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I. Introduction

For many years hospitals and physicians who practice primarily in hospitals, have been free to establish relations and to structure their activities almost without scrutiny. Hospitals and their internal organizations were shielded from external review for several reasons: there was a relative shortage of doctors and hospitals; health care costs were relatively modest; and the public service aspect of the profession of healing the sick insulated it from reproach.

The events of the past twenty years, however, have caused a number of concerned parties to view hospitals in a more pragmatic light. This changed perspective was brought about principally by the workings of the bedrock marketplace forces of supply and demand. Paramount among these factors is the increase in the number of physicians in the country and the predictions for a future oversupply.[1] As the number of physicians increases there will be heightened competition for patients and access to hospital privileges and facilities.

A second key factor leading to the recent critical analysis given hospital-physician structuring is the increased involvement of the state and federal government in the reimbursement of medical costs. Government entry into reimbursement has led to increased concern over rising medical costs and, consequently, to calls to curtail these rising costs.[2] As a result, hospitals are

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1. *See* Katz, Warner & Whittington, *The Supply of Physicians and Physicians' Incomes: Some Projections*, 2 J. HEALTH POL., POL'Y & L. 227 (1977-1978) (number of active physicians per 100,000 population predicted to increase by one-third in the decade ending in 1985); N.Y. Times, April 14, 1980, at A16, col. 1 (from 1970 to 1978, number of physicians in United States increased by 17%).

2. The government policies include certificate of need controls over entry and other

being required to justify and limit costs.

Accommodating the interplay (some would say collision) between these and other competing market forces has led to increased dissatisfaction by those who have been excluded or "disadvantaged" by hospital decisions. The hospital-physician relationship that has led to the greatest amount of litigation and dissatisfaction is the exclusive contract between hospitals and physicians.[3] Such exclusive contracts are primarily between hospitals and hospital-based physician specialists such as anesthesiologists, radiologists, pathologists and emergency room physicians. The central aspect of all these exclusive contracts is the same: physicians who are parties to the agreement provide specified services to the hospital to the exclusion of those not parties to the contract.

While this is a constant theme in cases involving exclusive contracts, the connection between the hospital and the favored group may take myriad forms. Arrangements may, for instance, alternatively characterize the physician as an employee or an independent contractor. The financial arrangements may vary tremendously, as physicians opt to retain independent billing, receive fees for services, or receive a percentage of the gross. Sometimes the "details" of the arrangement will have no effect whatsoever on the merits of any challenge; yet in other instances, these "details" may determine the outcome.

II. Application of Antitrust Laws

A. *General Application*

Despite the steady development of competitive forces in the hospital marketplace, it has been only recently that antitrust law has recognized challenges to arrangements involving health care professionals. Previously, the practice of medicine was ex-

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federal and state laws that are designed to limit hospital revenues. *See Symposium: Certificate-of-Need Laws in Health Planning*, 1978 UTAH L. REV. 1. *See generally* D.S. ABERNATHY & D.A. PEARSON, REGULATING HOSPITAL COSTS: THE DEVELOPMENT OF PUBLIC POLICY (1979); Lewin, Somers, & Somers, *State Health Cost Regulation: Structure and Administration*, 6 U. TOL. L. REV. 647 (1974-1975).

3. *See* Cardio-Medical Assocs. v. Crozer-Chester Medical Center, 536 F. Supp. 1065, 1069 *after amended complaint*, 552 F. Supp. 1170 (E.D. Pa. 1982), *rev'd in part, aff'd in part on other grounds*, 721 F.2d 68 (3d Cir. 1983); *see also* Dolan & Ralston, *Hospital Admitting Privilege and the Sherman Act*, 18 HOUS. L. REV. 707, 787-88 (1981).

cluded from antitrust application based on the "learned profession" defense,[4] because the practice of a profession was not "commerce" for purposes of the antitrust laws. Recent decisions,[5] however, have abolished this exemption. Indeed, the Supreme Court recently applied the standard of per se illegality to a price fixing arrangement within the medical profession itself.[6] *Arizona v. Maricopa County Medical Society*[7] made clear that the antitrust laws apply to the conduct of the medical profession.[8] Faced with the unequivocal holding of the Supreme Court in *Maricopa*, the medical profession and hospitals must be prepared to evaluate their conduct based solely upon the competitive model of the marketplace for hospital services.

B. *Jurisdiction*

Even after the "learned profession" exemption was abolished by the Supreme Court,[9] medical defendants in antitrust cases sought to dismiss antitrust claims on the ground that the challenged conduct did not have a substantial effect on interstate commerce.[10] Early in the quest for dismissals, however, hospitals were stung by the Supreme Court's decision in *Hospital Building Co. v. Trustees of the Rex Hospital*,[11] in which the Court, analyzing a variety of factors, determined that a hospital can be shown to have a substantial effect on interstate commerce.[12] Despite the Supreme Court's recognition that even local

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4. *E.g.*, Goldfarb v. Virginia State Bar, 497 F.2d 1, 13 (4th Cir. 1974), *rev'd*, 421 U.S. 773 (1975); *see also* FTC v. Raladam Co., 283 U.S. 643, 653 (1931); Federal Baseball Club, Inc. v. National League of Prof. Baseball Clubs, 259 U.S. 200, 209 (1922). *See generally* Heitler, *Antitrust, Restraint of Trade, and Unfair Business Practices: Impact on Physicians*, 3 J. LEGAL MED. 443 (1982).

5. *See, e.g.*, Goldfarb v. Virginia State Bar, 421 U.S. 773, 787 (1975); United States v. National Soc'y of Prof. Eng'rs, 389 F. Supp. 1173, 1197-98 (D.D.C. 1974), *vacated*, 422 U.S. 1031 (1975).

6. Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 347-48 (1982).

7. 457 U.S. 332 (1982).

8. *Id.* at 347-48.

9. Goldfarb v. Virginia State Bar, 421 U.S. at 787.

10. *See, e.g.*, United States v. Oregon State Medical Soc'y, 343 U.S. 326, 338-39 (1952).

11. 425 U.S. 738 (1976).

12. *Id.* at 744 (factors the Court considered were purchases of out-of-state supplies, revenue from out-of-state insurance companies, management fees paid to out-of-state parent corporations and multi-million dollar out-of-state financing).

medical activity in a hospital may be sufficient to invoke the jurisdictional prerequisites of the antitrust laws, defendants were given revived hope for this defense in *Capili v. Shott*.[13] In *Capili*, the Fourth Circuit found that there had been an insufficient showing of the hospital's effect on interstate commerce.[14] Absent a showing of a substantial and adverse effect on commerce, the antitrust laws do not apply.[15] Today, *Capili* stands as practically the sole support for a claim that a hospital does not have a substantial and adverse effect on interstate commerce. Many decisions hold that a hospital's activities satisfy the jurisdictional requirements of the antitrust laws.[16]

III. *Hyde v. Jefferson Parish Hospital Disrtrict No. 2*

When analyzing exclusive contracts today, the immediate and primary focus must be upon the recent United States Supreme Court decision in *Hyde v. Jefferson Parish Hospital District No. 2*.[17] In *Hyde*, the Supreme Court denied an anesthesiologist's claim that the exclusive contract in question was an illegal tying arrangement.[18] This long-awaited decision provides a useful vehicle to begin to analyze the future of exclusive contract litigation in the hospital context.

Dr. Edwin G. Hyde was an anesthesiologist who practiced in Jefferson Parish, Louisiana. Dr. Hyde applied for admission to the East Jefferson medical staff and received favorable recommendations. However, the hospital board voted to deny staff privileges to Dr. Hyde due to the fact that anesthesia services

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13. 620 F.2d 438 (4th Cir. 1980).

14. *Id.* at 439.

15. *E.g.*, Hospital Building Co. v. Trustees of Rex Hosp., 425 U.S. at 743; United States v. Employing Plasterers Ass'n, 347 U.S. 186, 189 (1954); Atlantic Cleaners & Dyers Inc. v. United States, 286 U.S. 427, 435 (1932); Cardio-Medical Assocs. v. Crozer-Chester Medical Center, 721 F.2d 68, 71-72 (3d Cir. 1983).

16. *See, e.g.*, Tarleton v. Meharry Medical College, 717 F.2d 1523, 1531-32 (6th Cir. 1983); Crane v. Intermountain Health Care, Inc., 637 F.2d 715, 720 (10th Cir. 1980); Konik v. Champlain Valley Physicians, 561 F. Supp 700 (N.D.N.Y. 1983), *aff'd*, 733 F.2d 1007 (2d Cir. 1984); Robinson v. Magovern, 521 F. Supp. 842, 876 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 824 (3d Cir.), *cert. denied*, 459 U.S. 971 (1982). *But see* Furlong v. Long Island College Hosp., 710 F.2d 922, 928 (2d Cir. 1983) (more specific jurisidictional facts needed to satisfy the jurisidictional element of an antitrust claim).

17. 104 S. Ct. 1551 (1984).

18. *Id.* at 1567-68.

were supplied to the hospital by Roux & Associates (Roux) under an exclusive contract. Under the contract Roux determines the fee for the services rendered. Patients are then jointly billed for the anesthesia services provided by the doctor and those provided by the hospital. After certain small deductions, fifty percent of the gross receipts of the department are sent to Roux.[19]

The district court rejected Hyde's claim that this arrangement represented an illegal tie under the antitrust laws on the basis that the hospital did not have sufficient market power over the tying product (operating rooms) in the market in which it competed.[20] The court relied upon the fact that large numbers of Jefferson Parish residents went to other hospitals in the New Orleans area.[21] Thus, in the view of the district court, Hyde failed to show that East Jefferson Hospital "dominated the market."

So, too, the district court accepted the hospital's contention that the exclusive contract between the hospital and Roux was to ensure the continued and quality care of their patients.[22] The court found the following factors relevant:

> Specifically the system insures twenty-four hour anesthesiology coverage, aids in the control and standardization of procedures and the efficient and less costly operation of the department; it lends flexibility to the scheduling of operations because it is not necessary to accommodate physicians with outside commitments; it permits the physicians, nurses, and other technicians in the department to develop a work routine and a proficiency with the equipment they use in patient treatment; and it increases the Board's ability to monitor the medical standards excercised be-

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19. Hyde v. Jefferson Parish Hosp. Dist. No. 2, 513 F. Supp. 532, 536 (E.D. La. 1981), *rev'd*, 686 F.2d 286 (5th Cir. 1982), *rev'd*, 104 S. Ct. 1551 (1984).

20. *Id.* at 544.

21. *Id.* at 539-40.

22. *Id.* at 540-41, 545. In the past, state court decisions have primarily justified exclusive contracts for this reason. *See* Dattilo v. Tuscon Gen. Hosp., 23 Ariz. App. 392, 533 P.2d 700 (1975); Centeno v. Roseville Community Hosp., 107 Cal. App. 3d 62, 167 Cal. Rptr. 183 (1979); Letsch v. Northern San Diego County Hosp. Dist., 246 Cal. App. 2d 673, 55 Cal. Rptr. 118 (1966); Blank v. Palo Alto-Stanford Hosp. Center, 234 Cal. App. 2d 377, 44 Cal. Rptr. 572 (1965); Rush v. City of St. Petersburg, 205 So.2d 11 (Fla. Dist. Ct. App. 1967); Benell v. City of Virginia, 258 Minn. 559, 104 N.W.2d 633 (1960); Adler v. Montefiore Hosp. Ass'n., 453 Pa. 60, 311 A.2d 634 (1973), *cert. denied*, 414 U.S. 1131 (1974).

