Correspondence

To the Editor:

The response by James W. Rankin and Bruce A. Hubbard[1] (R&H) to our article, *Private Credentialing of Health Care Personnel,*[2] challenges our "hypothetical academic theories" and our suggestion that the antitrust laws should be applied to prohibit intraprofessional agreements that have the net effect of eliminating sustainable competition in the production of information and opinion concerning the quality or qualifications of various types of health care providers. They aver that the existing voluntary system for accrediting and credentialing has "worked well, stood the test of time and rendered substantial benefits to the health care profession and the public at large." (p. 200). We, of course, have no doubt that the medical profession has benefitted from this system. Our concern is that some of the benefits to the profession have been derived at the expense of the general public, resulting from artifical suppression of competition and diversity in the production of information useful to consumers in purchasing health services. Although we do not disagree with R&H that individual physicians active in the accrediting and credentialing effort sincerely believe that they are working for the public good, it is not necessary to impugn anyone's sincerity in order to believe that self-interest frequently shapes conviction and action. We would also observe that, as R&H have noted (p. 193), antitrust law turns only on effects on competition, not on good intentions—or even, for that matter, on proof of what is in some ultimate sense in the public's best interest.

Because our 143-page article is to date the only sustained scholarly effort to understand the role of information in health care markets and the consequences of intraprofessional agreements affecting the nature and quantity of information available, we are quite prepared to learn that we have overlooked something. R&H, however, provide no new evidence and no argument that we did not anticipate. Indeed, their authority for most of their points is a quotation from our article. Needless to say, we believe that we have already supplied our answers to these points. A few observations on our differences with R&H may be in order, however, if only as a way of

[1] Rankin & Hubbard, *Private Credentialing of Health Care Personnel: A Pragmatic Response to Academic Theory,* 10 Am. J.L. & Med. 189 (1984).

[2] Havighurst & King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective—Part One and Part 2,* 9 Am. J.L. & Med. 131 (1983) and 9 Am. J.L. & Med. 263 (1983).

inducing readers to look more closely at our analysis, which R&H summarize only imperfectly.

It is clear that R&H disagree with our sense that an unencumbered market for information and opinion, policed by the antitrust laws, would serve consumers well. Although they call our preference for competition and diversity in the production of information and opinion "peculiar" (p. 190), we would have thought that the idea of letting citizens decide for themselves the correctness of several competing views could not be so characterized in a nation that has long fostered competition in the marketplace of ideas as well as in economic markets. Indeed, Americans generally disapprove of regimes in which a dominant elite works out its differences internally, promulgates a "party line," and frowns on taking matters "to the people." The first amendment tradition, which distinguishes the United States from such regimes, strongly suggests the importance of diversity in information sources. The diversity we seek is not "artificial," as R&H state, but is the natural state of a market freed of artificial restraints imposed by those who agree not to disagree publicly.

We are not persuaded that one-party rule has a place in medicine. We are impressed instead that the history of science is replete with examples of scientific establishments which defended, sometimes viciously, apparently objective theories only to have those theories subsequently found to be invalid as a result of the work of unconventional outsiders. These lessons seem relevant to the attempt by R&H to demonstrate that "unitary"—that is, monopolistic—accrediting and credentialing systems protect the public and are therefore preferable to a market in which conflicting opinions are aired for consumers' benefit. In our view, the search for the one system that is objectively "best" obscures the existence of the nonobjective factors that are hidden within *any* concept of the best. Moreover, forcing consumers to rely on a single authoritative source of guidance reduces their opportunity to choose alternatives that might espouse values not highly regarded by the dominant system or that might simply be less costly. (Although we are impressed by the threat of ideological monopoly in medical care, we did not mean to imply that professional control of information and opinion does not also have important economic consequences.)

To us, the most interesting legal issue, on which R&H shed no new light, is whether information and opinion produced by competitors in the form of accreditation or certification are articles of "trade or commerce" whose production and dissemination may be illegally restrained. R&H's assertion that this is not commercial activity is only that—an assertion. Production of information in this form is supported not by charitable gifts but by fees and dues paid by those who benefit in the marketplace from the possession of credentials. Consumers also value the information produced and would undoubtedly pay for it were it not for the market failure that makes it impossible for producers of a public good to collect from those

who benefit from it. We have already observed how fundamental values embedded in the first amendment (including the doctrine of commercial speech) and elsewhere in American culture strongly support the desirability of a multiplicity of information sources. We believe that it would be highly desirable and easily within traditional antitrust notions to focus antitrust attention on intraprofessional agreements that affect the supply of commercially valuable information.

Some such agreements are clearly procompetitive, in that they permit the production of information and opinion that would otherwise not be available. Part One of our article was a vigorous defense of competitor collaboration to create accrediting and credentialing programs. Although R&H wish we had stopped there, we did not. Instead, we proceeded to ask whether the scale and sponsorship of some such intraprofessional efforts might cause them to have, on balance, an anticompetitive effect, restricting the diversity of views available to consumers. We found, for example, that the 23 specialty boards recognized by the American Board of Medical Specialties have agreed to divide the market—not the market for physician services, as R&H imply, but the market for information itself. By mutually agreeing on the precise definition and limits of each specialty, the ABMS boards have effectively agreed that each will publish only a certain type of information not produced by the others, thus ensuring that the public will hear only one authoritative opinion as to who is competent to provide each professional service. Although R&H are correct that competition between different types of specialists is not totally suppressed, market-division agreements are normally per se violations, so that there should be no need for proof of the specific adverse effects of this collaboration—not that it would be impossible to show any.

Another leading candidate for scrutiny under our theory is the Joint Commission on the Accreditation of Hospitals, a joint venture of four leading organizations each of which possesses a different opinion about what makes a good hospital. To our eye, the agreement of these bodies to resolve their differences and to speak with one voice is an agreement not to compete. Because we think that the harmful effects of the JCAH in unduly standardizing hospitals in the interest of physicians can be demonstrated, we would regard the joint venture forming the JCAH to be so large and powerful as to be an unlawful combination in restraint of trade.

We welcome further discussion of these issues, not only because the legal stakes are high but also because it is important to understand the function of information in health care markets and the precise role of professional organizations in informing consumers.

Clark C. Havighurst, J.D.
Nancy M. P. King, J.D.