No. 82-1031

In the Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and
EAST JEFFERSON HOSPITAL BOARD, PETITIONERS

v.

EDWIN G. HYDE, RESPONDENT

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE PETITIONERS

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QUESTION PRESENTED

Whether an arrangement by which a hospital secures the full-time, exclusive services of anesthesiologists to attend its patients is unlawful per se under the Sherman Act because it "ties" the patient's use of the hospital's operating room to the use of the hospital's anesthesiologists.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-19a) is reported at 686 F.2d 286. The opinion of the district court (Pet. App. 20a-47a) is reported at 513 F. Supp. 532.

JURISDICTION

The judgment of the court of appeals (Pet. App. 48a) was entered on September 20, 1982. The petition for a writ of certiorari was filed on December 17, 1982, and granted on March 7, 1983. The jurisdiction of this Court rests on 28 U.S.C. § 1254(1).

STATUTE INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. § 1 (1976), provides in relevant part: "Every contract, combination

in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal."

STATEMENT

1. East Jefferson General Hospital is a large public hospital in the New Orleans metropolitan area.[1] See the maps at A. 35-37. At its opening in 1971 the Hospital concluded that anesthesia services would be best provided if the Hospital had the full-time services of one or more anesthesiologists. It accordingly invited anesthesiologists to make proposals for a contract to provide these services. 5-16 Tr. 128-131, 172-73.

After some negotiations, which included discussions with respondent, the Hospital entered into a contract with Roux & Associates ("Roux"), a professional medical corporation (Pl. Ex. 8; 5-15 p.m. Tr. 41; 5-16 Tr. 90). The contract was "exclusive": Roux promised that its anesthesiologists would not work elsewhere, and the Hospital agreed not to engage other anesthesiologists during its term. The term of the contract was one year,

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1. The Hospital is governed by petitioner Board of Directors, twelve people selected by petitioner Jefferson Parish Hospital District No. 2. The District is a political subdivision of the State of Louisiana. The Hospital was constructed with public funds in 1969. Day to day administrative decisions for the Hospital are made by an executive director selected by the governing body of the District. For convenience we refer to the two petitioners, the Hospital, and its executive director as "the Hospital."

The Hospital generally operates as a business, and petitioners have not argued that their decisions are protected by the state action doctrine of *Parker v. Brown*, 317 U.S. 341 (1943). See *Community Communications Co. v. City of Boulder*, 455 U.S. 40 (1982).

renewable for additional yearly periods unless either the Hospital or Roux should give 90 days' notice (A. 22 ¶ 17).

The Hospital was well satisfied with the services of the Roux anesthesiologists, and it allowed the contract to be renewed automatically until 1975, when it again reviewed the arrangement. It considered other options and proposals and once more selected Roux to provide services. 5-16 Tr. 133-35, 159-63, 200-01.

The contract signed in 1976 ran for five years (A. 23-28). Although it was not labeled "exclusive," it provided that Roux would supply all anesthesiology services required for the care of the Hospital's patients (A. 25; Pet. App. 2a n.1, 23a). Like the 1971 contract, this one also called for Roux to supervise the anesthesia department and the nurse anesthetists who performed many of the routine procedures (A. 23). It gave Roux the ability to hire and fire the nurse anesthetists who would be employed by the Hospital (A. 24). It gave the Hospital complete discretion to establish the charges to patients for anesthesia, requiring only consultation with Roux (A. 25-26). The fees of Roux were set at 46% of the total billings of the anesthesiology department; the remainder of the billings pay the nurses' salaries and compensate the Hospital for space, equipment, and supplies (A. 27). Roux thus was compensated whether its anesthesiologists performed the services or supervised their performance by nurse anesthetists.

Respondent applied in 1977 for a position on the Hospital's medical staff (A. 29-34). The Credentials Committee of the staff approved his credentials, but the Board of Directors declined to admit respondent to the

staff. It based this decision on the ground that the contract with Roux called for its anesthesiologists to supply all of the needed services (Pet. App. 25a-26a). Respondent then filed this suit under the Sherman Act, contending that the contract with Roux was unlawful because it "tied" patients' use of the Hospital's operating rooms to their use of Roux's services.[2] Respondent sought an injunction admitting him to practice in the Hospital, but he did not seek damages (A. 3-11).

2. The district court entered judgment for petitioners after a bench trial (Pet. App. 20a-47a). It assumed without discussion that the contract establishes a tie-in (*id.* at 33a) and applied the Rule of Reason to the contract because, it concluded, the Hospital has no significant market power.[3] It then held the contract lawful because it produces significant competitive benefits and no countervailing anticompetitive effects.

