No. 20-1776

In the United States Court of Appeals for the Third Circuit

BRUCE E. ELLISON,
Plaintiff-Appellant,

v.

AMERICAN BOARD OF ORTHOPAEDIC SURGERY,
Defendant-Appellee.

ON APPEAL FROM U.S. DISTRICT COURT FOR THE DISTRICT OF NEW JERSEY, NO. 2-16-cv-8441-KM-JBC
HON. KEVIN MCNULTY, DISTRICT JUDGE

BRIEF FOR *AMICUS CURIAE* NATIONAL MEDICAL ASSOCIATION AND ALAN D. ULLBERG IN SUPPORT OF APPELLANT IN SUPPORT OF REVERSAL

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the FEDERAL RULES OF APPELLATE PROCEDURE, *amici curiae* National Medical Association and Alan D. Ullberg make the following disclosures:

1) For non-governmental corporate parties please list all parent corporations: None.

2) For non-governmental corporate parties please list all publicly held companies that hold 10% or more of the party's stock: None.

Dated: October 7, 2020

Respectfully submitted,

/s/ Lawrence J. Joseph

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IDENTITY, INTEREST, AND AUTHORITY TO FILE

Amici curiae National Medical Association ("NMA") and Alan D. Ullberg file this brief pursuant to the accompanying motion for leave to file.[1] As explained below, each *amicus* has direct and urgent interests in the issues presented here.

NMA is the professional organization representing Black physicians and their patients, with 129 state and local chapters and affiliated societies across the United States and its territories. NMA was founded in 1895 when "Negro" (*i.e.,* African American or Black) physicians were not allowed to join — or even to apply for membership in — the American Medical Association. At that time, nearly all hospitals prohibited Black physicians like the plaintiff-appellant, no matter how well trained, experienced and skilled, from applying to be "credentialed," *i.e.*, to have "hospital privileges," which provide physicians the right to admit and treat their patients in a hospital. That exclusionary rule kept Black doctors from practicing medicine in hospitals across the United States, the basic institutions in our healthcare system where patients can be treated. For 125 years, the NMA and its constituent chapters throughout the United States have worked to improve equality of access for Black physicians to high quality medical education, training, and nondiscriminatory

[1] Pursuant to FED. R. APP. P. 29(a)(4)(E), the undersigned counsel certifies that: counsel for *amicus* authored this brief in whole; no counsel for a party authored this brief in any respect; and no person or entity — other than *amicus*, its members, and its counsel — contributed monetarily to this brief's preparation or submission.

access to top-tier, well-equipped hospitals where they can diagnose, treat and operate on their patients.

NMA thus has 125 years of on-the-ground experience with the complexities faced by its physician-members, who endeavor to deliver quality healthcare to Black communities. As indicated on NMA's website,[2] NMA also represents the interests of over 44 million Black citizens, the principal patient demographic of NMA's more than 30,000 physician members. Through its leadership advocacy in American medicine, NMA promotes physician-choice for all patients who prefer a Black doctor, or a physician of their own ethnicity. For these reasons, NMA is intensely interested in the details of how, and why, board-certifying entities like the defendant-appellee keep qualified doctors like the plaintiff-appellant from obtaining the board certification needed for hospital privileges.

Amicus Alan D. Ullberg is a healthcare attorney with decades long interest in the issues of this appeal. Mr. Ullberg began working with the NMA 10 years ago. Mr. Ullberg is a graduate of Harvard Law School and has served as a permanent law clerk to the Chief Justice of the California Supreme Court, special counsel to NASA's Administrator, Smithsonian Institution deputy general counsel. He has taught at Georgetown University Law Center for 14 years as an adjunct professor

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[2] *See* https://www.nmanet.org/page/WhyJoin (last visited Oct. 7, 2020).

teaching Fiduciary Law. Physicians are fiduciaries, and *Amicus* Alan Ullberg has researched and taught the fiduciary duties, and the reciprocal legal rights, of doctors like Dr. Ellison.

INTRODUCTION

Plaintiff-appellant Bruce E. Ellison, M.D. — a Black orthopedic surgeon — appeals the district court's dismissal of his antitrust action against the American Board of Orthopaedic Surgery ("ABOS") for denying him the opportunity to complete his application for ABOS's board certification because he lacks the hospital privileges that ABOS requires. But without ABOS's seal of approval — Board Certification — Dr. Ellison cannot apply for hospital privileges. This is the Catch 22 referred to by the District Judge on page 5 of his opinion on appeal. While the antitrust focus of Dr. Ellison's challenge to ABOS may seem irrelevant to NMA's and Mr. Ullberg's concerns with race discrimination in the healthcare system, the two issues overlap in the critical area of allowing insiders with an agenda to erect barriers to entry to the system. Whether injury is competitive or race-based, this Court should not allow system imbalances to continue because that is how we have always done it: "Arbitrary agency action becomes no less so by simple dint of repetition." *Judulang v. Holder*, 565 U.S. 42, 61 (2011). This Court should reject ABOS's plea to carry on the same unfair process, simply "because."

