan their actions so as to keep them within the law. Finally, Golding notes, a legal system based on precedent can only exist where judges provide reasoned arguments for their decisions, for it is these reasoned arguments which become precedent. Thus, the study of legal reasoning is a significant one.

In Chapter II, "Types of Legal Argument," Golding reintroduces the reader to the concept of the formally valid argument (its conclusion necessarily follows from its premises) and to deductive and nondeductive argument. In a deductive argument "the premises claim to be sufficient grounds for accepting the conclusion." A deductive argument is a sound one only if all its premises are true and its form is a valid one. (One example of a sound deductive argument: All ruminants are mammals; all elks are ruminants; therefore, all elks are mammals.) By contrast, in a nondeductive argument, the premises, even when true, can do no more than establish the conclusion as more likely to be true than false. An example of nondeductive argument often used by judges is the argument by analogy: x has characteristics F, G; y has characteristics F, G; x also has characteristic H; therefore, y has characteristic H.

In Chapter II Golding next discusses the kinds of reasons judges



offer (implicitly or explicitly) for accepting as true the premises of the arguments in their judicial opinions. He does so by analyzing several old opinions. In *Joyner v. Joyner*, 59 N.C. 322 (1862), the North Carolina Supreme Court denied a wife's petition for divorce which alleged her husband had horsewhipped her but did not specify the circumstances surrounding the beating. The court stated that because there were some circumstances in which a husband is justified in beating his wife, the petition did not, as a matter of law, state sufficient grounds for divorce. The reason underlying the premise "there

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***A legal system based on precedent can only exist where judges provide reasoned arguments for their decisions.***

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are some circumstances in which wife-beating is justified," Golding terms a "goal-oriented" reason. To support its premise, the court, implicitly, made the following argument: preservation of the family is a goal the law ought to promote; a husband's right to use force to make his wife behave is a necessary means to this goal; therefore, unless there are countervailing considerations, the law ought to recognize this right to use force.

Golding next considers two early twentieth-century opinions which on substantially the same facts arrived at opposite conclusions on whether a legal right to privacy exists. ("In each case the plaintiff's picture was used without permission to advertise a product.") In *Roberson v. Rochester Folding Box Co.*, 171 N.Y. 538 (1902), the court found that there was no legal right to privacy and concluded as a result that a cause of action did not lie. The court employed what Golding terms a "rights-oriented" reason in support of the premise that no right to privacy exists. A rights-oriented reason, Golding notes,

refuses to recognize a primary right because it would necessitate acknowledging subsidiary legal rights which the court does not want to recognize. Thus, in *Roberson*, the court reasoned that recognition of a right to privacy would require recognition not only of a right not to have one's picture used in advertising without permission, but also of a right not to be gossiped about. Because no such right not to be gossiped about existed, there could be no right to privacy.

Conversely, in *Pavesich v. New England Life Insurance Co.*, 122 Ga. 190 (1904), the court concluded that because there was a right to privacy, a cause of action did lie. In support of its premise that there was a legal right to privacy, the court found that a natural right to privacy existed and that such a right could only be protected by legal recognition. Golding views this sort of subsidiary argument as simultaneously rights-oriented and goal-oriented.

The fact that the two opinions could reach opposite conclusions and yet, Golding argues, both appear reasonable, goes to the question of "coherence" ("the law seems to allow that two incompatible statements of law can each be justified."). This issue, Golding notes, is beyond the book's scope.

The remainder of the chapter provides materials which amplify Golding's discussion of legal argument. He reprints excerpts from the classic Warren and Brandeis law review article which first suggested the right to privacy. Golding then offers portions of six legal opinions each presenting a challenging question of law (e.g., does the joint owner of a bank account have a right to the entire account after he murders the other joint owner?). Golding asks the student to analyze each case using the methods he presented in Chapter II.

In Chapter III, "Precedent and Analogy," Golding discusses the significance of precedent in our legal system and "the role that arguments from analogy play in the use of precedent in legal reasoning." Courts

rely on precedent because justice requires that like cases be treated alike, that an individual's expectation that his case will be resolved in the same way as similar cases not be frustrated. By providing predictability in the law, a system based on precedent also enables individuals to plan their actions more efficiently. Nonetheless, "[t]he principle of following precedent is not a rigid doctrine . . . the way in which courts handle precedents allows for their extension to new subject matter and, as well, their restriction to a limited range." In this process, arguments by analogy play a crucial role. Their

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***By providing predictability in the law, a system based on precedent... enables individuals to plan their actions more efficiently.***

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function, Golding notes, can be viewed as one of classification. When a court argues by analogy, it asks "is X a Y for certain legal purposes?" (e.g., should bees be treated as domesticated animals for importation tax purposes?).