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2. Respondent also argued that the denial of his application for staff privileges violated the Fourteenth Amendment's due process clause (both substantively and procedurally) and two Louisiana statutes (A. 6-7, 9-10). The district court rejected all of these contentions (Pet. App. 42a-47a). The court of appeals did not reach them in light of its antitrust holding (*id.* at 5a n.3), and they are therefore not before this Court unless respondent should invoke them in support of his judgment. See *Rice v. Norman Williams Co.*, 102 S. Ct. 3294, 3301-02 (1982).

3. The district court also concluded that the Rule of Reason should be applied because of the special circumstances of the medical profession (Pet. App. 39a-41a). The court of appeals rejected this conclusion (*id.* at 14a-18a) in light of *Arizona v. Maricopa County Medical Society*, 102 S. Ct. 2466 (1982), and we have not presented this aspect of the Fifth Circuit's decision for review by this Court. We assume throughout this brief that the same antitrust principles apply to professional services as to other trades or businesses; respondent's assertion that we seek some special dispensation for hospital care (Br. in Opp. 9-14) is unfounded.

With respect to market power, the district court made a factual finding that the Hospital does not have "any advantages over any other hospitals in the area" (Pet. App. 34a) and is in no "position to charge patients higher prices or to impose burdensome terms which could not be extracted in a completely competitive market" (*ibid.*). It based this latter conclusion on findings that the Hospital competes for patients in the New Orleans metropolitan area (*id.* at 33a). The court observed that patients choose hospitals throughout the area and that only 30% of those who live in East Jefferson Parish obtain hospital care at the Hospital (*id.* at 33a, 38a-39a; see also A. 35 et seq. for the maps and patient origin data on which this finding is based). The court acknowledged that 70% of the Hospital's patients come from its neighborhood (*id.* at 39a) but reasoned that this does not show market power.

With respect to the benefits of the contract, the district court concluded that the arrangement ensured 24-hour service, "aids in the control and standardization of procedures and the efficient and less costly operation of the department[,] lends flexibility to the scheduling of operations[,] . . . 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 exercised because there are fewer individuals involved" (Pet. App. 32a-33a; see also 5-15 a.m. Tr. 59-66, 74-75, 93; 5-16 Tr. 12-15, 172-73, 191-94 for supporting testimony). Moreover, the court explained, the contract did not suppress competition but rather created more competition: "A closed department may enhance competition among the hospitals in the market by increasing the quality of medical

care available. It may also serve to benefit competition among anesthesiology groups if the terms of the exclusive contract are not for unreasonable periods of time. Such a system would serve to encourage anesthesiologists to improve the quality of their services in order to obtain these contracts with hospitals" (*id.* at 34a). It therefore entered judgment for petitioners.

3. While the case was on respondent's appeal, petitioners moved to dismiss the appeal as moot because the 1976 contract had expired, the anesthesiology department was now "open," and respondent was free to apply for privileges. Respondent opposed the motion, which the court of appeals denied (A. 77-79).

We agree with the court that the case is not moot. The Roux anesthesiologists continue to have a position that is exclusive in fact, even though not made so by contract. Although voluntary discontinuation of the challenged acts would not moot the case, see *City of Los Angeles v. Lyons*, No. 81-1064 (Apr. 20, 1983), this case does not even involve voluntary discontinuation. The Hospital continues to have "closed" departments in radiology, pathology, cardiology, respiratory therapy, and emergency room services. The Hospital intends to review the status of anesthesiology as soon as the termination of this litigation permits. We therefore proceed as if the challenged 1976 contract were still in effect.

4. The court of appeals reversed on the merits. It first held that there is exclusivity in fact (Pet. App. 2a n.1). Then it concluded that the contract is a "tie-in" because patients in the "hospital's operating room (the tying product) are also compelled to purchase the hospital's chosen anesthesia service (the tied product). It is

also clear that we are dealing with two distinct services which a buyer should be able to obtain separately" (*id.* at 5a-6a).

It next held that the Hospital possesses market power as a matter of law because of "market imperfections in the health care industry" (Pet. App. 9a). Although the Fifth Circuit did not find any of the district court's conclusions clearly erroneous, it pointed to the fact that the Hospital is a nonprofit institution, to the prevalence of third-party payments that reduce the incentives of patients to shop for low prices, and to the patients' lack of complete information about the services they are buying; it also asserted that "patients tend to choose hospitals by location rather than price or quality" (*ibid.*). As a result, the court of appeals held, the geographic market is smaller than metropolitan New Orleans, the Hospital's market share is larger than the district court thought, and the Hospital thus has "sufficient market power in the tying product to coerce purchase of the tied product" (*id.* at 10a).