The NMA was founded and is operated to protect and secure minority medical professionals' legal rights to serve their patients, and to defend and fight for their civil and legal rights as physicians and patients. As Dr. Julius W. Hill explained in 1969, the reason for NMA's founding was to confront the racial discrimination in the medical field:

> The *raison d'etre* for NMA was that the pattern of racial separation and discrimination was so prevalent in this country that the Negro physician found that it was almost impossible after their medical training to receive internships or residencies, or even to practice medicine in accredited hospitals and many non-accredited hospitals.

Julius W. Hill, M.D., *The Golden State Medical Association: The California Chapter of the National Medical Association*, 111 CALIF. MED. 46 (1969).[3] Dr. Hill noted that NMA was the "only national organization of physicians to declare for Medicare, now the law of the land." *Id.* at 47. Dr. Hill emphasized NMA's focus on equality of access to healthcare education and hospital facilities for Black physicians. *Id.* at 49.

The procedural interests of an antitrust plaintiff — whatever his or her race — coalesce with the procedural interests of a civil rights group like NMA or a race-discrimination plaintiff. Although they have different concrete interests — *e.g.*, economic injury versus equal-protection injury — both need a rational process that

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1503550/pdf/califmed00013-0048.pdf (last visited Oct. 7, 2020).

is not rigged against them by an in-group that can use an unfair process that allows the in-group to press its anti-competitive interests or personal animus to bar entry to deserving applicants.

As relevant here, moreover, both are concerned with the judiciary's typical hands-off approach to claims by physicians against authorities in the U.S. healthcare system. Courts' historical, "we-don't-interfere" approach granted *de facto* absolute power to decision making authorities: hospitals, medical specialty certifying boards like ABOS, as well as to the dominant, umbrella medical specialty certifying board the American Board of Medical Specialties ("ABMS"). This judicial attitude has been especially damaging in cases of adverse but hard-to-prove treatment of Black physicians. Courts tended to adhere to their non-intervention policy, refusing to "interfere in hospital system politics." This let-them-fight-it-out approach allowed hospitals and other decision-maker authorities in the healthcare system to make, and live by, their own rules. One result so far: ABOS has exercised monopolistic, arbitrary, and unaccountable powers, no matter how unfair the result for a physician-litigant like Dr. Ellison.

Dr. Ellison's challenge to American Board of Orthopaedic **S**urgery is extraordinarily important to this entire Nation. Especially now, as the COVID-19 pandemic makes all levels of governments, elected and appointed officials, government employees, contractors, and volunteer workers, painfully aware of the

fatal disparities in the medical care available or provided to minority patients. Even those minorities working in healthcare are suffering disproportionately. Adia Harvey Wingfield, *The Disproportionate Impact of COVID-19 on Black Healthcare Workers in the U.S.,* HARVARD BUSINESS REVIEW, May 14, 2020.[4] Sadly, ABOS's inexplicable denial of Dr. Ellison's due process to complete his board certification prevents him from using his proven medical skills to provide care for patients during this pandemic.

At the same time physician-members are trying their best to deliver the highest possible healthcare to their patients, they must endure and navigate around endemic racism and discriminatory practices. Some of the racist and discriminatory practices are obvious, others are indirect, and still more are buried so deep in our healthcare system they are difficult to discuss. The historic, lingering, and persistent civil rights issues inherent in the U.S. healthcare system are of constant concern to NMA and its physician-members.

STATEMENT OF THE CASE

Amici adopt the facts as stated in Dr. Ellison's opening brief. Unconstrained by modesty, *Amici* also call this Court's attention to several additional facts about Dr. Ellison's exemplary career and skills In addition, *Amici* inform this Court on

[4] https://hbr.org/2020/05/the-disproportionate-impact-of-covid-19-on-black-health-care-workers-in-the-u-s (last visited Oct. 7, 2020).

ways in which this antitrust action fits into the national medical system and *Amici*'s concerns about endemic race discrimination within that system.