> cause there are fewer individuals involved, maintenance of equipment is simplified and equipment breakdowns are minimized by limiting use to one group of physicians.[23]

The court deferred to the hospital's contention and found that these benefits rendered the exclusive contract reasonable.

On appeal, the Fifth Circuit reversed primarily because it did not require dominance in the tying product's market.[24] The Fifth Circuit initially noted that no party had seriously disputed the existence of a tying arrangement.[25] Once a tie was found to exist, the court of appeals addressed the second element of an illegal tying arrangement: whether the hospital had sufficient economic power over the tying product (operating rooms) to affect competition in the tied product market (anesthesia services).[26] Although the trial court had required "dominance" over the tying product,[27] the Fifth Circuit required the plaintiff to show merely that there had been an "appreciable restraint on free competition in the tied product."[28] Moreover, in order to determine whether an appreciable restraint had occurred, the Fifth Circuit examined the relevant geographic market in which the hospital operated. The Fifth Circuit disagreed with the district court's broad definition of the relevant market. The trial court defined a substantial portion of the New Orleans area as the proper geographic market of the hospital. The Fifth Circuit limited the relevant geographic market to the East Bank of Jefferson Parish.[29] Using this limited market definition, the court of appeals had no difficulty in finding that there had been a sufficient restraint of trade in the market for the tied product (anes-

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23. Hyde v. Jefferson Parish Hosp. Dist. No. 2, 513 F. Supp. at 540.

24. Hyde v. Jefferson Parish Hosp. Dist. No. 2, 686 F.2d 286 (5th Cir. 1982), *rev'g* 513 F. Supp. 532 (E.D. La. 1981), *rev'd*, 104 S. Ct. 1551 (1984).

25. *Id.* at 289. Both lower courts found that there were two separate products in the tying arrangement. *See infra* note 43 and accompanying text. This statement is somewhat curious in light of the fact that the briefs in support of the hospital in the Supreme Court argue strenuously that no tie existed. Brief for the Petitioners at 11, 41-42, Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551 (1984) (No. 82-1031). So, too, the failure of proof as to an actual tying arrangement was argued before the Supreme Court in early November 1983 during the oral arguments in *Hyde*.

26. Hyde v. Jefferson Parish Hosp. Dist. No. 2, 686 F.2d at 291.

27. Hyde v. Jefferson Parish Hosp. Dist. No. 2, 513 F. Supp. at 542; *see supra* text accompanying notes 19-21.

28. Hyde v. Jefferson Parish Hosp. Dist. No. 2, 686 F.2d at 289.

29. *Id.*

thesia services).[30]

Having found that economic power over the tying product existed, the Fifth Circuit also held that the profit sharing arrangement between the hospital and the anesthesiologists was anticompetitive,[31] particularly where the anesthesiologists relied heavily on nurse anesthetists.[32] Thus, the Fifth Circuit held that the true purpose behind this contract was economic gain, and not quality medical care.[33] Finally, the Fifth Circuit set forth the standard by which it would judge tying arrangements: "An illegal tying arrangement will never be excused if there is a less restrictive way to accomplish the end which the business justification purports to serve."[34] Using this standard, the court criticized each alleged justification for the tying arrangement in question based on the existence of less restrictive alternatives.[35] The court of appeals held that the exclusive contract was illegal.[36]

The Supreme Court unanimously reversed the court of appeals' decision, finding that, on the record before the Court,

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30. *Id.* at 290.

31. *Id.* at 292. The Fifth Circuit found the primary purpose of the tie was economic gain. The court discounted the quality of care rationales put forth in the case. It found patients lacked free choice as to anesthesia services and that anesthesiologists were unfairly excluded from the hospital staff.

32. *Id.* Anesthesia services in East Jefferson Hospital are primarily undertaken by nurse anesthetists. The anesthesiologists employed by Roux supervised the nurse anesthetists as needed, remaining with patients only for the more difficult operations. *Id.* at 288.

33. *Id.* at 295. In reaching their decision the court noted that "the profit motive caused the hospital to hire nurse anesthetists in place of needed anesthesiologists, a practice which dilutes the professional coverage available." *Id.* at 292.

34. *Id.* at 292 (citing Carpa, Inc. v. Ward Foods, Inc., 536 F.2d 39, 47 (5th Cir. 1976)).

35. For example, the court suggests:

> Monitoring of the professional competence of the anesthesiologists, another asserted business justification, can be accomplished by the much less restrictive means of relying upon the medical staff, which is already set up to provide this service. The need to place the responsibility for development and management of the department upon one individual can also be accomplished without an exclusive contract. In sum, appellees have failed to provide this Court with one reason for the exclusive contract which could not be resolved by a much less drastic solution.

Id.