The court of appeals did not hold that the contract elevated prices of either anesthesia services or the package of operating rooms and anesthesia (Pet. App. 11a-12a). The court concluded, however, that constant or declining prices coupled with the lower costs of service made possible by the contract just led to profits for the Hospital, which demonstrated the vice of the contract (*ibid.*).

Finally, the court of appeals turned to the consequences of the contract. It held that the benefits found by the district court could not be used to sustain the contract because the Hospital had not established that a closed anesthesia department is the least restrictive

alternative for the creation of these benefits (Pet. App. 13a). Moreover, the court expressed doubts about the existence of these benefits. One finding, concerning the contract's utility in guaranteeing 24-hour service, was held clearly erroneous (*id.* at 3a-4a & n.2, 11a n.7); others, such as the findings concerning competition among anesthesiologists for the contract, were put to one side (*id.* at 12a n.9); still others, such as the findings concerning the supervision by Roux of the nurse anesthetists and the Hospital's supervision of Roux, were simply not mentioned.[4]

5. On April 28, 1983, the district court, acting pursuant to the court of appeals' mandate (which has not been stayed), ordered respondent admitted to the Hospital's staff pending proceedings in this Court.

SUMMARY OF ARGUMENT

A. The packaging and joint sale of multiple products is usually beneficial. Cars come with motors installed, razors with blades, hospitals with nurses, blood, and oxygen. This is advantageous for the same reason it is usually beneficial for business corporations to make more than one product apiece: there are savings from joint production and distribution. Antitrust law

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4. The court of appeals stated, for example, that the contract "reduces the incentive for improving or initiating techniques or procedures. Quality is lowered" (Pet. App. 12a). The court did not mention, let alone hold clearly erroneous, the district court's contrary finding of fact. (It did hold erroneous, *id.* at 11a n.7, any finding that "strictly quality considerations" account for the arrangement, but this appears to represent only a conclusion that some considerations *in addition to* quality motivated the Hospital's decision.)

recognizes and preserves these advantages. *United States Steel Corp. v. Fortner Enterprises, Inc.*, 429 U.S. 610 (1977) (*Fortner II*).

B. Joint sales of products are unlawful only when some feature distinguishes a given sale from its beneficial cousins. That feature usually is market power. But not just any market power with respect to customers will condemn a joint sale. It is only power that enables a firm to get a dispositive advantage over its rivals, and so create a further monopoly. *Fortner II* thus held that market power in a tie-in case means some feature of a product or arrangement that rivals cannot copy. When they can copy the package, the design of the package *is* competition on the merits.

C.1. The Hospital has many competitors. All can copy its methods of packaging medical services, and most do. The contract thus cannot create a monopoly of the package or a monopoly price for the package or its components.

C.2. Even if the Hospital has "market power" in a conventional sense, the exclusive anesthesiology agreement does not either exercise or augment the Hospital's power. The Hospital is in privity with every patient. It knows which ones have which operations. Thus if it is able to extract a monopoly price for its services, it can get that price by levying a high fee for an operation or a surcharge for anesthesia. Nothing depends on the Hospital's ability to contract for or furnish anesthesia services in any particular fashion. The arrangement thus cannot be an exercise of leverage from one monopoly profit to another.

D. Antitrust law encourages any firm, even one with market power, to save costs and increase the quality of its products. The arrangement challenged here does just that, as the district court found. It ensures the full attention of the anesthesiologists to the Hospital's patients, permits them to supervise and use the services of nurse anesthetists effectively, ensures that the Hospital can supervise the anesthesiology work, and so on.

The court of appeals' belief that the Hospital was spurred by profits to adopt the arrangement, and that it substitutes nurse anesthetists for anesthesiologists in some procedures, offers only praise. Profit is the drive of any competitive system. And it is desirable to furnish a service by using specialized non-physician medical staff if that reduces the costs of medical care without reducing quality.

E.1. At all events, the Hospital lacks the market power that would be the foundation for antitrust scrutiny. If the right perspective is power over charges to patients, the Hospital has none because there are tens of hospitals in the New Orleans area, and the Hospital must compete for the patients' custom. That some patients prefer nonprofit hospitals, or hospitals close to home, is irrelevant if enough other patients shop around that the Hospital must be competitive, as the district court found it to be.

E.2. The relation between Hospital and patients is not, however, the right focus. Any system of staffing restricts patients' choice of anesthesiologist to those admitted to practice in the Hospital. The locus of competition is obtaining a position on the staff. In the market in which anesthesiologists sell their services, there is competition in abundance. Anesthesiologists regularly

move from city to city, seeking positions. Hospitals solicit bids from out of town (and from out of the country too).

E.3. Although the contract does not permit respondent to compete for the right to serve each patient, there is nonetheless vigorous competition among anesthesiologists for the position. The fact that one bidder is unsuccessful in securing a position does not signal the elimination of competition. Competition for the contract is common in business, and here it was particularly effective.