Dr. Ellison's Qualifications

Dr. Ellison graduated from the University of California at Berkeley, School of Engineering with a Bachelor of Science in Mechanical Engineering and worked for the United States Navy in Engineering Design, Construction Management and Project Management. Dr. Ellison received his Medical Degree from Stanford University School of Medicine. Dr. Ellison completed orthopedic surgery Junior Residency at the University of Massachusetts at Worcester, completed orthopedic surgery Senior Residency at Phoenix Orthopaedic Residency Program, and completed an orthopedic surgery research fellowship at the University of Massachusetts at Worcester.

Dr. Ellison is licensed to practice as an orthopedic surgeon in California and Arizona, but he has no New Jersey hospital in which to operate. Because of the actions ABOS has taken against Dr. Ellison by refusing to allow his completion of board certification, Dr. Ellison is unable to obtain privileges in any New Jersey hospital. Dr. Ellison cannot even take the risk of applying for hospital privileges — to any hospital — anywhere at any time in this United States.

Despite being in professional limbo, Dr. Ellison has an excellent record as an orthopedic surgeon. Dr. Ellison has "clean," *i.e.*, unrestricted, State medical licenses

in California and Arizona. Dr. Ellison is Major League Baseball's player Mr. Willie H. Mays' personal orthopedic surgeon.

Hall of Fame Willie Mays is arguably the greatest baseball player of all time. Mr. Mays is undoubtedly a national treasure (and deserves appropriate medical treatment). It follows that Mr. Willie Mays' right-side throwing arm is a national treasure. Mr. Mays personally chose Dr. Ellison to be his orthopedic surgeon; Dr. Ellison performed exceptionally successful surgery on Mr. Mays' throwing shoulder in April 2007. As Mr. Mays stated in a letter to NMA in 2009, "Dr. Bruce Ellison is my orthopedic surgeon" and very soon "[a]fter my shoulder surgery I was able to throw my fastball at the All Star Game of 2007… Dr. Ellison is an excellent orthopedic surgeon." Letter from Willie Howard Mays, Jr., to Dr. Willarda Edwards, President, Nat'l Med. Ass'n, at 1 (Sept. 28, 2009) (Add. 1a).

Dr. Ellison was selected to be part of the team that performed orthopedic surgery on Harvard Professor of African American Studies Dr. Henry Louis ("Skip") Gates. As with Mr. Willie Mays, while caring for Professor Gates Dr. Ellison developed a relationship beyond doctor/patient. "Skip" Gates became a mentor to Dr. Ellison, successfully advising him during his orthopedic residency training in the Boston area.

The Need for Racial Diversity in Board-Certified Physicians

In the past, very few hospitals even acknowledged the expressed preference — or even demands — by Black patients to have their Black personal physicians admit and follow them into the hospital. The result, except at a tiny percentage of U.S. hospitals, was that Black citizen-patients could not be treated by their Black personal physicians in the hospitals where Black citizens were admitted as patients. The NMA is particularly concerned about the relatively small number of Black physicians in the United States. Compared to the 13% of U.S. citizens who are Black, many who prefer to be treated by an Black physician, less than 5% of doctors practicing in the United States are Black.[5] This limited availability of Black physicians has a parallel with the limited physician-gender choice that confronted most women until 40 or 50 years ago. Until the later decades of the 1900's, most physicians in the U.S. were male, including specialists in women's healthcare. Many women preferred to be treated by a physician of their own sex, but there were not enough female physicians to go around.

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[5] According to the Census Bureau, the category "Black or African American alone" (*i.e.*, excluding mixed-race respondents) makes up 12.8 percent of the U.S. population. *See* https://data.census.gov/cedsci/profile?g=0100000US (last visited Oct. 7, 2020). According to the website of the Association of American Medical Colleges, 5.0 percent of active physicians identified as Black or African American. *See* https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018 (last visited Oct. 7, 2020).

STANDARD OF REVIEW

The issues presented here all are issues of law, which this Court reviews *de novo*. *Covell v. Bell Sports, Inc.*, 651 F.3d 357, 360 (3d Cir. 2011).

SUMMARY OF ARGUMENT

Section I argues that board-certification procedures like the ABOS procedure that Dr. Ellison challenges authorize insiders at hospitals to erect barriers to new entrants for a host of impermissible reasons such as avoiding economic competition and exclusion based on personal and professional animus, including racial discrimination. This Court should not ratify procedures that allow improper action by insiders. Section II argues that ABOS exercises monopolistic control over access to board certifications and thus hospital-admitting privileges by requiring applicants already to have privileges before seeking board certification. Section III argues that allowing procedures like the ABOS procedure to survive judicial scrutiny insulates racial discrimination in the healthcare system from review. Specifically, Section III.A explains that the "Rule of Reason" under antitrust law contemplates not only anti-competitive effects under a purely economic analysis but also other social concerns including the avoidance of outright racism and disparate outcomes; Section III.B explains the ways in which the ABOS board-certification procedures fail the Rule of Reason on racial issues.