The fact that argument by analogy is central to the system of precedent raises a problem of logic. As noted above, Golding states in Chapter II that in nondeductive arguments—including arguments by analogy—the premises can do no more than establish the conclusion as more likely to be true than false; yet courts rely on argument by analogy to establish conclusions as unqualifiedly true. Golding states that they are justified in doing so because legal argument by analogy is "normative" and employs "practical reasoning" (i.e., because it deals with *how* a court ought to decide a given case and *why* the court has reached its particular decision). Reduced to symbols, a legal argument by analogy thus appears as follows: x has characteristics F, G; y has characteristics F, G; x also has characteristic H; F and G are



characteristics which are relevant to possessing characteristic H; unless there are countervailing considerations of equal importance, y has characteristic H; there are no countervailing considerations of equal importance; therefore, y has characteristic H. Given the truth of its premises, Golding demonstrates, a legal argument by analogy necessarily yields a true conclusion.

Golding reveals this form of argument at work in the opinion *Adams v. New Jersey Steamboat Co.*, 151 N.Y. 163, 45 N.E. 369 (1896), in which the question of law presented was whether steamboat proprietors should be strictly liable for theft of possessions from passengers' rooms in the same manner in which innkeepers were, at that time, strictly liable. The court proceeded as follows:

(i) A hotel guest procures a room for personal use, and his money and personal effects are highly subject to fraud and plunder from the proprietor. (ii) A steamboat passenger procures a room for personal use, and his money and personal effects are highly subject to fraud and plunder from the proprietor. (iii) A hotel guest's proprietor has a stringent responsibility, such that the proprietor is liable, without proof of negligence, if money is stolen from the guest's room. (iv) Procuring a room for personal use and having one's money and personal effects highly subject to fraud and plunder from one's proprietor

are reasons for the proprietor's having such a stringent responsibility. (v) If there are no countervailing considerations of equal importance, a steamboat passenger's proprietor is liable, without proof of negligence, if money is stolen from the passenger's room. (vi) There are no countervailing considerations of equal importance. (vii) Therefore, a steamboat passenger's proprietor is liable, without proof of negligence, if money is stolen from the passenger's room.

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*Legal argument by analogy is "normative" and employs "practical reasoning."*

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(The analogy here is, of course, that for a certain legal purpose, a steamboat should be treated as a "floating inn."). Golding notes that when a court weighs "countervailing considerations" (typically those of public policy) it engages in the familiar process of balancing which is essential to establishing its opinion as a correct one.

Towards the end of the chapter, Golding prints excerpts from the famous line of New York cases, beginning with *Thomas v. Winchester*, 6 N.Y. 397 (1852), and culminating in *MacPherson v. Buick Motor Co.*, 217 N.Y. 382, 111 N.E. 1050 (1916), which overturned the rule that a manufac-

turer owed no duty of care to a party with whom he had no privity of contract. The cases provide a vivid example of how courts apply legal argument by analogy to extend and restrict precedent. *Thomas v. Winchester* created a judicial exception to the privity of contract rule as regards the manufacture of an "imminently dangerous object" (in *Thomas*, a jar of poison). Through a series of subtle redefinitions of "imminently dangerous object" subsequent cases expanded the concept to include objects (e.g., a soda bottle in *Torgesen v. Schultz*\*) which were not dangerous in and of themselves, but only when manufactured negligently. Thus in *MacPherson*, Cardozo found an automobile manufacturer liable for a defective wheel despite the fact that no contract existed between the manufacturer and the plaintiff. The leading authority for the privity of contract rule, the 1842 English case *Winterbottom v. Wright* had held the manufacturer of a defective mail coach free from liability on substantially similar facts. Thus through the use of precedent and analogy, the judicially created exception ultimately consumed the rule. As Golding notes, "[t]he doctrine of precedent and the employment of the technique of analogical argument enable the law to meet two societal demands, stability and change."

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\*192 N.Y. 156, 84 N.E. 956 (1908).



# SPECIALLY NOTED

## Obituaries

### Death of a Young Preservationist

In late January, 1984, Carolyn Jean Hamm, '79, an expert in the field of historic preservation law, died in Arlington, Virginia. (As of this writing, the individual indicted for Hamm's murder has received a continuance in order that tests may be performed to determine his competence to stand trial.) In her life, Carolyn Hamm was unusually successful in combining an interest in art and architecture with an interest in law and an interest in teaching with an interest in practice to build a career of lasting benefit to her students, her clients, and to the American historic preservation movement.