F. The joint sale of operating rooms and anesthesia is not even a "tie-in", as antitrust defines that term. Products are deemed "tied" only when there is no good justification for their joint provision. Here there is such justification: no one wants operations without anesthesia, and patients do not purchase anesthesia as a distinctive product. They buy "surgery" and rely on the surgeon and the hospital to assemble the necessary complementary services. It is pointless for a court to compel competitors to tear asunder what patients want and need to purchase as a unit.

G. Ultimately this is an employment case. The exclusive arrangement with Roux is functionally identical to the Hospital's decision to employ anesthesiologists on its staff. It differs only in being easier to terminate an exclusive contract than to fire staff members, and thus the exclusive contract is better at preserving competition. If a nurse brought suit, claiming that the Hospital could not hire nurses for its staff but must accept freelance nurses roaming the halls looking for work, the Hospital would be given judgment on the pleadings. This is the same case.

ARGUMENT

BECAUSE IT CREATES NO HARM TO THE USERS OF MEDICAL SERVICES, THE EXCLUSIVE ANESTHESIOLOGY CONTRACT IS LAWFUL

A. *Packaging Two Products Together is Common and Beneficial*

We start from what must be common ground among the parties: there is ordinarily no antitrust objection to any firm's putting two or more things together and selling them as a unit. Such package sales are common and beneficial. Cars come with motors and tires, left and right shoes come in a box, a new razor may come with ten blades. Joint sales are as common in professional services as in manufactured goods. To get the top partner of a major law firm, the client must take the firm's associates. The podiatrist in a group practice of medicine (such as the Group Health Association) comes packaged with the group's dermatologist. Any hospital furnishes nurses, blood, oxygen, and hundreds of other complementary inputs that together make up the package of medical care it supplies to patients.

These things are put together and sold as a unit because there are substantial savings in joint sales. Cars *could* be furnished without engines or tires — airplanes often are sold that way — but it would impose needless costs on consumers if firms separately furnished products that consumers ordinarily combine anyway. It is better and cheaper to combine them at the plant in the first place. Similarly, the whole idea of law firms and the joint practice of medicine is that the cooperation of many people in the creation of a single, packaged product produces cost savings and other benefits.

People compete to create the methods of packaging and delivery that consumers want to purchase. There are both large law firms and solo practitioners. Consumers have a choice, and the method that best serves their needs will prosper. Similarly, some hospitals furnish anesthesia through contractual arrangements, others have open staffs, still others provide such services through full-time employees (who may be nurse anesthetists rather than anesthesiologists). Again consumers have a choice — giving them the choice *is* competition — and they can select which organizational method best serves their interests. In a competitive market one form may dominate (almost no one sells left shoes without right shoes, or cars without engines) or both forms may exist (solo and firm practice of law), but in either event the structure of the market is determined by what people want to buy.

Nothing in antitrust law prohibits producers from competing in the methods they use to create or package what they have to sell. *United States Steel Corp. v. Fortner Enterprises, Inc.*, 429 U.S. 610 (1977) (*Fortner II*), this Court's most recent tie-in case, makes that clear. U.S. Steel sold Fortner a package of prefabricated houses and credit, a package much more unusual than the one involved in this case. But the Court held the package sale lawful, for it appeared that many customers wanted to buy both houses and credit. Similarly, in *Times-Picayune Pub. Co. v. United States*, 345 U.S. 594 (1953), the Court sustained a package sale of morning and afternoon advertising. Even in *Northern Pacific Ry. v. United States*, 356 U.S. 1, 7 (1958), the high water mark of tying doctrine, the Court observed that "if one of a dozen food stores in a community were to refuse to sell flour unless the buyer also took sugar it

would hardly tend to restrain competition if its competitors were ready and able to sell flour by itself." The joint sale of products may have the same benefits as their joint production. Joint sales are, as a rule, no more objectionable than the formation of the firms that produce them. See also *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 8 n.13, 9-10 (1979) (sustaining against per se antitrust challenge the joint sale of performing rights in music); *Arizona v. Maricopa County Medical Society*, 102 S. Ct. 2466, 2480 (1982) (group practice of medicine, which entails joint provision of services, is "perfectly proper").

B. *A Joint Sale May be Unlawful only if it has Anticompetitive Elements Distinguishing it from Ordinary Joint Sales*

If most package sales of products are beneficial to consumers and hence lawful, then there can be an antitrust objection to the Hospital's joint provision of operating rooms and anesthesia only if something distinguishes this from the other sales. That "something" must be a powerful distinction indeed in order to call the joint provision unlawful per se, as the court of appeals has done.