36. *Id.* at 291-92.

there was insufficient proof of an illegal tying arrangement.[37] The Court split five to four, however, on the applicable legal standard to apply. The majority reaffirmed the applicability, in certain cases, of applying a per se rule to tying arrangements.[38] The Court noted that it was "far too late in the history of our antitrust jurisprudence to question the proposition that certain tying arrangements pose an unacceptable risk of stifling competition and therefore are unreasonable 'per se.' "[39]

The concurring opinion written by Justice O'Connor and joined by Justices Burger, Powell and Rehnquist, advocated a significant change in antitrust analysis by urging a rule of reason approach to tying cases.[40] Justice O'Connor argued that "the time has . . . come to abandon the per se label" on tying arrangements.[41] In the view of the concurring justices, tying arrangements should be condemned only where there is a "substantial threat that the tying seller will acquire market power in the tied-product market."[42]

IV. The Effect of *Hyde* on the Tying Arrangement Approach to Exclusive Contracts

Several key points emerge from an analysis of the *Hyde* decision which affect the manner in which hospitals and hospital-based physicians can structure their affairs. Unfortunately, the degree of "guidance" offered by the Court's opinion is at best minimal.

Existence of a Tie

The fundamental requirement of a claim of tying is that there are two distinct products involved in the tying relationship: a tying product and a tied product. In any tying claim, therefore, a plaintiff must demonstrate that independent products were involved in the challenged arrangement.

In *Hyde*, both the district court and the court of appeals

37. Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551, 1567 (1984).
38. *Id.* at 1560.
39. *Id.* at 1556.
40. *Id.* at 1570 (O'Connor, J., concurring).
41. *Id.*
42. *Id.* at 1572.

presumed that two distinct products were involved: operating rooms and anesthesia services.[43] The conclusion that separate products were involved finds support in the fact that the clinical practice of anesthesiology is independent of hospital support services to a significant degree. Anesthesiologists are called upon to diagnose, treat and care for patients directly.[44] Indeed, the strongest support for the existence of two distinct products is the fact that anesthesia services were provided to the hospital in *Hyde* by a completely distinct economic entity.[45] The anesthesia group was not an employee of the hospital but rather was a separate business entity that billed its services separately from those of the hospital.

By contrast, East Jefferson Hospital argued on appeal to the Supreme Court that the hospital offered one service — operating rooms — and that ancillary support, such as anesthesia, was incidental to this service. The hospital argued that it had achieved "complete functional integration" and that the service or product offered to the public was a vertically integrated unit.[46] In support of this position, commentators have endorsed the concept that the hospital and medical staff are joint producers of one product: "hospitalization services."[47] This unitary

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43. "The existence of a tying arrangement in this case has never been seriously disputed by appellees, since it is clear that . . . we are dealing with two distinct services which a buyer should be able to obtain separately." Hyde v. Jefferson Parish Hosp. Dist. No. 2, 686 F.2d at 289.

"The provision of anesthesia services is a medical service separate from the other services provided by the hospital. The hospital charges the patient a separate charge for this service." Hyde v. Jefferson Parish Hosp. Dist. No. 2, 513 F. Supp. at 540.

44. Indeed, the American Society of Anesthesiologists argued in its amicus brief before the Supreme Court in *Hyde* that anesthesiologists are fundamentally different from other "hospital based" physicians such as pathologists and radiologists. The latter groups do not practice in a direct physician-patient relationship; moreover, both pathologists and radiologists do not need to be in the hospital itself to perform their services. Brief Amicus Curiae of the American Society of Anesthesiologists, Inc. at 6, Jefferson Parish Hosp. Dist. No. 2, 104 S. Ct. 1551 (1984) (No. 82-1031).

Interestingly, it may be possible to have a tying arrangement involving anesthesiologists but have no tie with the identical contract involving pathologists and radiologists. *See* text accompanying note 55.

45. *Cf.*, Fortner Enters. v. United States Steel Corp. ("Fortner I"), 394 U.S. 495 (1969), (credit and the sale of the product were viewed as different products).

46. Brief for Petitioners at 41-42, Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551 (1984) (No. 82-1031).

47. Kissam, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CALIF. L. REV. 595, 666 (1982). *See also* Pauly &

product approach, it is argued, is consistent with the rationale of *National Society of Professional Engineers v. United States*[48] that courts in antitrust cases should be sensitive to the special facts of professional situations.[49] Moreover, courts have refused to consider related items as two separate products where the buyer did not discriminate between the items,[50] or where economic efficiency and technical quality were significantly enhanced by one package.[51]

The Supreme Court upheld the finding of the lower court that a tying arrangement existed on the record before the Court.[52] The Court, however, found the issue of "functional integration" to be irrelevant: "the answer to the question whether one or two products are involved turns not on the functional relation between them, but rather on the character of the demand for the two items."[53] Using this framework, the Court observed that there was sufficient demand for the purchase of anesthesiological services apart from the demand for hospital services to identify a distinct product market in the tied product.[54]

Finding a tie under the exclusive anesthesiology contract in question, the Court, nevertheless, opened the door for uncertainty in regard to other hospital-based physicians. In a footnote, the Court indicated that only twenty-seven percent of anesthesiologists have a financial relationship with the hospitals, implying that anesthesiologists, in this respect are different from other physicians, such as radiologists and pathologists, who are

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Redisch, *The Not-For-Profit Hospitals as a Physicians Cooperative*, 63 AM. ECON. REV. 87, 88 (1973).

48. 435 U.S. 679 (1978).

49. *Id.* at 686-87 (quoting Goldfarb v. Virginia State Bar, 421 U.S. 773, 778-79 n.17 (1975)).

50. *E.g.*, Times-Picayune Publishing Co. v. United States, 345 U.S. 594, 613-14 (1953).

