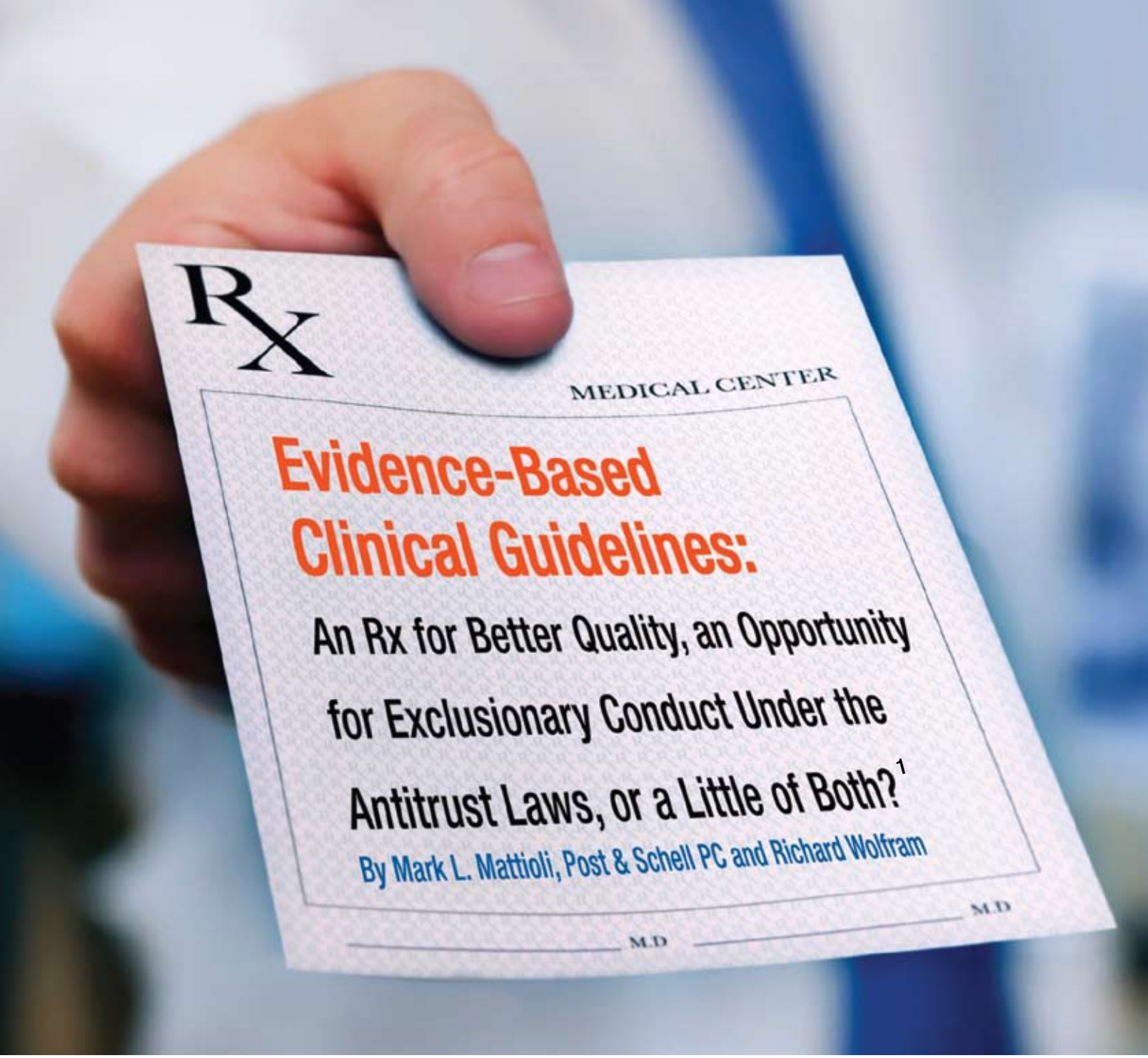


Introduction

Evidence-based clinical practice guidelines are a central component of the recently passed federal healthcare law and continue to assume great importance in the practice of medicine today.[2] Clinical-practice guidelines inform clinical decisions by providing criteria for diagnosis, management, and treatment of specific diseases and medical conditions. These guidelines are intended to summarize and integrate the best scientific evidence into their recommendations and standardize medical care. Structured appropriately, clinical guidelines increase overall efficiency, enhance quality, and reduce complications in healthcare delivery. When used to limit competition, however, through the exercise of market power—such as by raising prices, excluding competitors or raising rivals' costs, suppressing innovation, and creating entry barriers—their creation and use can give rise to antitrust issues.

Most, if not all, professional medical specialty associations have established guideline committees or panels that develop practice guidelines pertinent to their areas of specialization. Since the 1990s, evidence-based guidelines have had a pronounced effect on healthcare, influencing not only clinical practice decision making (increasingly, by limiting clinical discretion), but also coverage of treatments by payors and to some extent, legal standards of care.

Given the ever-increasing importance of evidence-based medicine, providers and payors must pay attention to the possible anticompetitive development and application of clinical guidelines. Clinical guideline development is a form of standard setting whereby a small group of specialists makes decisions for the medical market, thereby effectively preempting market choice. As such, this process may be subject to the antitrust laws, no differently than all other types of standard setting. Accordingly, clinical standards, as with any other standards, can be misused to foreclose competition. A particularly illuminating example, discussed below, was an 18-month investigation by the Connecticut Attorney General (AG) regarding the development of guidelines by the Infectious Diseases Society of America (IDSA) for the diagnosis and treatment of Lyme disease. Pursuant to a settlement with the AG, the IDSA reconstituted the panel, which held a public hearing with presentations on the science of Lyme disease and recently issued a report stating its conclusions.

Evidence-Based Medicine Plays an Increasing Role in Healthcare Delivery

The role of clinical guidelines in improving healthcare quality and delivery must be viewed in the wider context of healthcare developments and reform. For instance, clinical guidelines increasingly are treated as a key component in clinical integration by providers. Thus, the Federal Trade Commission (FTC), in several advisory opinions commenting on clinical integration programs, favorably cited the utilization of clinical guidelines as key to the approval of such programs.[3] Clinical guidelines also are playing a larger role in public and private payment issues. For instance, their presence or absence is a key factor in determining whether integrated organizations formed as a result of the new federal healthcare reform law will be entitled to additional payments under Medicare or Medicaid. Further, such guidelines will become a central focus in determining whether Medicare will pay for complications that could have been prevented by the use of evidence-based guidelines.