Practices may be condemned per se only when they have a "pernicious effect on competition and lack . . . any redeeming virtue" (*Northern Pacific, supra*, 356 U.S. at 5). "Per se rules of illegality are appropriate only when they relate to conduct that is manifestly anticompetitive." *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 32, 50 (1977). See also *Broadcast Music, supra*, 441 U.S. at 7-8, 19-20; *National Society of Professional Engineers v. United States*, 435 U.S. 679, 692 (1978). Per se rules are based on the conclusion, drawn after

judicial experience with a particular class of industrial practices, that the likelihood of there being a beneficial example of that class is so remote, and the social gains from these scattered examples so small, that it is better to condemn the whole class than to spend time and money in litigation looking for the few beneficial examples. See *Continental T.V., supra*, 433 U.S. at 50 n.16.

Yet the discussion above, fortified by *Fortner II*, demonstrates that the joint provision of different products is not ordinarily pernicious. It is common and ordinarily beneficial. The producer's decision about how to package and sell things *is competition*, and a rule condemning package sales would reduce competition.

Fortner II holds that package sales are not unlawful at all, let alone unlawful per se, unless the seller has market power in the market for the tying good. Only then, the Court reasoned, could a joint sale be deleterious, presumably because the firm's market power might restrain competition for the package as a whole. (This is referred to in earlier cases as "leverage," the transfer of market power from one product to another.) The Court defined market power as the ability "to raise prices or to require purchasers to accept burdensome terms that could not be exacted in a completely competitive market" (*Fortner II*, supra, 429 U.S. at 620; footnote omitted). The Court also explained how to show this: "In short, the question is whether the seller has some advantage not shared by his competitors in the market for the tying product." *Ibid.*

The "advantage not shared by his competitors" is an essential link in the chain of reasoning by which a customary, procompetitive packaging of products can be turned into something unlawful per se. Only if a firm

has "some advantage not shared by [its] competitors" will competition fail to develop among different packages and packagers of products. Only if such competition fails to develop could a joint sale — even a joint sale by a firm with a large market share — increase whatever harm to consumers the market share alone would create.

If a firm's rivals can copy the package or mechanism it has created, then competition is not diminished by the packaging. In *Fortner II* itself, U.S. Steel's rivals were free to copy its package sale. That they chose not to suggested not an antitrust problem but just that U.S. Steel was "willing to accept a lesser profit" (429 U.S. at 621), or "to provide cheap financing in order to sell expensive houses" (*id.* at 622; footnote omitted). When other firms are able to "go ye and do likewise"[5] there is simply no risk of injury to consumers, and therefore no reason for illegality, whether under a Rule of Reason or a per se approach.[6] Leverage won't work.

C. *Other Hospitals Could and Did Use the same Packaging Methods as Petitioners, Making Leverage Impossible Even if it were in the Hospital's Interest to Attempt It*

Under the market power-leverage approach of *Fortner II* and earlier tying cases, there is no cause for antitrust concern about petitioners' conduct even if one

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5. Jones, *The Two Faces of* Fortner*: Comment on a Recent Antitrust Opinion*, 78 Colum. L. Rev. 39, 42 (1978).

6. For cases holding that the ability of rivals to mimic the defendant's practices negates any claim of illegal tying, see *Spartan Grain & Mill Co. v. Ayers*, 581 F.2d 419 (5th Cir. 1978), cert. denied, 444 U.S. 831 (1979); *General Business Systems v. North American Phillips Corp.*, 699 F.2d 965 (9th Cir. 1983).

assumes (which we dispute below) that the Hospital has some limited power to affect the price it charges to patients. There are two reasons for this. First, other hospitals could and did use the same method of delivering services. Second, because operations and anesthesia are delivered in fixed proportions at the Hospital, the packaging of operating rooms and anesthesia adds nothing to the Hospital's ability to collect from patients. Consequently, nothing the Hospital did could harm consumers' interests. If the Hospital lawfully may exist (and, we assume for now, exercise market power) there is no antitrust reason why it may not use any selling practice it likes, so long as the practice does not add to its power by excluding equally or more efficient rivals.[7] See *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 273-76, 286-88, 291-92 (2d Cir. 1979), cert. denied, 444 U.S. 1093 (1980) (even a monopolist may choose packaging methods that increase its market share, so long as it does not exclude competition or use leverage that wrongfully increases its monopoly profit; it is otherwise entitled to a "lawful monopoly profit") (collecting earlier cases).