51. *See* Siegel v. Chicken Delight, 448 F.2d 43, 48 (9th Cir. 1971), *cert. denied*, 405 U.S. 955 (1972); Dehydrating Process Co. v. A.O. Smith Corp., 292 F.2d 653, 655 (1st Cir.), *cert. denied*, 368 U.S. 931 (1961); Automatic Radio Mfg. Co. v. Ford Motor Co., 242 F. Supp. 852, 855-58 (D. Mass. 1965); United States v. Jerrold Elecs. Corp., 187 F. Supp. 545, 559-60 (E.D. Pa. 1960), *aff'd per curiam*, 365 U.S. 567 (1961). *See generally* Ross, *The Single Product Issue in Antitrust Tying: A Functional Approach*, 23 EMORY L.J. 963 (1974).

52. Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551, 1564-65 (1984).

53. *Id.* at 1562.

54. *Id.* at 1563-64.

based in hospitals.[55] Given a contract identical to the one challenged in *Hyde*, with the exception that radiologists are the contracting physicians, the Court may very well hold that no tie exists because in the case of radiology there is not an independent market for the tied services.[56] Each specialty, therefore, may need to be analyzed separately in order to determine whether it offers a market separate and distinct from the hospital.

Another uncertainty in the Supreme Court opinion centers around the tying concept of two separate sellers. An essential element of the illegal tie in *Hyde*, according to the Fifth Circuit, was the economic benefit received by the hospital from the existence of the exclusive contract itself.[57] The absence of this "profit factor" led several courts after the Fifth Circuit opinion to conclude that no tie exists if, under the terms of the exclusive contract, the hospital does not share in the anesthesiologist's profit.[58] The basis for this distinction was that in *Hyde* the entity offering the tying product had an economic interest in the tied product; that is, the hospital derived a profit from the anesthesia services themselves. Generally, most products in a tying arrangement are offered by the same seller. A tying arrangement may still be found to exist even if the sellers are separate, so long as the seller imposing the tie (in this case the hospital) has some economic interest in the supplier of the tied product or derives some benefit from the sale of the tied product.[59] Nevertheless, if anesthesia services and hospital care are in fact two distinct products and yet there is no economic benefit to the seller by the use of the designated supplier of the tied product, then an illegal tying arrangement does not exist.

Although this "economic benefit" analysis was vital to the Fifth Circuit, the Supreme Court did not even discuss the dis-

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55. *Id.* at 1564 n.36. This distinction finds support in the fact that anesthesiologists (as opposed to other hospital-based specialists) have direct patient contact, *see supra* note 44, and frequently bill separately.

56. *See supra* note 44.

57. Hyde v. Jefferson Parish Hosp. Dist. No. 2, 686 F.2d at 291-92.

58. *See, e.g.*, Griffing v. Crosby Memorial Hosp., 1984-1 Trade Cases (CCH) ¶ 65,854 (S.D. Miss. 1984).

59. Keener v. Sizzler Family Steak Houses, 597 F.2d 453 (5th Cir. 1979); Ohio-Sealy Mattress Mfg. Co. v. Sealy, Inc., 585 F.2d 821 (7th Cir. 1978), *cert. denied*, 440 U.S. 930 (1979); Kentucky Fried Chicken Corp. v. Diversified Packaging Corp., 549 F.2d 368 (5th Cir. 1977).

tinction. In future cases, the existence or nonexistence of economic benefit derived by a hospital in the tied product may be a key element that allows the lower courts to explain away the result in *Hyde*.

Economic Power over the Tying Product

Proof of sufficient economic power in the context of exclusive contracts with hospitals is a potentially difficult burden for the plaintiff. Until recently, this element did not require a showing of domination by the seller of the tying product in the relevant market.[60] Rather, the Supreme Court has held that tying arrangements are illegal if there is merely some "appreciable economic power" over the tying product,[61] a standard which does not require "that the defendant have a monopoly or even a dominant position throughout the market for a tying product."[62]

Economic power, however, can only be measured with reference to a specific geographic market for the hospital's services. The definition of this geographic market[63] will in large measure decide the issue of economic power. The district court in *Hyde* held that the relevant geographic market included an area of at least twenty hospitals, and therefore concluded that if both patient and surgeon are free to go to any one of a large number of competent institutions, the hospital does not possess the power to force the tied product upon consumers.[64] Other courts have accepted this reasoning.[65] The Fifth Circuit in *Hyde*, however, took note of market imperfections in the health care industry: "First, the prevalence of third party payment of bills eliminates a patient's incentive to compare the relative cost effectiveness of competing hospitals. A second market imperfection is the lack of

60. *But see* Jefferson Parrish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551 (1984) (modifying this requirement).

61. United States Steel Corp. v. Fortner Enters., 429 U.S. 610, 611-12 (1977) (Fortner II). *See also* Fortner Enters. v. United States Steel Corp., 394 U.S. 495, 502-03 (1969) (Fortner I).

62. United States Steel Corp. v. Fortner Enters., 429 U.S. at 620.

63. The geographic market is the area in which the seller competes and where the buyer would look for a supply of the goods or services.

64. Hyde v. Jefferson Parish Hosp. Dist. No. 2, 513 F. Supp. at 542-43.

65. *See* Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346, 1353-54 (7th Cir. 1982).

complete information regarding the quality of medical care offered."[66] Because of these imperfections, the court concluded, patients tend to choose hospitals by location rather than by price or quality, which means that the geographic market area may subsume only an individual hospital.[67]

The Supreme Court abandoned traditional formulas and labels for market power, however, and focused on the actual effects in the marketplace involved in the case before the Court.[68] While this "hands-on" approach has some inherent appeal, the effect of this ruling will be to cast doubt on any definition of market power. The Fifth Circuit in *Hyde* had found sufficient economic power because there were market imperfections which made patients tend to choose a local hospital. The Supreme Court acknowledged these unique market factors in the hospital market, yet failed to find that market power existed as it chose to define the term: "While these factors may generate 'market power' in some abstract sense, they do not generate the kind of market power that justifies condemnation of tying."[69] Market power only exists, the Court noted, when power over the tying product "force[s] patients to buy services they would not otherwise purchase."[70] The Court found that the record contained no evidence that the hospital "forced" anesthesia services on unwilling patients.[71] If a patient truly cared about the anesthesiologist he had for surgery he could choose another hospital where that anesthesiologist was permitted to work.