ARGUMENT

I. ABOS'S BOARD-CERTIFICATION PROCEDURE ENABLES HEALTHCARE OFFICIALS TO TAKE — AND TO MASK — BAD-FAITH ADVERSE ACTIONS TO ELIMINATE COMPETITORS OR PERSONAL ENEMIES.

Because Black physicians often are the canaries in the coal mines, they and their patients can be disproportionately harmed by adverse trends in healthcare. For reasons discussed below, minority physicians frequently are the first targets — and victims — of any wave of unfair procedures. Because NMA's constituent physicians are likely to be among the first to be targeted and to fall, NMA stays alert to developments in healthcare system management practices across the United States that can adversely affect all physicians' opportunities and rights to treat their patients in hospitals.

NMA has been watching the increasing misuse of administrative and legal processes in the healthcare system to eliminate real or apparent economic competitors of any ethnicity. *See*, *e.g.*, John Zicconi, *Due Process or Professional Assassination? A Texas case brings to light how the system can be contaminated by economic competition,* UNIQUE OPPORTUNITIES, THE PHYSICIAN'S RESOURCE, March/April 2001.[6]

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[6] The journal UNIQUE OPPORTUNITIES, THE PHYSICIAN'S RESOURCE (formerly uoworks.com) is out of print and no longer directly available online. A copy of the Zicconi article is available at http://www.allianceforpatientsafety.org/chal.pdf (last visited Oct. 7, 2020) and included in the addendum (Add. 2a-8a).

From long, bitter experience, the NMA knows that the earliest victims of unfair procedures are likely to be those physicians and their patients who are of concern to NMA and its membership. Too often the inherent discrimination or animating discriminatory intentions are beyond the reach of the law. In a law review article about retaliation, Professor Deborah Brake discusses how difficult it can be to prove "intention" in a civil rights case involving race. Deborah Brake, *Retaliation,* 18 MINN. L. REV. 86, 90 n.249 (2005). Professor Brake quotes Justice Stevens concurring in *Washington v. Davis*, 426 U.S. 229, 253-254 (1976) (Stevens, J., dissenting). Justice Stevens cautioned about relying too much on direct evidence of a party's intention, especially when evidence of intention is hard to obtain. The Justice emphasized the importance of using evidence in the record of "what actually happened":

> Frequently the most probative evidence of intent will be objective evidence of what actually happened rather than evidence describing the subjective state of mind of the actor … [and] the line between discriminatory purpose and discriminatory impact is not nearly as bright, and perhaps not quite as critical, as the reader of the Court's opinion might assume.

Davis, 426 U.S. at 253 (Stevens, J., dissenting); *see also* Linda Hamilton Krieger & Susan T. Fiske, *Behavioral Realism in Employment Discrimination Law: Implicit Bias and Disparate Treatment*, 94 CAL. L. REV. 997, 1010, 1033-38 (2006). The NMA sees Dr. Ellison as an example of the legal trend that can allow

economic rivals or professional and personal enemies to steal the controls of board certification and drive out competitors and other adversaries. The actual reasons that ABOS refused to allow Dr. Ellison to complete his examinations to become "Board Certified" remain a mystery.

The only way to determine ABOS's motives is for this Court to order this case returned to the Federal District Court for discovery. Following review of the ABOS's scant record of documented defense for its action refusing Dr. Ellison's completion of his board certification, *Amici* regrettably conclude that ABOS may have acted out of racism and discrimination. Discovery could prove *Amici* wrong and exonerate ABOS from *Amici*'s presumption of possible racist motives and actions. But for now, *Amici* believe racism may have been a factor in ABOS's destruction of Dr. Ellison's career as an orthopedic surgeon.

From *Amici*'s perspective, Dr. Ellison's career as an orthopedic surgeon — available to Black patients who prefer to be treated by a Black physician like Dr. Ellison — should not have been cut short. Dr. Ellison's career was destroyed based on opaque, unexplained — and as to Dr. Ellison, in *Amici*'s knowledge — monopolistic, arbitrary, and possibly racist/discriminatory actions by ABOS. ABOS is keeping Dr. Ellison from practicing orthopedic surgery, denying the patient demographic that desperately needs his education and training.