Evidence-based medicine plays a central role in the Patient Protection and Affordable Care Act (PPACA) signed into law on March 23, 2010.[4] PPACA encourages the use of accountable care organizations (ACOs) that coordinate care among providers at different levels, such as hospitals and physicians, in order to provide a seamless web of care. PPACA creates a Medicare shared savings program whereby ACOs that meet certain requirements may share in the savings their efforts produce. One requirement is that the ACO develop and utilize evidence-based medicine.[5] In addition, utilization of evidence-based guidelines will play a major role in Medicare reimbursement where, under the ever-increasing "never-events" policy, the Centers for Medicare and Medicaid Services (CMS) will deny payments for hospital-acquired complications when such complications could have been avoided through the use of evidence-based guidelines.[6] Finally, under the PPACA's insurance exchange provisions, the Department of Health and Human Services Secretary is required to provide guidelines for increased reimbursement to reward the use of "evidence based" medicine.[7]

Evidence-based guidelines also have been an essential component in clinically integrated networks. For instance, in the FTC's favorable advisory opinion regarding MedSouth Inc., the agency cited the fact that the Colorado-based independent practice association would adopt and utilize clinical protocols covering the majority of MedSouth physicians' patient population and provide measurable performance goals relating to the quality and appropriate utilization of services that are linked to those protocols.[8] The protocols covered both office and hospital practice, and MedSouth proposed to monitor physician compliance and expel physicians who did not meet the goals. Forty-eight such guidelines were developed, and the network anticipated developing 100-150 such guidelines covering 80-90% of the diagnoses of patient-members.[9] Due to the substantial integration, the FTC opined that the network of independent physicians was able to negotiate jointly with payors, as such joint negotiation would be essential to achieve the quality goals of the network.[10]

While clinical guidelines play an expanded role in Medicare, Medicaid, the PPACA, and clinical integration, the development of clinical guidelines can run afoul of antitrust law and draw unwanted scrutiny from courts and enforcement agencies for those involved in the creation and adoption of such guidelines.

Overview of Antitrust Issues Involved in Standard Setting

A major goal of antitrust is to protect and enhance free-market competition by prohibiting unilateral or joint conduct that unlawfully restrains trade and suppresses competition in a relevant market. Organized standard setting, although potentially a restraint of competition, is treated leniently under the antitrust laws because it is designed to produce procompetitive benefits and efficiencies; examples include enhanced safety, technological interoperability, and, in the case of clinical guidelines, improved medical care and delivery. For clinical guidelines, the affected "market" might consist of alternative treatment modalities, alternative drugs or medical devices that may be substituted for each other, or alternative medical delivery methods.

Guideline development necessarily reduces choice in the market because key decision-makers/guideline develop-

ment participants—such as physicians, hospitals, and other providers—who also may compete to have their favored treatment modality or product chosen for the guideline, collectively decide on a guideline and thereby effectively preempt competition in the market. Competition thus occurs not *in the market*, directly, but *for the standard*, which in turn may significantly affect or control the market. Typically, as noted, this activity does not create antitrust concerns.

On the other hand, for the same reason that standards can achieve efficiencies by having specialists choose *for* the market and thus preempt market choice, this power to control a relevant market also holds the potential to unlawfully suppress competition or result in market capture. If participants or the entity responsible for a clinical guideline have an economic interest in the outcome of the standard, subvert the guideline development process through deception or related conduct (including violating the standard setting rules of the organization itself or common law principles of due process or good faith and fair dealing),[11] and have or will thereby obtain market power in a relevant antitrust market, then such conduct can raise issues under Sections 1 and 2 of the Sherman Act, state unfair competition law, or Section 5 of the Federal Trade Commission Act.[12] Thus, the normal focus of antitrust law on the nature and quality of competition in the *market* turns, with respect to standard setting, to the nature and quality of competition for the *standard*, which in turn might control the market.[13] Since the 1980s, antitrust law has been applied to standard setting to ensure that standard setting organizations (SSOs) are not captured, and competition subverted, through abuse of the standard-setting process.[14]

In recognition of the procompetitive benefits and efficiencies of standard setting, the antitrust rule of reason, which weighs procompetitive benefits against anticompetitive effects, is normally applied to the exchange of information and related conduct undertaken by competitors in SSOs in choosing a standard.[15] But antitrust law also has a role to play, to ensure that standard setting does not devolve into anticompetitive, exclusionary conduct, which, if unconstrained, can lead to the unlawful acquisition of monopoly power. After all, private, competitive actors involved in the process are making decisions that may favor their economic interests and harm the economic interests of others, such as, in the case of clinical guidelines, competitors, providers, insurers, and patients. It is therefore imperative that members of clinical guideline panels with economic interests not bias the guideline development and stifle competition, and that entities with oversight responsibility for those panels ensure that such abuse of the process not occur.[16]

As medical guidelines have come to play a much larger role in healthcare in recent years, there also has been an increasing number of revelations about financial conflicts of interest on the part of medical-guideline panelists, whose financial interests may have influenced the guidelines ultimately decided upon by their panels.[17] The implications of such financial interests for clinical guideline development, although not widely appreciated, now loom larger in healthcare, as illustrated by the Connecticut AG's recent investigation and settlement regarding guidelines for the diagnosis and treatment of Lyme disease.

The role of clinical guidelines in improving healthcare quality and delivery must be viewed in the wider context of healthcare developments and reform.