Despite its recognition of market factors that indicated market power in an "abstract sense," the Supreme Court found no "real" power over the tying product.[72] A plaintiff in any tying case must demonstrate that the defendant "forced" the plaintiff to buy the tied product. This forcing, moreover, will not necessarily be presumed even if certain formal indicia of market power are present. The full ramifications of this characterization of market power are far from clear.

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66. Hyde v. Jefferson Parish Hosp. Dist. No. 2, 686 F.2d 286, 290 (5th Cir. 1982).
67. *Id.* at 290-91.
68. Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. at 1567-68.
69. *Id.* at 1566 (footnote omitted).
70. *Id.*
71. *Id.* at 1567.
72. *Id.* at 1567-68.

V. Other Antitrust Theories

As can be seen in this brief overview, there are significant and difficult issues which remain even after the decision in *Hyde*.[73] Moreover, the limits of the decision in *Hyde* must be stressed. The Supreme Court offered some "guidance" for applying the tying arangement theory to exclusive contracts between hospitals and physician groups. Challenges to exclusive hospital arrangements based upon a tying arrangement claim, however, have been secondary to a wide variety of other theories which were not presented for decision in *Hyde*. *Hyde* did not determine with any finality the legality of exclusive contracts with hospital-based physicians. Indeed, given the complexity of the economic models in force in the health care field, it will be difficult to provide any generalizations concerning hospital organization and operation, regardless of the legal theory presented in a given case.

To analyze the various theories which have been, and will be, asserted against exclusive contracts, it is helpful to consider the interplay between the interests and powers of the hospital and the interests and powers of the medical staff. Professor Kissam ("Kissam") suggests three models as a framework for this analysis.[74]

Some privilege questions may be determined entirely by the medical staff and are referred to by Kissam as the "physician-cartel" model.[75] One example is a situation in which physicians are denied privileges because of their association with a non-hospital based health maintenance organization (HMO).[76] Here the physician's interest predomiates and there is little legitimate need for hospital input.

In situations in which the hospital and staff each have significant interests, Kissam terms the model a "joint venture."[77] For example, a hospital's decision to require board certification for staff privileges affects vital interests of both hospital and staff. While in these circumstances the physician may be pro-

73. Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551 (1984).
74. *See* Kissam, *supra* note 47, at 611-13.
75. *Id.* at 611.
76. For a discussion of this problem, see *id.* at 651-52.
77. *Id.* at 656-58.

tecting his own business from competition, the hospital may have its own independent interest in quality care.

Finally, Kissam presents a model in which the interests of the hospital in the quality of care or in efficiency of hospital operations appear paramount, while any separate interests of the medical staff in general are weak.[78] This "employer hospital" model[79] includes exclusive contracts because, in Kissam's opinion, the interests of the staff generally coincide with those of the hospital in promoting quality medical care.[80] Thus, the manner in which any arrangement is characterized under these models may go a long way toward determining whether anticompetitive forces are at work.[81] The following brief outline of other possible claims against exclusive contracts should be examined with these models and concepts in mind.

Exclusive Dealing

The Supreme Court clearly limited the scope of the *Hyde* opinion to the specific claim of tying presented in the record before it. The Court noted, however, that the hospital's contract

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78. *Id.* at 621.

79. *Id.* at 612, 663.

80. *Id.* at 612-13.

There are, however, numerous anticompetitive effects which are claimed to result from exclusive contracts. The hospital may be seeking, for example, to recover a portion of the professional fee from the physicians subject to the exclusive contract in order to increase profits and avoid the restrictions of new federal regulations. *See* Nord, *Antitrust Laws and Exclusive Contracts: Obstacles to Patients' Benefits?*, LAW, MED. & HEALTH CARE 66, 69 (April 1983).

So, too, qualified physicians are unfairly (it is argued) excluded from facilities to which they need access in order to work. Thus, physicians must abide by the financial structure of the favored group (assuming they are invited to join) or they should not be allowed to practice in the hospital.

81. Kissam is quick, however, to recognize that the unique circumstances and purposes involved in any case may alter the formal categories he has set forth:

> For example, the facts surrounding a particular exclusive privileges contract with radiologists may support characterization of the privilege decision as physician cartel behavior rather than as an employer hospital decision. This would be the case if the hosptial can provide no good reason for granting the contract (other than pleasing the incumbent radiologists) and the radiologists have obtained their contract by threatening to withdraw their services from the hospital. Our three forms of privilege decisionmaking are thus intended for use only as organizing principles, that is, as prima facie assumptions about the appropriate characterization of physician-hospital relationships.

Kissam, *supra* note 47, at 613 (footnote omitted).

with Roux removed the hospital from the market open to Roux's competitors. Under traditional exclusive contract analysis the Court stated: "this contract could be unlawful if it foreclosed so much of the market from penetration by Roux's competitors as to unreasonably restrain competition in the affected market, the market for anesthesiological services."[82] While acknowledging this possibility, the Court made clear that Hyde had "not attempted to make this showing."[83] Thus, exclusive contract analysis was not brought to bear on the facts presented in *Hyde*.