1. Other Hospitals Commonly Furnish Operations and Anesthesia Together

Respondent is not the Hospital's competitor. The Hospital competes, rather, against other hospitals that put together medical care. And these other hospitals

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7. A firm with market power has no obligation to avoid harming less efficient rivals. Antitrust law exists to protect the welfare of consumers, not competitors, and it does not safeguard the interests of rivals for the rivals' sake. E.g., *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 487-88 (1977); *Continental T.V., Inc. v. GTE Sylvania Inc.*, *supra*, 433 U.S. at 53 n.21.

commonly use the practice challenged here. The district court found that it is a "common practice in the health care industry for hospitals to enter into exclusive contracts with physicians" (Pet. App. 32a). See also *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346, 1351 (7th Cir. 1982) (similar arrangements are "widespread" and have "been adopted by most hospitals in the Chicago area").

Hospitals routinely put together services, including space, equipment, drugs, blood, nurses, food, and some medical specialties such as anesthesiology, radiology, and pathology, that are delivered to patients as a package of medical care. Data on just the three most common hospital-based specialties (anesthesiology, radiology, and pathology), summarized in our petition for certiorari (Pet. 10-11), demonstrate that approximately half of all hospitals in the United States have exclusive contracts for the provision of one or more of these services, and half of all medical professionals rendering these services do so under exclusive contracts. The figures are probably higher than 99 percent for nursing, food, oxygen, and the other components of medical services that any hospital assembles for the benefit of its patients.

The prevalence of exclusive contracts also is illustrated by the number of antitrust attacks waged against them. There have been many in the last few years, although until now every court that has considered an antitrust attack on such assembly of medical services had upheld the hospital.[8] The Federal Trade Commission has issued an advisory opinion about hospitals'

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8. E.g., *Smith v. Northern Michigan Hospitals, Inc.*, 1983-1 Trade Cas. ¶65,289 (6th Cir. Mar. 25, 1983) (rejecting a challenge to

exclusive contracts for medical services. The FTC unanimously took the position that such contracts are not unlawful, in large part because exclusive contracts are a way for one hospital "to compete with other hospitals by obtaining efficiencies and a desired level of quality and service."[9]

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an exclusive staffing arrangement for emergency rooms); *Dos Santos, supra* (adopting the reasoning of the *district* court in this case and rejecting an argument that exclusive medical contracts amount to a boycott or other per se violation); *Harron v. United Hospital Center, Inc.*, 522 F.2d 1133 (4th Cir. 1975), cert. denied, 424 U.S. 916 (1976) (an antitrust challenge to an exclusive medical contract is so "frivolous" that the suit must be dismissed for want of federal jurisdiction); *Capili v. Shott*, 620 F.2d 438 (4th Cir. 1980) (exclusive arrangement is reasonable and challenge also fails to show effect on interstate commerce); *Robinson v. Magovern*, 521 F. Supp. 842, 919 (W.D. Pa. 1981), aff'd mem., 688 F.2d 824 (3d Cir. 1982), cert. denied, Nov. 1, 1982, No. 82-415 (by using a closed staff the hospital has built a "high quality staff" and "improved its ability to compete"; rejecting a large number of different antitrust claims).

Every state court that has encountered similar claims under state antitrust law also has sustained the hospitals' practices. *Rumple v. Bloomington Hospital*, 422 N.E.2d 1309 (Ind. App. 1981); *Centeno v. Roseville Community Hospital*, 167 Cal. Rptr. 183 (Cal. App. 1979); *Dattilo v. Tucson General Hospital*, 23 Ariz. App. 392, 533 P.2d 700 (1975); *Letsch v. Northern San Diego County Hospital District*, 55 Cal. Rptr. 118 (Cal. App. 1966); *Blank v. Palo Alto-Stanford Hospital Center*, 234 Cal. App. 2d 377, 44 Cal. Rptr. 572 (1965).

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9. For the convenience of the Court, we reproduce the advisory opinion as Appendix A to this brief. The quoted portion appears at A-7.

2. The Exclusive Service Contract Cannot be Used by the Hospital to Augment any Market Power it May Possess

Because other hospitals can and do use the same method of staffing as petitioners, there is nothing unique about petitioners' product and methods, no "advantage not shared by [the Hospital's] competitors," (*Fortner II*, supra, 429 U.S. at 620), and no reason for antitrust concern. The district court found, as a matter of fact, that the Hospital has no special advantage (Pet. App. 33a-34a), and the court of appeals did not conclude that this finding is clearly erroneous. In light of the prevalence of exclusive contracts, it could not have disturbed the district court's finding.

The court of appeals instead bypassed the whole controversy by holding that the Hospital has market power vis-a-vis patients. We dispute this at pages 30-34 below. For now, however, there is a more important point: *Even if* the Hospital has its patients over a barrel, the exclusive anesthesiology arrangement does not make the patients any worse off. Instead it almost surely makes them better off. So there is no ground of antitrust condemnation.