Case Study: Connecticut AG Antitrust Investigation of IDSA Lyme Guidelines

In May 2008, the Office of the Connecticut AG reached a settlement with the IDSA after an 18-month investigation into alleged anticompetitive practices by the IDSA in its development of clinical-practice guidelines for the diagnosis and treatment of Lyme disease.[18] The investigation was prompted in part by complaints from patient advocacy groups, a competing physician specialty association, and a diagnostics laboratory (complainants). The matter is unusual, and received extensive coverage in the national and legal press, for its ostensible application of antitrust standard setting principles—typically applied in a conventional commercial context—to the competitive analysis of the development of clinical guidelines.[19]

Pursuant to the settlement agreement, the IDSA formed a new panel to reassess the guidelines. An ombudsman, a specialist in medical ethics and conflicts of interest, was responsible for ensuring that no panel members had financial conflicts of interest.[20] Sixteen physicians and researchers and two patient advocates made formal, public presentations to the panel in a full-day proceeding aired live over the Internet. Based on these presentations and other evidentiary submissions, the panel then determined, by supermajority vote, whether the science supported the guideline recommendations. The panel had the option to vote to make no changes, modify the guidelines, or replace them entirely. The Connecticut AG retained general oversight over the process to ensure compliance with the settlement agreement. In April 2010, the panel released its report, upholding the previous guideline as supported by the scientific evidence.[21]

Central Dispute: Chronic Lyme Disease

The AG's investigation focused on IDSA guidelines developed in 2000 and 2006 for the treatment of Lyme disease. Among other things, the guidelines implicitly conclude that there is no scientific basis for "chronic Lyme disease," a condition in which patients can suffer a range of ill effects for months or years. This conclusion was based on the view that the spirochete that carries the disease does not persist in the body long term. As a result, the guidelines state that treatment with a course of antibiotics beyond 30 days is not appropriate and that persistent symptoms represent, at most, a "post-disease syndrome." Although a substantial body of scientific and empirical studies suggests that long-term antibiotic treatment can be effective and that the spirochete can persist in the body notwithstanding "standard" courses of antibiotics, the IDSA did not find these studies persuasive—a view now also endorsed by the reconstituted panel in its April 2010 report.

Evidence-based clinical practice guidelines are a central component of the recently passed federal healthcare law and continue to assume great importance in the practice of medicine today.

Findings of the Attorney General

According to the AG's press release, the investigation revealed "significant procedural deficiencies related to the IDSA's development of its 2006 Guidelines" and found that the panel and the IDSA failed to ensure that the guideline development comported with due process, as required by antitrust law when persons (or their association) involved in standard setting have an economic interest in the outcome.[22] In particular, the AG said the panel "improperly ignored or minimized consideration of alternative medical opinion and evidence regarding chronic Lyme disease, potentially raising serious questions about whether the recommendations reflected all relevant science."[23]

Notably, the AG also found that:

- key panel members had significant conflicts of interest based on financial interests in drug companies regarding vaccine development, Lyme disease diagnostic tests, patents, and consulting arrangements with insurers and that these individuals "exclude[d] divergent medical evidence and opinion";[24]
- the IDSA failed to conduct a conflict-of-interest review for any of the panelists prior to their appointment to the guideline panels;
- the IDSA did not comply with its own policies for selecting a panel chair, "enabling the chairman, who held a bias regarding the existence of chronic Lyme, to handpick a likeminded panel without scrutiny by or formal approval of the IDSA's oversight committee";
- the IDSA's 2000 and 2006 panels "refused to accept or meaningfully consider information regarding the existence of chronic Lyme disease," among other things by "removing a panelist from the 2000 panel who dissented from the group's position on chronic Lyme disease to achieve 'consensus'" and by "block[ing the] appointment of scientists and physicians with divergent views on chronic Lyme";
- the IDSA improperly sought to portray a second set of Lyme disease guidelines (issued by the American Academy of Neurology) as independently corroborating its findings, when the IDSA knew that the two panels shared key members in violation of the IDSA's own conflict-of-interest policy; and
- a number of insurers have used the IDSA guidelines as justification for denying reimbursement for long-term antibiotic treatment.[25]

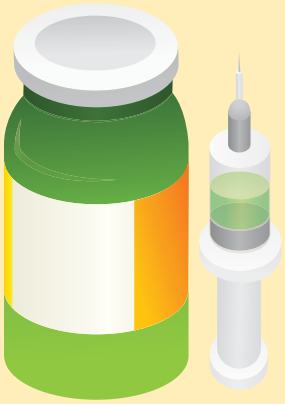
Complainants' Legal Theory

The complainants—patient groups, a physician specialty association, and a diagnostics laboratory—had urged the AG's Office, acting in its *parens patriae* capacity, to investigate the guideline development, with a focus not directly on the

scientific legitimacy of the guidelines but on the legality of the development process. They contended that the IDSA, in combination with members of its Lyme disease guidelines panel, engaged in an unlawful refusal to deal in, and monopolization of, the market for the treatment of Lyme disease in violation of federal and state antitrust laws by abusing the guideline development process for Lyme disease and implementing the disease definition and treatment modality propounded by the resulting guidelines.[26]