Born in Plainfield, New Jersey, in 1951, Carolyn Hamm graduated from Princeton University in 1973. At Princeton, Hamm wrote her senior honors thesis on a topic in American Architectural History, and received her B.A. degree, magna cum laude, in Art History. Hamm did graduate work at Cornell University, receiving her M.A. degree in 1975 in the History of Architecture and Urban Development and in Preservation Planning.

In 1975, Carolyn Hamm entered Duke Law School. At Duke Law, Hamm excelled academically (also finding time to pursue an interest in photography and to take classes in pottery). Hamm went to law school, at least in part, out of a sense that a law degree would better enable her to establish a career in historic preservation. Historic preservation—efforts to preserve historic and architecturally significant buildings and



Hamm

areas—had been in existence in one form or another for decades. (Cities such as New Orleans and Charleston, South Carolina, enacted preservation ordinances in the 1930's. By the 1970's virtually every state had passed enabling legislation for local preservation ordinances, and hundreds of such ordinances had become law.) It was in the late 1970's, however, that a marked expansion in American preservation activity occurred, due in large part to judicial and legislative action by the federal government. In *Penn Central Transportation Co. v. New York City*, 438 U.S. 104 (1978), the Supreme Court upheld a decision by the New York City Landmark Preservation Commission barring construction of a skyscraper atop

Grand Central Terminal. In so holding, the Court removed the uncertainty which had existed as to whether local preservation controls constituted a valid exercise of the police power. Meanwhile, Congress, beginning with the Tax Reform Act of 1976, gave a strong economic impetus to historic preservation by providing tax incentives for the rehabilitation of landmark structures. As historic preservation came of age in the late 1970's, historic preservation law grew into a defined practice area, one increasingly in demand.

After receiving her J.D. degree, with distinction, in 1979, Hamm joined the Washington, D.C., law firm of Wilkes, Artis, Hedrick & Lane, Chartered. The firm, which had since its first years enjoyed an active land use practice, hired Hamm as a practicing historic preservation lawyer, having determined that, with the growth of local restrictions on the demolition of historic buildings and the institution of federal preservation tax incentives, its developer clients needed the services of an attorney with preservation expertise.

Hamm was exceptionally well-qualified for the job, both by virtue of her education and her employment experience. (Hamm had spent 1976-77 working in Washington, D.C., at the National Trust for Historic Preservation, at the Historic Preservation Office of the General Services Administration, and at the National Register of Historic Places, U.S. Department of the Interior.)

Perhaps Hamm's greatest talent in her practice at Wilkes, Artis was in finding a middle ground between developers who, with their focus on the bottom line, would initially prefer



demolition of older buildings, and those historic preservationists who were reluctant to approve alteration of historic structures.

The area of preservation tax incentives offers one example of Hamm's ability to find this middle ground. Hamm made developers aware that, because of the federal tax incentives, rehabilitating a landmark building could, frequently, be as cost effective as demolishing it. She oversaw the process of having clients' buildings listed on the Department of the Interior's National Register of Historic Places, obtained Interior Department certification for clients' buildings listed on the Department of the Interior's National Register of Historic Places and obtained Interior Department certification for clients' proposed rehabilitation of those structures (consistent with their historic character)—both steps were necessary in order to receive the preservation tax benefits. The applications process drew both on her skills as lawyer-advocate (including her superb sense of what types of development projects were feasible politically) and her extensive architectural and historical expertise (her ability to identify and describe the architecturally and historically important features of a building, her knowledge of what constituted good workmanship and who the masters of a given style were).

Among the projects on which Hamm worked during her years at Wilkes, Artis were ones involving the National Savings and Trust Building, the Army-Navy Club, and the Demonet Building. In the Demonet project, the developer preserved the exterior of the building almost in its entirety (while building a compatible new structure adjacent to the old).

Hamm had long had an interest in teaching (she was, for example, a teaching assistant during her years at Cornell). Thus, in 1981-82, she took a leave of absence from Wilkes, Artis to accept a temporary position at the University of Vermont as visiting Associate Professor and Acting Director of the Graduate Program in Historic

Preservation. At the University of Vermont, Hamm taught courses in preservation history, planning, and advocacy. Her teaching drew heavily on the insights she had gained as a practicing lawyer, was marked by its real-world focus (Hamm, for instance, staged mock hearings before a local preservation board). Hamm's students went on to careers in historic preservation throughout the United States (one student is now a research associate at the National Trust for Historic Preservation, another is working for a preservation architect and still another is employed by a preservation developer).