II. ABOS MONOPOLIZES ORTHOPEDIC MEDICAL SERVICES WITH ITS ARBITRARY "CATCH-22" BOARD-CERTIFICATION REQUIREMENTS.

Amici understand that Dr. Ellison is neither challenging nor disputing the basic mission of ABOS, which is to determine — presumably by fair and rule-based examination procedures — which orthopedic surgeons are sufficiently trained and experienced to obtain the designation "Board Certified." *Amici* further understand that Dr. Ellison correctly — and also for the benefit of all orthopedic surgeons (and, by extension all other physicians who might apply to be board certified by their specific medical specialty certifying board) — challenges and vigorously disputes what the District Judge called ABOS's "Catch 22" rule.[7] In order to apply to ABOS to become board certified, the applicant first must have hospital privileges; to apply to receive hospital privileges, the applicant must be board certified. These mutually dependent requirements define the ABOS Catch 22 requirement.

[7] Presently, ABOS is among less than 10 medical specialty certifying boards of the 24 total that comprise the American Board of Medical Specialties (ABMS) that require applicants to have hospital privileges as a precondition for board certification. *Amici* see a trend for this prerequisite by more specialty boards in the future. For one reason, it restricts the number of physicians practicing a medical specialty. Specialty physicians earn two to four times more than primary care doctors; and the fewer there are the more they earn. Challenging ABOS's Catch-22 rule potentially benefits all the nearly 900,000 board-certified U.S. doctors. Eventually, every physician could be required to have hospital privileges in order to apply for or maintain board certification.

Unfortunately for the patient public, the corollary general rule among hospitals is that experienced physicians applying for hospital privileges already must be board certified. ABOS's reciprocally restrictive Catch 22 rule, requiring that ABOS applicants have hospital privileges, makes it impossible for Dr. Ellison and other physicians like him to meet ABOS's prerequisite to apply to become board certified.

Unlike the board certification process that appears rational at least in theory, acquiring and maintaining hospital privileges can be unpredictable — often chaotic — because in too many hospitals, obtaining and keeping one's hospital privileges depend largely on personal and/or professional relationships, rather than any written bylaws and rules. As described by Mr. Steven Kern, a New Jersey plaintiffs' health law attorney and veteran of hospital bureaucracy:

> "In the 30 years that I've been a health law attorney … I've never seen anyone who admits a lot of patients and is well- liked have a problem with the hospital disciplinary mechanism. On the other hand, if you're competing with such a doctor, especially if you're new to the hospital or on the wrong side of hospital politics, you're a potential target."

Gail Garfinkel Weiss, *Is Peer Review Worth Saving?* MEDICAL ECONOMICS, Feb. 18, 2005.[8]

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[8] http://www.peerreview.org/acrobat_files/ispeerreviewworthsaving.pdf (last visited Oct. 7, 2020).

Compared to the chaos in obtaining hospital privileges, ABOS's written, published rules for an orthopedic surgeon to become board certified appear superficially reasonable. In stark contrast, the actual rules and the in-practice procedures for an orthopedic physician to obtain — and to keep — hospital privileges are decentralized and specific to every individual hospital.

As expected for the large and essential U.S. healthcare industry, there are standardized bylaws that hospitals are supposed to follow when credentialing physicians to obtain and maintain their hospital privileges to practice in a particular hospital. These model bylaws are designed to govern why and how a physician obtains and maintains her hospital privileges.

In fact, however, obtaining and maintaining one's "privileges" to practice medicine in a particular hospital tends to be a personalized, chaotic process. The process can depend upon how well a physician relates to (*i.e.*, is connected to) the individual or individuals who in fact control the hospital and have *de facto* power to decide which physicians are to be "allowed in" to treat their patients. A physician will never know and cannot know when such a connection is pivotal to obtaining privileges. Many physicians who are not connected or "don't or can't fit in," never get hospital privileges. Once credentialed their hospital privileges are often later revoked, typically because hospital management either selectively enforces a rule against a doctor or finds a plausible pretext to use to revoke the doctor's privileges.

Revocation of privileges usually takes place through a procedure known as "peer review." This is a supposedly fair hearing process. But typically, the dice are loaded in favor of the outcome wanted by, and for the personal or economic benefit of, those who control the hospital. *See* Lawrence Huntoon, M.D., Ph.D., *Sham Peer Review: the Destruction of Medical Careers,* JOURNAL OF AMERICAN PHYSICIANS AND SURGEONS, v. 24, no. 4, winter 2019, editorial. As a practical matter, whether or not a doctor has hospital privileges is too much a matter of chance — dependent on individual or professional likes and dislikes, or the economic interests of those in power — to be a threshold requirement for obtaining board certification.