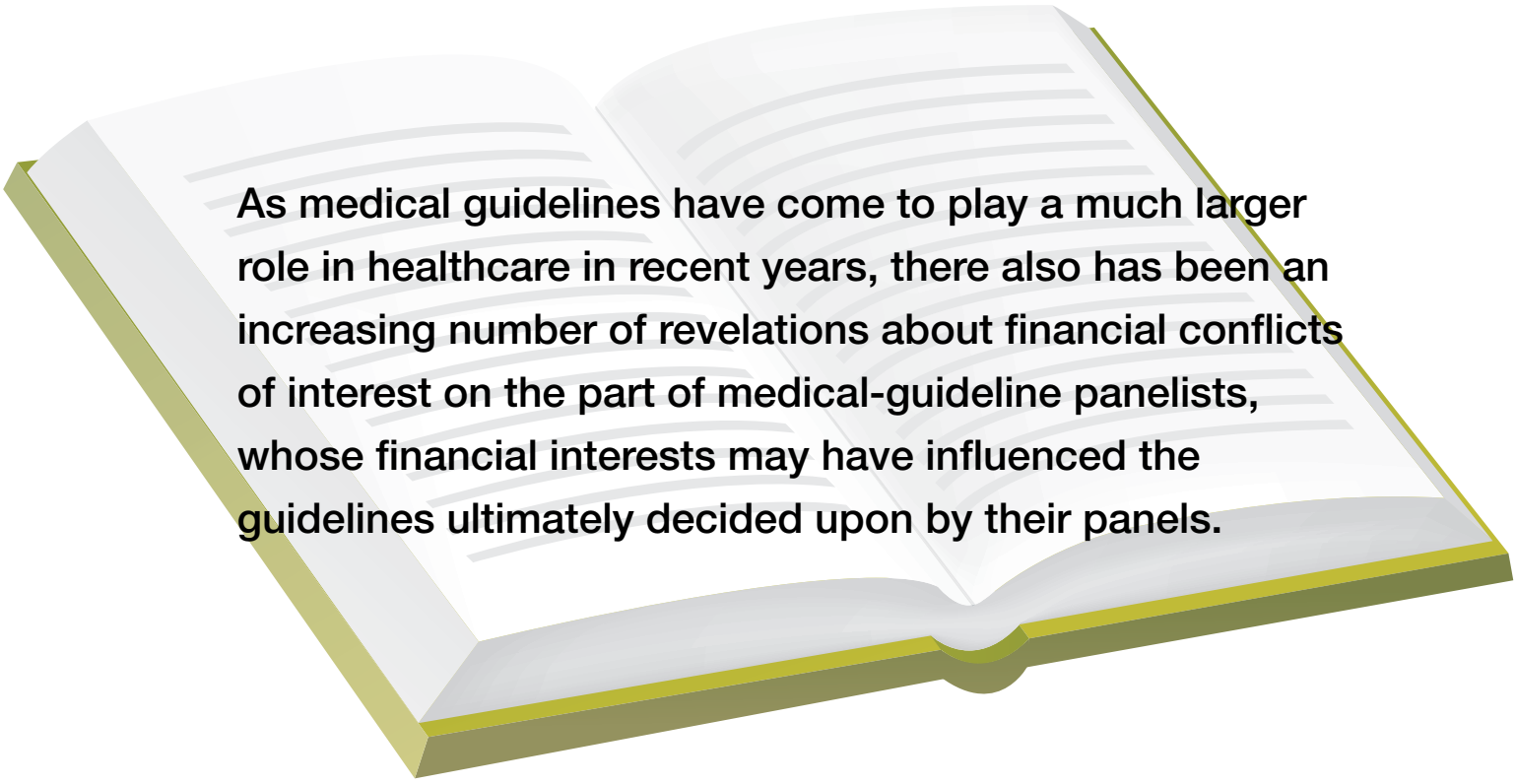
The complainants alleged the following: (1) the relevant product market was the treatment of Lyme disease, in which adherents and non-adherents of the IDSA guidelines compete for patients; (2) members of the IDSA's guideline panel on Lyme disease biased, and thus distorted, the standard-setting process by bringing their own commercial interests to bear and then excluded competing points of view (by stacking the panel and subsequently cutting off any debate); (3) this conduct resulted in guidelines that denied the existence of chronic Lyme disease as a separate diagnosis and excluded long-term antibiotics as an acceptable treatment; (4) the IDSA, the dominant professional association developing guidelines for Lyme disease, exercised market power through enforcement conduct intended to compel adherence to its guidelines; and (5) these actions caused anticompetitive harm by limiting treatment options, foreclosing clinical discretion, and causing economic harm to physicians and chronic Lyme patients.[27]

[F]or the same reason that standards can achieve efficiencies by having specialists choose for the market and thus preempt market choice, this power to control a relevant market also holds the potential to unlawfully suppress competition or result in market capture.



In sum, the complainants alleged claims under Sections 1 and 2 of the Sherman Act on the grounds that the IDSA's relevant conduct was commercial in nature, exclusionary, and it has contributed substantially to the alleged anticompetitive effects.[28] For clinical guideline development to be actionable, first, the conduct must be sufficiently commercial to trigger subject matter jurisdiction under the Sherman Act.[29] Second, subversion of the development of medical guidelines can constitute exclusionary conduct under the Sherman Act, provided the responsible association or panel participants are economically interested in the outcome. This further depends on showing (a) they had market power and/or obtained or extended such power as a result of the process;[30] (b) that they competed with injured parties;[31] (c) that they engaged in substantive exclusionary conduct, in the form of abuse of the association and/or common law rules for guideline development;[32] and (d) quite importantly, that antitrust law applies to standard setting without the need to evaluate the objective, scientific merits of the standard beyond threshold reasonableness.[33]

Third, complainants contended that the necessary causal link between the suspect conduct and alleged anticompetitive effects is established by showing that abuse of the guideline development procedure substantially contributes to anticompetitive effects, including the foreclosure of treatment options available to patients, a chilling effect on physicians otherwise amenable to treating with long-term antibiotics, and resulting decisions by insurance companies not to cover long-term antibiotic treatment. To satisfy the causation requirement, the guidelines must be effectively mandatory rather than merely informational.[34] The complainants contended that illegal restraint, however, can be inferred from economic influence, even without coercive enforcement[35] and that the requisite coercion may be found even absent evidence of compulsory adherence to the association rules.[36] Next, complainants contended that *Schachar v. American Academy of Ophthalmology, Inc*,[37] sometimes cited for the proposition that a clinical guideline does not impose any restraint cognizable under the antitrust laws, is distinguishable and would not apply to the Lyme matter. Whereas in *Schachar* there was no enforcement restraint—the press release was informational and not backed up with enforcement power—and little if any reduction of output and a drop in demand, in the Lyme matter, they maintained, there was a reduction in output and no evidence of a drop in demand. Also relevant to a showing of the requisite causation is the power of medical "gatekeeping."[38] Furthermore, they contended, a product need not be excluded entirely from the market for there to be anticompetitive harm.[39] Finally, the complainants took the view that although the Department of Justice/FTC Health Care Policy Statement on Treatment Guidelines[40] create a safety zone for a good deal of conduct relating to guideline development, coercive enforcement of such guidelines is excluded from the safety zone.