Exclusive contracts in many different kinds of markets have been analyzed under a rule of reason analysis.[84] The fundamental inquiry under this analysis is what effect the challenged practice has on competition. In making a determination regarding exclusive dealing contracts between physicians and hospitals, a number of factors, including the following, will be considered:

1. the number of hospitals in the relevant market area;

2. the number of physicians covered by the challenged contract;

3. the dollar value of the commerce affected by the arrangement;

4. the relative size of the hospital and the physician group compared to other hospitals and groups;

5. the business justification for the arrangement (for example, the hospital's need for an assured source and quality of services and the physician's need for consistent employment);

6. the ability of other physicians to practice in the relevant market area;

7. the initiator of the discussions concerning the contract;

8. the extent of the hospital's commitment of capital equipment;

9. the physician's compensation (hospital control may suggest hospital concerns with efficiency);[85]

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82. Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. at 1568 n.51.

83. *Id.*

84. *E.g.*, Tampa Elec. Co. v. Nashville Coal Co., 365 U.S. 320 (1961); Standard Oil Co. v. United States, 337 U.S. 293 (1949).

85. Hospitals have exercised more control over pathologists and radiologists, than over anesthesiologists. This may be indicated by the manner in which these specialists are paid. Pathologists and radiologists are frequently paid on a salaried basis, while anesthesiologists normally work on a fee-for-service basis.

10. the length of the contract and procedures.

A court would then weigh all these factors and determine whether the exclusive contract unreasonably restrains competition.

It was under this exclusive dealing analysis that the Seventh Circuit in *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*[86] lifted a preliminary injunction that a district court granted in favor of an excluded anesthesiologist. Although noting that some had argued for horizontal treatment of the challenged conduct, the Seventh Circuit did not find any evidence "contradicting the district court's conclusion that the exclusive contract is an instrument of vertical integration and not a horizontal restraint."[87] In order to find a violation of the antitrust law, the court would need to find "a substantial foreclosure of competition in an area of effective competition, that is, in a relevant market."[88]

In analyzing this relevant market the court in *Dos Santos*,[89] raised a critical point to be considered concerning the *actual purchaser* of the product in question (in this case, anesthesia services). The court posited that patients generally have little or no control or choice over the anesthesiologist.[90] Thus, it reasoned, it "may . . . be more appropriate for antitrust purposes to treat the *hospital* as the purchaser . . . ."[91] On this proposition, the court made the following analysis: "if the hospital rather than the individual patient is regarded as the purchaser, the relevant market could be defined as the area in which Associates operates and in which the Medical Center (rather than the patient) can practicably turn for alternative provision of anesthesia services."[92] This analysis is, of course, at least arguably at odds with *Hyde*,[93] because *Hyde* implicitly found the patient to be the purchaser of the "tied" products.[94]

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86. 684 F.2d 1346 (7th Cir. 1982).
87. *Id.* at 1352 n.9.
88. *Id.* at 1353.
89. 684 F.2d 1346 (7th Cir. 1982).
90. *Id.* at 1354.
91. *Id.*
92. *Id.*
93. 104 S. Ct. 1551 (1984).
94. *Id.* at 1563-65.

Commentators have supported this rationale to justify exclusive contracts. Kissam, for example, sees a strong, independent hospital interest in this kind of privilege decision.[95] Moreover, due to the fact that only a limited portion of the medical staff is involved in the agreement, there is less likelihood of the "physician cartel" interests bearing on a decision.[96] Even the Federal Trade Commission has given its approval to the general concept of exclusive hospital arrangements.[97]

In any event, traditional exclusive contract analysis under the rule of reason may still provide a vehicle for an excluded physician to challenge such a contract. The specifics of each case will determine the outcome under the perimeters discussed above.

Group Boycott

Unilateral refusals to deal with any customer are certainly permitted under the antitrust laws unless the refusals are part of an attempt to monopolize. Thus, a hospital's unilateral refusal to deal with an anesthesia group could not be challenged realistically by the excluded anesthesiologists. Cognizant of this situation, a plaintiff would allege that the decision to refuse to deal with him was not merely a unilateral decision of the hospital, but rather was a joint decision of the hospital, the favored anesthesia group, and perhaps the medical staff of the hospital. By raising allegations of joint conduct amounting to a group boycott, a plaintiff satisfies the plurality of actors requirement of section one of the Sherman Act[98] and thereby eases his burden of proof at trial.

The group boycott claim has the advantage of permitting analysis under a per se theory. A plaintiff could argue that a group boycott is presented in a vertical combination among competitors at different marketing levels and is designed to exclude from the market direct competitors of some member of the com-

95. Kissam, *supra* note 47, at 665.

96. "The real agreement in these cases is the one between the hospital and specialists involved, not among the entire medical staff, and there is, therefore, less reason for antitrust concern about these contracts." *Id.*

97. Burnham Hosp., 101 F.T.C. 991 (1983).

98. 15 U.S.C. § 1 (1982).

bination.[99] In such boycott cases, "the cornerstone of per se illegality has been the *purpose* and *effect* of the questioned arrangement."[100] Thus, courts have held that the "per se rule is justified only when there exists the presence of exclusionary or coercive conduct which, when present, warrants the view that the arrangement is a 'naked restraint of trade.' "[101]

Price Fixing

Depending on the nature of the contract between the hospital and the physician group, an excluded plaintiff may be able to make a claim of price fixing under section one of the Sherman Act.[102] For example, the contract at issue may state a maximum price for services that may be charged by the physician group. While price fixing is unquestionably a per se violation, even if maximum prices are being set,[103] the market analysis in any given case may show that the hospital is actually a purchaser of a product rather than a co-conspirator, and is therefore entitled to set the fee for the product under the contract.[104] Thus, there would not be a horizontal price fixing conspiracy, but rather a straightforward purchase and sale.