Fortner II establishes that if a package sale simply entails a low price on one item and a high price on another, there is no antitrust problem. "Cheap financing in order to sell expensive houses" (429 U.S. at 622) is perfectly lawful. This is because the leverage objection to tie-ins is that the price of the package rises as it partakes of the tying good's monopoly power. If this

does not or cannot happen — if, as in *Fortner II*, the package sells for an unchanged price) — there is no violation.[10] No one is harmed.

Respondent has not alleged, and the court of appeals did not find, that the anesthesiology arrangement caused an increase in the price of the operating room — anesthesia "package." To the contrary, the court observed that the price of anesthesia had not risen (Pet. App. 11a-12a), and it did not suggest that there was a corresponding rise in the price of operating room time. Because antitrust law is a "consumers' welfare prescription"[11] and is directed only against practices that reduce consumers' welfare, that should have been the end of this case.

There is, moreover, a reason why an exclusive contract *cannot* harm users of medical services. In most tie-in cases, such as IBM's lease of tabulating machines on condition that lessees buy cards as well, and International Salt's sale or lease of salt-injecting machines tied to salt, the purpose or function of the tie is to compel

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10. E.g., *Kypta v. McDonald's Corp.*, 671 F.2d 1282 (11th Cir. 1982), cert. denied, Oct. 4, 1982, No. 82-6, holding in light of *Fortner II* that a tying complaint must be dismissed on the pleadings unless the plaintiff offers to prove that the tie-in increased the price of the package over what it would be in the absence of the joint sale; *General Business Systems v. North American Phillips Corp., supra.*

11. E.g., *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979), quoting from R. Bork, *The Antitrust Paradox* 66 (1978). See also *Broadcast Music, supra; Continental T.V., supra; Brunswick, supra; Valley Liquors, Inc. v. Renfield Importers, Ltd.*, 678 F.2d 742, 745 (7th Cir. 1982); *Products Liability Ins. Agency, Inc. v. Crum & Forster Insurance Cos.*, 682 F.2d 660, 663 (7th Cir. 1982).

the user to buy from the vendor a good it would ordinarily buy from someone else. *IBM v. United States*, 298 U.S. 131 (1936); *International Salt Corp. v. United States*, 332 U.S. 392 (1947). Unless it compelled or induced the buyer to take *its* cards or salt, the defendant had no way to extract any profit on those sales.

Here, however, the ratio of operating rooms to anesthesia is fixed — each patient (except the foolhardy) will use anesthesia on each operation. The Hospital is in privity of contract with the patients, and it knows how much anesthesia each patient requires. If "imperfections" in the market for medical services enable the Hospital to raise the price of medical care, it can do so no matter how patients secure anesthesia. The Hospital will just increase the price for operating room time until it has extracted the full profit available. If it wants, it can levy an anesthesia surcharge. In either event, nothing turns on whether the Hospital has an exclusive contract for anesthesia. The patient's bill is unaffected. See also 5 P. Areeda & D. Turner, *Antitrust Law* ¶1134 (1980).

Indeed if, as respondent says, the exclusive contract reduced competition in the market for anesthesia, the Hospital harmed only itself. The cost of anesthesia is ultimately borne by the patient, who sees it as part of the cost of medical care. If the Hospital has market power, it wants to hold as low as possible the costs of all medical services other than its own. If it allows the price of anesthesia to rise, or the quality to fall, it is shooting itself in the foot. It loses the opportunity to keep for itself all that the traffic will bear. No firm, no matter

how much market power it has, wants to increase the cost of an input into its own production. See *Continental T.V., Inc. v. GTE Sylvania Inc., supra.*

So market power is an implausible explanation for the exclusive contract, and damage to consumers of medical care is an impossible consequence of it. On the assumption that the Hospital has market power, the arrangement just makes the patients better off by reducing the costs (or increasing the quality) of anesthesia. If a monopolist reduces its costs, at least some of the reduction will be passed on to the consumer.[12] Consumers therefore want any firm, no matter how much market power it possesses, to assemble its products in the least-cost fashion. For reasons we discuss next, an exclusive contract may well enable the Hospital to reduce its costs and increase the quality of its services.