The IDSA admitted no liability in entering into the settlement agreement and maintained throughout that, among other things, the guidelines are not mandatory (as noted in a disclaimer on the IDSA website for all of its guidelines) and that the financial interests of the members of the original panel were disclosed and in any case created no conflicts of interest.[41] Although the IDSA has offered no public, detailed legal defense, some of these same points were echoed in more legal and policy-based terms in a comment in JAMA in 2009 by two healthcare legal scholars.[42] The authors criticize the AG's investigation as legally unfounded and a misguided elevation of normative, "political" values over positive, scientific evidence and evidence-based medicine. They note, *inter alia*, that the IDSA could not have market power over treatment options that are the subject matter of non-binding guidelines, but that even if it did, a challenger could not show that any alleged anti-competitive effects of the guideline development outweighed patient benefits. The guidelines, they said, "substantially advanced patients' interests" and, furthermore, "[t]he courts should defer to professional medical associations when standards are set on the basis of valid science aimed at protecting patient health or safety." Citing from *Schachar*, they added that "ultimately professional guidelines are a 'medical not a legal question,'" so "when a professional organization bases its work on the weight of science there can be no improper restraint of trade." Finally, the authors warn that "the daunting potential for litigation by those unhappy with the outcomes of treatment guidelines may well chill the willingness of medical associations to make appropriate scientific evaluations of controversial topics . . . [which] would significantly threaten patient care and increase medical costs."[43] These are clearly but a few points on which lively, constructive debate can deepen an understanding of the nature and difficulty of developing clinical guidelines.

Guideline Development and Unanswered Questions: How Should Participants Evaluate Standards?

The example of the Lyme investigation, settlement, and review by the reconstituted IDSA panel, which concluded by endorsing the IDSA guidelines, holds some important lessons for various participants in healthcare markets including physicians, hospitals, other providers, payors, or patients. The Lyme matter was of course not litigated and the theory not tested in a court of law. A defendant targeted by the kinds of claims here, based on an antitrust theory of abuse of standard setting, can raise various defenses that, depending on the facts, may be reason for dismissal of the action. Nonetheless, the investigation clearly suggests that the improper creation of standards can justify antitrust and other scrutiny of the development of clinical guidelines to ensure that relevant markets are not captured by economically interested parties who improperly control the guideline development process. In order to fulfill the principle of evidence-based medicine in the development of clinical guidelines, it is therefore worth recalling that "an ounce of prevention is worth a pound of cure."

Finally, the Lyme investigation prompts two additional questions that bear on the proper implementation of the principles of evidence-based medicine in guideline development. First, what is the appropriate evidentiary standard by which each individual panelist should determine whether the scientific evidence supports the guideline, in particular when the guideline is effectively mandatory? Might a preponderance of evidence be enough, "clear and convincing" evidence, or proof beyond a reasonable doubt, given that mandatory guidelines constrain clinical discretion? The settlement agreement was silent on this question, even though it required a supermajority of panelists to determine that the science supported any given recommendation.[44] And second, if a subsequent guideline review, run as here pursuant to a settlement agree-

In order to fulfill the principle of evidence-based medicine in the development of clinical guidelines, it is therefore worth recalling that "an ounce of prevention is worth a pound of cure."

ment or other procedure intended to prevent any potential subversion of the guideline development, concludes that the original guideline is supported by the scientific evidence, does that invalidate the antitrust foundation of an investigation into the original development process? Arguably, because "the objective validity of a restraint has never been a defense to an antitrust charge,"[45] the only way to determine the proper outcome of guideline development, given that a court or investigating agency is not equipped to judge the scientific validity of the guideline on its merits, is to ensure that it is carried out in conformity with the rules and guidance of antitrust standard setting law. Opponents would argue, however, that this raises form over substance and is simply a dispute among academicians and not subject to antitrust scrutiny because the economic interests are either trivial or fully disclosed. Further, they might argue that if the review concluded that the original guidelines were correct on the science, then whatever the arguable flaws in the guideline development process, there was no resulting harm to competition. The response would be that sustaining an antitrust claim of anticompetitive harm in guideline development does not turn on whether the guideline is later found to be objectively valid: a finding of objective validity may ultimately determine whether there are damages, but it is irrelevant to whether the guideline was developed in an anticompetitive fashion.

Conclusion

Although healthcare providers do not typically think about the antitrust implications of standard setting, as discussed above, such issues can arise in a variety of ways. For instance, for a hospital, integrated provider organization, or ACO seeking to adopt standards, it is important to understand how the standard was developed, because a standard developed through an improper process not only might be medically incorrect but also might improperly exclude providers and procedures. Similar issues can arise with regard to physicians developing standards, especially when the standard will favor one group of providers over another. Finally, for a payor, utilization of an improperly created standard can result in a challenge that it somehow improperly conspired to skew the standard in a way to reduce, improperly, payment for services, thereby giving rise to claims of an improper conflict of interest. Hence, understanding the pitfalls is critical to reducing the potential antitrust risks, as clinical standards continue to assume an increasing role in healthcare delivery. As the Lyme matter illustrates, hammering out consensus-based clinical guidelines is an arduous task, and now that they are in the spotlight, all the more scrutiny is required to ensure that they properly implement the goals of evidence-based medicine. C

About the Authors

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ENDNOTES

1 For more detailed treatments of these topics *see,* M. Mattioli, *Standards, Quality, and Healthcare Reform: A Unified Antitrust Theory for the Creation of Clinical Guidelines*, 2010 Health Law Handbook, Ch. 9 (West 2010) (A. Gosfield ed.); R. Wolfram, *Connecticut Attorney General Investigation and Settlement Highlights Possible Applicability of Antitrust Standard Setting Law to the Development of Clinical Practice Guidelines*, 22 Antitrust Health Care Chronicle 8 (2008), also *available at* Health Lawyers Weekly, vol. 6, no. 46 (Am. Health Lawyers Ass'n Dec. 5, 2008), www.healthlawyers.org/News/Health%20Lawyers%20Weekly/Pages/default.aspx.

2 *See, e.g.,* M.L. Sheetz, *Toward Controlled Clinical Care Through Clinical Practice Guidelines: The Legal Liability for Developers and Issuers of Clinical Pathways*, 63 Brook L. Rev. 1341 (1997) (types of clinical guidelines).