Having hospital privileges also can depend on being part of a physician practice group that might provide a significant percentage of one or more types of medical services within a geographically drawn patient service area. Most individuals who do not understand the preferred-physician structuring of what often is a monopolistic patient demographic, probably assume that the health system monopolists would rather contract with the best available physicians who practice in their delineated geographical area.

The better doctors, however, tend to be more independent of spirit, mobile as to where and with whom they practice, with the professional courage to speak out about the medical errors they observe and the unsafe procedures they know are in the system. Because these high-quality physicians may be less inclined to join the

area's practice group that likely also controls the local hospital, physicians that practice independently do not have the political backup — clout — of those doctors within the practice group. As outsiders, these doctors are more vulnerable to losing their hospital privileges. Such doctors consequently risk becoming ineligible to apply for board certification, a severely negative impact resulting from ABOS's Catch 22 rule.

The reasons above help explain why in *Amici*'s experience, the very good — too often the very best — physicians get targeted and stripped of hospital privileges. Because NMA advises and advocates for doctors who have been unfairly deprived of access to hospitals, consequently draining the pool of available physicians, *Amici* are acutely aware of the monopolistic effect resulting from ABOS requiring hospital privileges as a precondition of becoming board certified by ABOS.

If Dr. Ellison were to apply for hospital privileges, his application would be rejected because he is not board certified. The hospital that rejects him would report its rejection to the National Practitioner Data Bank ("NPDB"). *See* 45 C.F.R. pt. 60; 42 U.S.C. §§ 11101-11152. NPDB is a federal repository of physicians' records, similar to the criminal records in police and FBI data banks of U.S. citizens' violations of criminal laws. NPDB's records are not accessible to the general public, but they are available to all hospitals and physician practice groups. Hospitals and practice groups usually view any rejection of an application for hospital privileges

as a serious, adverse indicator of a rejectee's status as a medical provider, questioning her character and professional abilities as a doctor.

The predominance of health insurers is another factor determining if a doctor gets hospital privileges. Insurers provide the principal revenue stream for most hospitals, and health insurance companies regularly access NPDB's records. Most hospitals depend upon health insurers for revenue. A hospital's management cannot take the chance that an insurer will delay or reject payment because the physician who provided the medical services that the hospital bills to its insurer has an adverse NPDB entry. Any rejection of an application for hospital privileges, or the termination of a physician's privileges (except a *bona fide* agreed-upon voluntary resignation), can create an adverse entry in the doctor's NPDB record.

There is a further reason Dr. Ellison cannot take the risk of applying for privileges at any hospital. Dr. Ellison cannot just randomly apply for hospital privileges without potentially serious consequences. Many hospitals are controlled by the doctors who practice there, and such controlling staff doctors may not welcome another competitor. That possible rejection of a doctor's application for hospital privileges creates a threat to her future career by placing an adverse entry in the applicant-physician's NPDB "record." Such an NPDB record of rejection provides, in turn, a ready excuse for future hospitals to reject his application for hospital privileges.

Based on its extensive experience vetting physician-applicants -- including Dr. Ellison — and Dr. Ellison's obvious credentials, NMA believes Dr. Ellison is a physician worthy of its strong support. The corollary conclusion is that any process that *per se* rejects such qualified applicants on arbitrary and circular grounds does not warrant this Court's deference.

III. ABOS'S BOARD-CERTIFICATION PROCEDURES VIOLATE THE "RULE OF REASON" BY ENABLING AND MASKING ANTI-COMPETITITIVE AND DISCRIMINATORY ACTIONS.

The NMA stays attuned to board certification and other proceedings affecting professional standing, which includes economic trends in healthcare — such as consolidation — that negatively impact racial outcomes and can even mask racially motivated actions by those acting within healthcare organizations. While not the outright bans from NMA's founding era through the 1960s, these ongoing actions and processes certainly impede further racial progress. Although Dr. Ellison does not sue for race discrimination, *Amici* respectfully submit that this Court must consider the systemic bias that the ABOS board-certification procedures *enable* as an integral part of analyzing whether those procedures meet the "rule of reason" under antitrust law.