Moreover, courts have not been eager to apply per se illegality to new or borderline cases. In *Vuciecevic v. MacNeal Memorial Hospital*,[105] the court noted that:

> the type of conduct alleged as anticompetitive here, denial of medical staff privileges, could be considered a per se violation only after the courts have become familiar with that conduct and any anticompetitive effect it causes. Moreover, although the Supreme Court has repeatedly disavowed any professional exemption from antitrust liability, it has nonetheless consistently indicated that the antitrust laws ordinarily will be applied less rigorously to professions than to trades and industries.[106]

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99. Klors v. Broadway-Hale Stores, 359 U.S. 207 (1959).

100. Konik v. Champlain Valley Physicians Hosp. Medical Center, 561 F. Supp. 700, 718 (N.D.N.Y. 1983).

101. *Id.*

102. 15 U.S.C. § 1 (1982).

103. Albrecht v. Herald Co., 390 U.S. 145 (1968).

104. Group Life and Health Ins. Co., v. Royal Drug Co., 440 U.S. 205 (1979).

105. 572 F. Supp. 1424 (N.D. Ill. 1983).

106. *Id.* at 1427.

The court refused to apply a per se analysis for purposes of summary judgment due to this lack of familiarity.[107]

Another court, however, has noted that if a plaintiff under a group boycott claim proves the purpose of the agreement was to drive the plaintiff out of business, the defendant hospital would be liable under a per se analysis.[108] This theory, therefore, continues to have viability for future exclusive contract litigation.

Essential Facility Doctrine

The essential facility (or bottleneck) doctrine provides that if a facility is unique and essential to a competitor's business, denial of access to that facility on a fair basis will be deemed a restraint of trade in violation of section one.[109] *Hecht v. Pro Football, Inc.*[110] is an example of the application of this theory where access to a football stadium was denied to a competitor of the Washington Redskins. A facility need not be indispensable in order to be considered "essential."[111] This standard may be met "if duplication of the facility would be economically unfeasable and if denial of its use inflicts a severe handicap on potential market entrants."[112] Thus, in the context of health care, this theory would be more viable in the case of an isolated hospital where no alternative staff privileges are available. A physician excluded from practice at the hospital due to the contract, then, would certainly be severely handicapped.

As the court in *Hecht*[113] warned, however, this doctrine must be very carefully employed: "The antitrust laws do not require that an essential facility be shared if such sharing would be impractical or would inhibit the defendant's ability to serve its customers adequately."[114]

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107. See generally, Silver v. New York Stock Exch., 373 U.S. 341 (1963) for the Court's analysis of legal standards to apply where defendant is engaged in self-regulation.

108. Konik v. Champlain Valley Physicians Hosp. Medical Center, 561 F. Supp. at 718.

109. Sherman Act § 1, 15 U.S.C. § 1 (1982).

110. 570 F.2d 982 (D.C. Cir. 1977), *cert. denied*, 436 U.S. 956 (1978).

111. *Id.* at 992.

112. *Id. See also* Helix Milling Co. v. Terminal Flour Mills Co., 523 F.2d 1317, 1320 (9th Cir. 1975), *cert. denied*, 423 U.S. 1053 (1976).

113. 570 F.2d 982 (D.C. Cir. 1977).

114. *Id.* at 992-93.

The essential facility doctrine has been asserted in the health care context, yet, to date, it has not prevailed.[115] In addition to the isolation of the hospital and the existence of an exclusive contract, other factors may assist an excluded physician in presenting an essential facility claim. Other relevant factors include whether hospital-based physicians are involved in the exclusive contract, and whether the excluded physician requires for his practice sophisticated equipment located only at the subject hospital.

Of course, once the essential nature of the facility has been established, the plaintiff must still prove he was denied "fair" access.[116] In the health care context, this will likely lead to an evaluation of the basis upon which the exclusive contract was formed.

VI. Conclusion

The preceding discussion of antitrust theories, other than tying which may be raised by excluded physicians, is only meant to describe the key theories which have been raised to date. Other antitrust theories may certainly be presented in future cases in which exclusive contracts are challenged. Indeed, claims have been made (although unsuccessfully) by excluded physicians under section two of the Sherman Act[117] for attempts to monopolize. Claims such as this open up whole new areas for analysis and discussion.

So, too, plaintiffs may begin to focus more on state court causes of action. Many state antitrust laws provide a different basis for analyzing and evaluating exclusive contracts. State claims may be based on any number of other theories such as unfair competition or tortious foreclosure. A plaintiff may foreclose the possibility of treble damages and attorney's fees by opting for state court, but if entrance into the hospital is the main relief sought, then either federal or state court may provide sufficient opportunity for success.

The final point, then, is the recognition that on the basis of

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115. Konik v. Champlain Valley Physicians Hosp. Medical Center, 561 F. Supp. at 719; Robinson v. Magovern, 521 F. Supp. 842, 913 (N.D. Pa. 1981).

116. *See supra* text acompanying notes 108-10.

117. 15 U.S.C. § 2 (1982).

a tying arrangement, even after *Hyde*, challenges to exclusive contracts will certainly continue. A multitude of legal theories available to plaintiffs were untouched by the Court in *Hyde*. Moreover, the myriad factual differences among cases make it almost impossible for a court to answer satisfactorily the general question of the validity of exclusive contracts. And as the market forces act to create greater demand for hospital privileges, the excluded will be harder hit and will more frequently seek judicial resolution of the legality of the exclusion.