3 *See, e.g.*, MedSouth Inc., FTC Advisory Opinion to John J. Miles (Feb. 19, 2002), www.ftc.gov/bc/adops/medsouth.shtm; Greater Rochester IPA, Inc., FTC Advisory Opinion to Christi Braun (Sept. 17, 2007), www.ftc.gov/bc/adops/gripa.pdf; Tri-State Health Partners, Inc., FTC Advisory Opinion to Christi Braun (Apr. 13, 2009), www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf.

4 Pub. L. No. 111-148 (Mar. 23, 2010).

5 *Id.* at § 3022. *See also id.* at § 3502(c)(2).

6 42 U.S.C. § 1395ww(d)(4)(D)(iv)(III) ("By not later than October 1, 2007, the Secretary shall select diagnosis codes associated with at least two conditions, each of which codes meets all of the following requirements

(as determined by the Secretary): The code describes such conditions that could reasonably have been prevented through the application of evidence-based guidelines.")

7 *See* Pub. L. No. 111-148, § 1311(g)(1)(C).

8 FTC Advisory Opinion to John J. Miles (Feb. 19, 2002), *supra* note 3.

9 *See also* Greater Rochester IPA, Inc., FTC Advisory Opinion to Christi Braun (Sept. 17, 2007), and Tri-State Health Partners, Inc., FTC Advisory Opinion to Christi Braun (Apr. 13, 2009), *supra* note 3.

10 Conversely, in Suburban Health Organizations, Inc., the FTC refused to provide a favorable opinion regarding a clinically integrated network where the network proposed only limited use of clinical protocols. *See* FTC Advisory Opinion to Clifton Johnson 1 (Mar. 28, 2006), www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaffAdvisoryOpinion03282006.pdf.

11 *See, e.g.*, *Indian Head, Inc., v. Allied Tube & Conduit Corp.*, 817 F. 2d 938, 947 (2d Cir. 1987), *aff'd*, 486 U.S. 492 (1988); *American Soc. of Mech. Eng'rs, Inc. v. Hydrolevel Corp.*, 456 U.S. 556 (1982).

12 Section 5 prohibits "unfair methods of competition . . . and unfair or deceptive acts or practices in or affecting commerce." 15 U.S.C. § 45(a)(1). Section 5 has been interpreted as applying to standard setting abuse, as a stand-alone violation not predicated on violation of the federal antitrust laws. *See, e.g.*, Concurring Opinion of Commissioner J. Leibowitz, *In Re Rambus*, Dkt. No. 9302 (Aug. 2, 2006), *available at* www.ftc.gov/os/adjpro/d9302/060802rambusconcurringopinionofcommissionerleibowitz.pdf.

13 There might of course be competing standards in the same market; arguably, however, the efficiency gained by having standards increases as their number in an identical market decreases. On the other hand, it is generally recognized that in the case of clinical guidelines, if the science is unclear, then guidelines should preserve clinical discretion. For one of the stronger articulations of this view, see American Academy of Pediatrics (Policy Statement of Steering Committee on Quality Improvement and Management): "Classifying recommendations for clinical practice guidelines," Pediatrics 2004, 114:874-877, *available at* http://aappolicy.aappublications.org/cgi/reprint/pediatrics;114/3/874.pdf.

14 *See, e.g., Allied Tube, Hydrolevel, supra* note 11; *Broadcom Inc. v. Qualcomm Corp.*, 501 F.3d 297 (3d Cir. 2007); *In re Dell Computer Corp.*, FTC Dkt. No. 3658, 121 F.T.C. 616 (Consent Order, May 20, 1996); *In re Union Oil Co. of Calfornia*, FTC Dkt. No. 9305 (Decision and Order, July 27, 2005).

15 *See generally* Deborah Platt Majoras, Chairman, Fed. Trade Comm'n, "Recognizing the Procompetitive Potential of Royalty Discussions in Standard Setting" (Sept. 23, 2005), www.ftc.gov/speeches/majoras/050923stanford.pdf.

16 *See, e.g., Allied Tube & Conduit v. Indian Head, Inc.*, 486 U.S. 492, 501 (1988). *Allied Tube* teaches that the standard-setting process should be unbiased and ensure that no economic interests of persons engaged in the standard setting are permitted to subvert the process and stifle competition.

17 This development has been widely reported on and is the subject of a growing body of scientific and public policy literature. *See, e.g.*, Richard Amerling et al., *Guidelines Have Done More Harm Than Good*, 26 Blood Purification 73 (2008); *see generally* Jerome Kassirer, On the Take: How Medicine's Complicity with Big Business Can Endanger Your Health (2004). Recent prominent examples of commercial conflicts of interest influencing guidelines include the National Kidney Foundation's panel that recommended erythropoietin in 2006, the American Society of Hypertension's panel in 2006 that narrowed the parameters of "normal" blood pressure (while prominent panel members stood to benefit from increased sales of blood pressure-lowering drugs), and numerous examples of psychiatrists serving on guideline panels while benefiting financially from work on behalf of pharmaceutical companies making psychiatric drugs. *See, e.g.*, Gardiner Harris & Janet Roberts, *Doctor's Ties to Drug Makers are Put on Close View*, N.Y. Times, Mar. 21, 2007; Sheryl Gay Stohlberg, *Study Says Clinical Guidelines Often Hide Ties of Doctors*, N.Y. Times, Feb. 6, 2002.

18 *See* Press Release, Connecticut Attorney General's Office, "Attorney General's Investigation Reveals Flawed Lyme Disease Guideline Process, IDSA Agrees to Reassess Guidelines, Install Independent Arbiter" (May 1, 2008), *available at* www.ct.gov/ag/cwp/view.asp?a=2795&q=414284&pp=12&n=1 (hereinafter "CT AG Lyme Press Release"), containing link to Settlement Agreement, *available at* www.ct.gov/ag/lib/ag/health/idsaagreement.pdf.