A. The rule of reason includes consideration of discriminatory actions and effects.

Under § 1 of the Sherman Act, "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce … is declared to

be illegal." 15 U.S.C. § 1. If "read literally, § 1 would outlaw the entire body of private contract law," *Nat'l Soc'y of Prof'l Eng'rs v. U.S.*, 435 U.S. 679, 688 (1978), and much else. Accordingly, courts have — with the congressional acquiescence — adopted a tiered analysis to separate proscribed restraints from permissible ones. That analysis divides challenged restraints into those that are *per se* illegal and those that are subject to a "rule of reason." *Id.* at 692; *Leegin Creative Leather Prods. v. PSKS, Inc.*, 551 U.S. 877, 886 (2007). If Dr. Ellison prevails on his *per-se* argument or even on a "quick-look" argument under the rule of reason,[9] this Court may not need to consider *Amici*'s arguments about the intersection between the antitrust law and the issues of racism and negative racial impacts in the credentialling process. If ABOS manages to survive those threshold analyses, however, this Court must consider *Amici*'s vitally important issues as part of deciding whether ABOS can defend its biased credentialling procedures under the rule of reason.[10]

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[9] The rule-of-reason analysis is further subdivided to include "quick look" cases for situations where "an observer with even a rudimentary understanding of economics could conclude that the arrangements in question would have an anti-competitive effect on customers and markets." *California Dental Ass'n v. FTC*, 526 U.S. 756, 769-71 (1999).

[10] As important as the issues *Amici* raise are and as much as those issues demand a hearing before an appropriate tribunal, *Amici* have no quarrel with the Court's either finding ABOS's procedures *per se* illegal or rejecting them on a quick look.

The rule of reason derives from – and Congress intended courts to rely on – the common law: "The legislative history makes it perfectly clear that it expected the courts to give shape to the statute's broad mandate by drawing on common-law tradition." *Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 688.[11] The core question presented is whether a restraint "promotes competition or whether it is such as may suppress or even destroy competition." *Id.* at 691 (internal quotations omitted). As explained, ABOS's credentialling process harms not only Black physicians but also their patients.

Significantly, the fact that ABOS operates in the field of credentialling learned professionals does not exempt ABOS from antitrust law.[12] *Arizona v. Maricopa Cty. Med. Soc'y*, 457 U.S. 332, 348-49 (1982). Especially because procedures that limit the availability of Black physicians for the Black-patient market affect not only physicians like Dr. Ellison but also consumers, disparate-impact law can complement antitrust and consumer protection law to make markets more competitive and more equitable. *See* Ian Ayres, *Market Power and Inequality: A*

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[11] Because courts rely on the reasoning of barrier-to-entry decisions in price-fixing cases, and *vice versa*, *Yakima Valley Mem'l Hosp. v. Wash. State Dep't of Health*, 654 F.3d 919, 930 (9th Cir. 2011), *Amici* do not distinguish between the types of decisions cited here.

[12] By contrast, state medical licensing is exempt from antitrust law, *Bates v. State Bar of Arizona*, 433 U.S. 350, 359 (1977), but all ABOS applicants are state-licensed physicians.

Competitive Conduct Standard for Assessing When Disparate Impacts Are Unjustified, 95 CAL. L. REV. 669, 674 (2007); *see generally* Daria Roithmayr, *Barriers to Entry: A Market Lock-in Model of Discrimination*, 86 VA. L. REV. 727 (2000). Indeed, because disparate-impact claims are unavailable to plaintiffs like Dr. Ellison, *Pers. Adm'r v. Feeney*, 442 U.S. 256, 279 (1979) (Equal Protection); *Alexander v. Sandoval*, 532 U.S. 275, 293 (2001) (Title VI), it is critical for the rule of reason to consider those impacts on not only physicians who seek credentialling but also the patient market whom those physicians will serve.

Indeed, under this Court's precedents, the rule-of-reason analysis requires consideration of "adverse, anti-competitive effects within the relevant product and geographic markets." *U.S. v. Brown Univ.*, 5 F.3d 658, 668 (3d Cir. 17, 1993). Put another way, an "improvement … that enhances the public's desire for that product or service [is] one possible procompetitive virtue." *Id.* at 674. Most importantly, this Court held that increased access and enjoyment of benefits for underrepresented sectors of the public is a concern that belongs in a court's analysis under the rule of reason:

> It is most desirable that schools achieve equality of educational access and opportunity in order that more people enjoy the benefits of a worthy higher education. There is no doubt, too, that enhancing the quality of our educational system redounds to the general good. To the extent that higher education endeavors to foster vitality of the mind, to promote free exchange between bodies of thought and truths, and better communication among a

> broad spectrum of individuals, as well as prepares individuals for the intellectual demands of responsible citizenship, it is a common good that should be extended to as wide a range of individuals from as broad a range of socio-economic backgrounds as possible. It is with this in mind that the Overlap Agreement should be submitted to the rule of reason scrutiny under the Sherman Act.