After her year in Vermont, Hamm returned to her practice at Wilkes, Artis. Hamm's tragic death ended her career just as her reputation in historic preservation law was becoming national in scope.

At its 5th Reunion this past October, Duke Law School's Class of 1979 began plans for a memorial, at the Law School, to Carolyn Jean Hamm. Proposals include a memorial scholarship, an annual prize for outstanding student work in historic preservation, and donation in Hamm's memory of an artistic work.

## Albert J. Esgain

Albert J. Esgain, class of '43, passed away November 2, 1983, in Naples, Florida, where he had resided since his retirement in 1976. A native of Maumee, Ohio, Mr. Esgain received his B.S. in education, as well as an M.A. in history from Ohio State University before attending Duke Law School. His education did not end when he received his J.D. degree, however; he also earned an LL.M. from George Washington University, a diploma in international law from Cambridge, and a certificate in international law from the Hague. After his graduation from Duke Law School in the spring of 1943, he passed the South Carolina bar prior to being inducted into the U.S. Army in August 1943. He also served the Army in Europe from 1946 to 1953; among the increasingly responsible posi-

tions he occupied during those years were Assistant Chief of the Military Justice Division at Headquarters EUCOM and Special Consultant to the Judge Advocate General of the Army on public and private international law. Returning to the United States in 1953, he served for fifteen years at the Pentagon as Assistant Chief of the International Affairs Division of the Judge Advocate General's Office—the top civilian position in that division. In 1968, Mr. Esgain returned to Germany, where he served as Legal Advisor to Headquarters EUCOM until his retirement. Mr. Esgain's expertise in international law, particularly as it related to the involvement of the U.S. Army, earned him many awards, including two gold medals and the Rockefeller Public Service Award.

## Walter J. Sidor, Sr.

Walter J. Sidor, Sr., class of '35, died October 1, 1984, in Hartford, Connecticut, after serving for over 40 years on the bench. Judge Sidor, a native of Hartford, graduated from Trinity College in Hartford before entering Duke Law School. After graduating from Duke, he returned to his native city, where he practiced law until 1939, when he was appointed assistant clerk of the Hartford Municipal Court. He was appointed a judge of the Municipal Court in 1943, and became a judge in the Court of Common Pleas in 1954 and a Superior Court Judge in 1966. Judge Sidor, the first Polish-American to be appointed to a statewide court in Connecticut, continued his service on the bench past the normal retirement age. From 1977 until 1982, he served as a senior judge on the Superior Court and, upon reaching the mandatory retirement age of 70 in 1982, he chose to become a referee, presiding over civil cases. Among Judge Sidor's numerous civic activities were his active involvement in the Polish-American community and his twelve years of service on the Republican Town Committee.



# Alumni Activities

## John A. Reed, Jr.

Judge John A. Reed, Jr., class of '56, announced in October that he was stepping down from the position of U.S. District Court Judge for the Middle District of Florida to return to private practice. Reed, who served for six years as a state appellate court judge before being appointed to the federal bench in 1973, has handled his duties on the bench in such an outstanding manner that attorneys in his district spoke of his resignation as "a tragedy" and "a disaster." Judge Reed's departure from the bench does not, however, signal his departure from the Orlando, Florida area; he will become a partner in the Orlando firm of Lowndes, Drosdick, Doster & Kantor on February 1, 1985.

## Gary S. Stein

Gary S. Stein, class of '56, has been nominated for appointment to the Supreme Court of New Jersey. During his law school career, Mr. Stein served as associate editor of the Duke Law Journal and as a research assistant for the U.S. Senate's antitrust and monopoly subcommittee; he was elected to the Order of the Coif upon graduation. After leaving law school, he worked in a Manhattan, N.Y., firm dealing with corporate antitrust and financial problems; he has since served as municipal attorney for Paramus, N.J., counsel to the New Jersey Election Law Revision Commission, and attorney for the Teaneck Board of Adjustment. Since 1981, he has been New Jersey's Director of

Policy and Planning, where he has worked to end prison overcrowding, create a stable financial source for transportation, and develop New Jersey's new science and technology program. If Mr. Stein's nomination is confirmed, one of his colleagues on the New Jersey Supreme Court bench would be another Duke Law School graduate, Robert Clifford, class of '50.



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## CHANGE OF ADDRESS

Name \_\_\_\_\_ Class of \_\_\_\_\_  
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