19 *See, e.g.*, Philip Shiskin, *Medical Society Settles in Lyme Disease Dispute*, Wall St. J., May 2, 2008, at B4; Rachel Bull, *Medical guidelines found to be anti-competitive*, Global Competition Rev., May 2, 2008; Jacqueline Bell, *Antitrust Lyme Disease Probe Sparks Debate*, Competition Law 360, June 12, 2008; *Medical Group Settles Probe into Guidelines for Lyme Disease*, 16 No. 2 Andrews Health L. Lit. Rep. 12 (June 26, 2008); Susan Landers, *Lyme treatment accord ends antitrust probe*, Am. Med. News (June 9, 2008); Brian Kehrl, *Connecticut AG Calls for Review of Lyme Treatment Guidelines*, The Enterprise (May 9, 2008); Jane Brody, *A Threat in a Grassy Stroll: Lyme Disease*, N.Y. Times, July 15, 2008.

20 The Settlement Agreement provided as follows:

> A conflict of interest exists when anyone involved in the guideline process has a functional or other beneficial interest in the products or concepts addressed in the guidelines or in competing products or concepts that might bias his or her judgment. For guidance purposes, if the combined financial or beneficial interests in the products or concepts addressed in the guidelines exceed $10,000, those interests may be considered to bias a participant's judgment.

The ombudsman, in his sole discretion, interpreted this provision to mean that no physician making more than $10,000 per annum from the treatment of what he or she viewed as possible "chronic Lyme disease" could serve on the panel, whereas a physician who treated what he or she regarded as "post-Lyme syndrome" could serve on the panel regardless of the earnings derived therefrom. *See* Settlement Agreement, *available at* www.ct.gov/ag/lib/ag/health/idsaagreement.pdf.

21 Final Report of the Lyme Disease Review Panel of the Infectious Diseases Society of America (IDSA), *available at* www.idsociety.org/Content.aspx?id=16499#guide. On April 22, 2010, upon the issuance of the panel's report, the AG stated in a press release that his office "will assess the final report and the review process leading to that report to determine whether the IDSA fulfilled the requirements of our settlement." Of possible relevance to the AG's comment, see letter dated February 1, 2010 from the AG to the IDSA, expressing "concern" over "improper voting procedures" used by the IDSA in the review voting process and requesting that the IDSA redo the vote to comply with the Settlement Agreement. (Letter on file with the authors.)

22 CT AG Lyme Press Release, *supra* note 18.

23 *Id.*

24 Furthermore, in the complainants' view, these economic interests were consistent with the guidelines' curtailment of recommended treatment beyond 30 days of antibiotics. Conflicts of interest in medical guidelines typically relate to panel members' commercial interests in drugs used for *treatment*. Here, the alleged conflicts pertain to panelists' commercial interests relating to vaccines, diagnostic tests, and insurance consultancies. Guidelines that restrict the disease definition favor vaccine manufacturers and developers because the guidelines increase the statistical rate of efficacy of the vaccines, so that fewer people taking the vaccine contract the disease. Guidelines that mandate testing to confirm a diagnosis promote the interests of those who develop and manufacture diagnostic tests. Here, the mandated test is widely alleged to be flawed, and the guidelines effectively deny that patients manifesting long-term symptoms are suffering from Lyme disease because they test negative. Finally, guidelines that effectively deny treatment to patients are favorable to insurance companies and specialists who consult for them.

25 CT AG Lyme Press Release, *supra* note 18.

26 For a more detailed explanation and analysis of complainants' claims, see R. Wolfram, *Connecticut Attorney General Investigation and Settlement Highlights Possible Applicability of Antitrust Standard Setting Law to the Development of Clinical Practice Guidelines, supra* note 1. In the view of the complainants and the AG, the guidelines also effectively deny physicians the ability to use clinical discretion in diagnosing and treating Lyme disease, despite the IDSA's general disclaimer that its guidelines are not mandatory. The guidelines also provide no additional treatment options, apart from palliative care, for patients who fail to improve under treatments identified by the IDSA's protocol.

27 Complainants presented evidence, *inter alia*, that doctors wishing to reserve the option to treat with long-term antibiotics, who compete for patients with doctors who adhere to the IDSA guidelines, increasingly face the prospect of professional misconduct sanctions and the loss of hospital privileges; that far fewer doctors are now willing to provide long-term antibiotics to people suffering from long-term symptoms of Lyme disease; that the guidelines substantially foreclose clinical discretion regarding long-term antibiotic treatment; and that the resulting suppression of output and sharply limited reimbursement by most insurance companies, in turn, have virtually foreclosed long-term antibiotics as a treatment option for significant numbers of patients.

28 *See* R. Wolfram, *Connecticut Attorney General Investigation and Settlement Highlights Possible Applicability of Antitrust Standard Setting Law to the Development of Clinical Practice Guidelines, supra* note 1.

29 *See, e.g., Paul Jung, M.D. v. Association of Am. Med. Colls*., 300 F. Supp. 2d 119, 146 (D.D.C. 2004) ("actors in the education world and/or professional associations [may be] held to be insulated from the antitrust laws if the activity is non-commercial in nature"); *Nara v. American Dental Ass'n*, 526 F. Supp. 452 (W.D. Mich. 1981); *Welch v. American Psychoanalytic Ass'n*, 1986 U.S. Dist. LEXIS 27182 (S.D.N.Y. 1986) ("distinctly non-commercial aspects of the learned professions are not, or may not be, subject to the Sherman Act"); *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787-88 (1975) (conduct should be classified as commercial or non-commercial in light of the "totality of the surrounding circumstances"); *see also* IB Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law ¶ 262a (3d ed. 2006) (explaining that "[t]he most viable rule is a strong presumption that a boycott or other claimed antitrust violation is 'economic,' or commercial, when the antitrust defendants are likely to receive direct economic benefits as a result of any reduction in competition in the market in which the target firm or firms operate.") and *FTC v. Superior Court Trial Lawyers Ass'n*, 856 F.2d 226 (D.C. Cir. 1988), *aff'd*, 493 U.S. 411, 425-27 (1990); and see CT AG Press Release, *supra* note 18 (noting that key panel members had significant commercial conflicts of interest), and *supra* note 24 (explaining that in the view of complainants, those panelists' economic interests were consistent with the guidelines' curtailment of recommended treatment beyond 30 days of antibiotics).