Id. at 678. If the rule of reason includes that analysis for admission to selective universities – as this Court found that it did in *Brown University* – that rule likewise includes that analysis for credentialling procedures like the ABOS procedure that Dr. Ellison challenges. As with higher education, the consideration of these equities will benefit not only the professionals themselves but also the profession and the public that the profession serves.

B. Accepting ABOS's board-certification procedures would thwart NMA's special mission — namely, identifying and ending racial discrimination and effects — for Black physicians and patients.

By way of this *amicus* brief in support of Dr. Ellison, a Black orthopedic surgeon, NMA expresses particular concern over biases by healthcare organizations directed at Black physicians. NMA's constituency includes physicians who have experienced, and continue to experience, daily insults, slights, slurs or pointed implications that they are incompetent: "Not up to the job of being a doctor," simply because of the color of their skin. Such experiences seriously erode the human spirit and lower one's professional self-esteem.

For some physicians, the repeated exposure to professional insults, or even casual slights, heightens vulnerabilities to any type of insult or slur. Certain kinds of even innocent questions, or common life situations, can serve as triggers to life-acquired anxieties and vulnerabilities just like particular sounds, smells, sights or visual images trigger the anxiety attacks that so many combat veterans with Post Traumatic Stress Disorder live with every day.

On July 14, 2020, the lead, in-depth article (page E1) in the Washington Post's Health & Science Section was, *Racism : A Public Health Crisis*. The bulk of this analysis was on jump page E5 under the headline *Racism: An unhealthy problem doctors are fighting* with the subheading *As they push for change, doctors and other experts say discrimination is causing serious disparities in care*. The text of the Washington Post article begins:

> [S]ome members of the [healthcare] profession are calling for transformation of a system they say results in poorer health for [B]lack Americans because of deep-rooted racism.
>
> *Racism is a public health emergency of global concern, a recent editorial in the Lancet [the leading British medical journal] said. It is the root cause of continued disparities in death and disease between Black and [W]hite people in the USA.*
>
> A New England Journal of Medicine editorial puts it this way: Slavery has produced a legacy of racism, injustice and brutality that runs from 1619 to the present, and that legacy infects medicine as it does all social institutions.

Tonya Russell, *Racism in care leads to health disparities, doctors and other experts say as they push for change*, WASH. POST, July 11, 2020, at E1. NMA has been fighting these disparities in the medical treatment of Blacks and minorities for 125 years.

Enough is enough. ABOS should be compelled to allow Dr. Ellison to complete his board certification.

CONCLUSION

The NMA prays that this Court will find relevant and helpful the above information and observations about the realities of today's hospital practice. It is the product of many medical professionals' disappointments and ruined lives, which in the worst cases have resulted in suicides. NMA respectfully wishes this Court to incorporate this information in the Court's accumulated experience, to better understand the facts and legal issues underlying and permeating Dr. Ellison's case. At this stage, only this Court's actions can begin to restore Dr. Ellison's professional reputation and his hospital-based orthopedic surgical practice. Good doctors are societal assets in short supply, especially well trained, highly qualified physicians like Dr. Ellison. Our healthcare system cannot afford to have a good orthopedic surgeon's promising practice — a true societal asset — destroyed as ABOS has done by denying Dr. Ellison the board certification that is required to obtain hospital

privileges. ABOS also is denying Dr. Ellison's patients the opportunity to be admitted to a hospital by their physician of choice.

For all of the above-stated legal reasons, to ensure all physicians' rights to work in hospitals, provide optimum levels of treatment, and to protect the related civil and professional free speech rights that physicians need to resist the pressures of production incentives when delivering high quality, safe and cost-effective patient care, the National Medical Association and *Amicus* Alan D. Ullberg, respectfully request this Court to consider the information in this *Amicus* brief, recognize the unfairness of the Catch 22 rule imposed by ABOS, and grant the Appeal in Dr. Ellison's case.

Dated: October 7, 2020

Respectfully submitted,

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COMBINED CERTIFICATE OF COMPLIANCE

The undersigned counsel certifies compliance of the accompanying brief with the following requirements of the FEDERAL RULES OF APPELLATE PROCEDURE and the Local Rules of this Court.

1. Pursuant to Local Rule 28.3(d), counsel for *amicus curiae* is a member of this Court's bar.

2. This brief complies with the type-volume limitation of FED. R. APP. P. 32(a)(7)(B) and 29(c)(5) because:

This brief contains 6,054 words, including footnotes, but excluding the parts of the brief exempted by FED. R. APP. P. 32(a)(7)(B)(iii).

3. This brief complies with the typeface requirements of FED. R. APP. P. 32(a)(5) and the type style requirements of FED. R. APP. P. 32(a)(6) because:

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Dated: October 7, 2020

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