30 The complainants submitted that the market power element can be satisfied—even if the professional association did not drive the plaintiff, or its product, entirely from the market—if the standard setting substantially raised competitors' costs, limited their output, or lessened their competitive presence in other respects. In this respect, the AG found, *inter alia*, that the "IDSA guidelines have sweeping and significant impacts on Lyme disease medical care. They are commonly applied by insurance companies in restricting coverage for long-term antibiotic treatment or other medical care and also strongly influence physician treatment decisions." CT AG Lyme Press Release, *supra* note 18.

31 *See Hovenkamp, supra* note 29, at ¶ 2232d2 ("when defendants are not in a position to profit by suppressing the plaintiff's product or service, dismissal of the antitrust complaint is appropriate without inquiry into the substantive merits of the challenged standard"), and at ¶ 2230a (noting that "effective standard setting often implicates the discretion of people who are in competition with the firm or person to which the standard setting is to be applied; this fact is most often the one leading to competitive abuse").

32 *See generally* Robert S. Hayward et al., *Users' Guides to the Medical Literature. VIII. How to use clinical practice guidelines. A. Are the recommendations valid? The Evidence-based Medicine Working Group*, 274 JAMA 570-74 (1995). In complainants' view, the IDSA's own rules for setting guidelines required that its guideline development process be flexible, consensus-driven, and non-exclusionary in the sense of representing a range of expert opinions on the treatment standard at issue. The AG found that the IDSA did not comply with its own guidelines for selecting a panel chair, "enabling the chairman, who held a bias regarding the existence of chronic Lyme, to handpick a likeminded panel without scrutiny by or formal approval of the IDSA's oversight committee." CT AG Press Release, *supra* note 18. In addition, the IDSA's 2000 and 2006 panels "refused to accept or meaningfully consider information regarding the existence of chronic Lyme disease;" the IDSA "remov[ed] a panelist from the 2000 panel who dissented from the group's position on chronic Lyme disease to achieve 'consensus'" which, in the complainants' view, made such "consensus" pretextual; and the IDSA "blocked appointment of scientists and physicians with divergent views on chronic Lyme." *Id*.

33 *See, e.g., Indian Head v. Allied Tube & Conduit*, 817 F.2d 938, 947 (2d Cir. 1987). This point is extremely important because, as noted, the reconstituted panel concluded that the science supports the guidelines, without the need for revision.

34 *See, e.g., Schachar v. American Academy of Ophthalmology, Inc.*, 870 F.2d 397 (7th Cir. 1989).

35 *See, e.g., Goldfarb v. Virginia State Bar*, 421 U.S. 773, 791, n.21 (1975) (even without the threat of enforcement, "the [state bar association's ethical] opinions would have constituted substantial reason to adhere" to the bar association's fee guidelines "because attorneys could be expected to comply in order to assure that they did not discredit themselves by departing from professional norms, and perhaps betraying their professional oaths").

36 *See, e.g., National Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679, 684, n.5 (1978) (regarding society's code of ethics prohibiting members from providing potential clients price information that would enable them to make price comparisons, holding that despite an absence of evidence of compulsory adherence to the ban through enforcement, the lower court's finding of educational campaigns and personal admonitions was sufficient to establish Section 1 agreement under the Sherman Act).

37 870 F.2d 397 (7th Cir. 1989) (holding that defendant's press release characterizing radial keratotomy—laser surgery to correct nearsightedness—as "experimental" was not illegal restraint of trade in violation of Section 1 because there was no restraint: the press release was not backed up with enforcement power, there was no reduction in output, i.e., no evidence of patients having a harder time finding a specialist to perform the procedure, and there was evidence of a drop in consumer demand).

38 In the complainants' view, examples, based on reports they received from treating physicians and other sources, include IDSA members ensuring compliance with the guidelines by supporting the denial and revocation of hospital privilege of physicians who do not comply; acting as gatekeepers to grand round opportunities, research grants, presentations at conferences, and the publication of journal articles; providing preliminary expert external review of prospective medical board conduct actions; and the like.

39 *See, e.g., Hovenkamp, supra* note 29, at ¶ 2232c2, ("In order to cause competitive injury a disapproval need not be so severe as to drive the plaintiff or its product out of the market altogether. But it must be sufficient to raise its costs, limit its output, or substantially lessen its competitive presence in other ways."). Here, complainants noted that the chilling effect on physicians' willingness to provide a longer course of antibiotic treatment to persistent symptoms has raised costs for consumers and curtailed treatment options.

40 *See* Fed. Trade Comm'n & Dep't of Justice, Statements of Antitrust Enforcement in Health Care (1996) *available at* www.ftc.gov/bc/healthcare/industryguide/policy/statement4.htm.

41 *See, e.g.*, IDSA Press Release ("Agreement Ends Lyme Disease Investigation by Connecticut Attorney General – Medical Validity of IDSA Guidelines Not Challenged" (May 1, 2009), *available at* www.idsociety.org/Content.aspx?id=11182.

42 J.D. Kraemer, L. O. Gostin, "Science, Politics, and Values: The Politicization of Professional Practice Guidelines," JAMA, 2009:301(6):665-667 (Feb. 11, 2009) (on file with the authors).

43 *Id*. For a response to the comment by Kraemer and Gostin, see R. Wolfram, "Clinical Practice Guideline Development and Antitrust Law," Letter to the Editor, *JAMA*, 2009:301(24):2548-2549 (June 23, 2009) (noting, *inter alia*, that the investigation offers important guidance for strengthening clinical guideline development in conformity with evidence-based medicine while also preserving clinical discretion; that clinical guideline development only faintly resembles the scientific method and is vulnerable to due process irregularities; that the AG focused on structural and process abuse and, contrary to the authors' assertion, was not "calling" the science; and that the patient care defense is quite limited). *See also* Reply by Kraemer and Gostin. *Id*. (Letter and reply on file with the authors.)

44 It should be noted that the appropriate evidentiary burden is not a matter of antitrust concern, which focuses instead on the issue of process integrity. Selecting the appropriate evidentiary burden is, however, a policy choice about how best to implement evidence-based medicine in the development of clinical guidelines.

45 *Indian Head, Inc. v. Allied Tube & Conduit Corp*, 817 F.2d 938, 947 (2d Cir. 1987).

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