D. *Exclusive Contracts for Medical Services May Enable Hospitals to Perform Those Services More Efficiently*

After hearing the evidence, the district court found that the contracts at issue enabled the Hospital to deliver better service at lower cost (Pet. App. 32a-34a). The FTC, which has a special expertise in medical service questions, agrees. Its recent advisory opinion on this subject recites that exclusive contracts "can facilitate efficient delivery of services" by ensuring, among other benefits, "full-time availability of services, lower costs of standardization of procedures and centralized

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12. How much depends, as the Court observed in a related pass-on context, on the elasticity of demand. *Illinois Brick Co. v. Illinois*, 431 U.S. 720, 741-42 (1977). See also 2 Areeda & Turner, *supra* at ¶408a; Posner, *Oligopoly and the Antitrust Laws: A Suggested Approach*, 21 Stan. L. Rev. 1562, 1585-87 (1969).

administration . . ., [and they] permit better scheduling of the use of facilities, facilitate maintenance of equipment, improve supervision of support staff. . . and improve the quality of services by assuring that physicians perform enough procedures to maintain their proficiency" (App. A, *infra*, at A-5). This is substantially the same list of benefits the district court found in this case. See also 3 Areeda & Turner, *supra* at ¶733c.

The nature and source of most savings is apparent. The brief of the American Hospital Association, as amicus curiae, elaborates on them. One source of the benefits deserves special comment, however.

Several of the gains from exclusive medical service arrangements are attributable to the allocation of duties between anesthesiologists and nurse anesthetists that the arrangement made possible. Because Roux is responsible for all anesthesia in the Hospital and is paid no matter who provides a given service, it uses whichever of the services is best for the patient. Because anesthetists and anesthesiologists cooperate, Roux's four anesthesiologists can cover the fourteen operating rooms in the Hospital. Highly specialized medical professionals can take the place of the more expensive anesthesiologists. In an "open" department, by contrast, anesthesiologists will try to supply their own services even though a particular procedure could be performed more effectively, and at lower cost, by the nurse anesthetists who operate under the constant guidance of Roux in the Hospital's "closed" department. This is innovative cost-saving technology at work,

made possible by the agreement. An "open" department would destroy both the incentives and the supervision that make these savings possible.[13]

The court of appeals responded to the proof of benefits by holding clearly erroneous the district court's conclusion that the arrangement ensured 24-hour service (Pet. App. 3a-4a & n.2, 11a n.7). We doubt that this finding was clearly erroneous, but we let the matter pass because there are so many other benefits, unquestioned by the court of appeals. The court of appeals' bald assertion that "quality is lowered" (*id.* at 12a) is simply untenable in light of the undisturbed factual findings of the district court.

The court of appeals also held that reasons in addition to "strictly quality considerations" (*id.* at 11a n.7) account for the arrangement. By this it apparently meant that the Hospital acted with a view to reducing the cost of service and, hence, increasing its "profit" (an odd term for a non-profit institution). The court stated that there was "testimony that the profit motive caused the hospital to hire nurse anesthetists in place of needed

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13. Another benefit is the elimination of free riders. Someone must coordinate the anesthesia department, train technicians, provide 24 hour coverage, and generally keep services up to snuff. An open department makes these things hard to accomplish; each physician may try to "skim the cream" of procedures while leaving "routine" or "housekeeping" chores to others, leading to a deterioration of quality. See 5-16 Tr. 195. This Court recognized in *Continental T.V., Inc. v. GTE Sylvania Inc.*, *supra*, 433 U.S. at 49, that the elimination of such free riding is a benefit of some forms of exclusive contracting. See also *USM Corp. v. SPS Technologies, Inc.*, 694 F.2d 505, 514 (7th Cir. 1982) ("[A]ntitrust law increasingly is tolerant of contractual arrangements that reduce free rider problems and thereby increase competition.").

anesthesiologists, a practice which dilutes the professional coverage available" (*id.* at 12a). (Perhaps this is why the court thought that "quality is lowered".)

Two things are wrong with this. First, there is nothing improper about cost reductions motivated by profit. Cost reductions are a boon, to be encouraged by antitrust, and the lure of profit is the engine that propels firms to save costs and offer services consumers prefer. It is bizarre for a court in an antitrust case to condemn actions simply because undertaken in pursuit of profit.

Second, the court of appeals appeared to be of the view that the use of nurse anesthetists presents an antitrust problem because physicians are more skilled. There is no support for the view that physicians must render all medical services, any more than there would be support for a view that surgical nurses should be expelled from operating rooms because they are inferior substitutes for surgeons. To the contrary, prevailing medical practice today emphasizes the use of nurse anesthetists.[14] Every hospital puts together medical professionals with a variety of skills, some of them specialized to the ordinary case and some adapted to the

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14. The record shows that every hospital in New Orleans uses nurse anesthetists, that respondent's anesthesia group at Lakeside Hospital (where respondent is chairman of the department of anesthesia) has ten nurse anesthetists to support anesthesiologists, and that respondent's anesthesiology expert, Dr. Adriani, conceded that supervised nurse anesthetists play a proper role in rendering service. 5-16 Tr. 23, 32, 55, 63, 107. Some hospitals provide complete coverage using nurse anesthetists. 5-15 p.m. Tr. 78-79. It was estimated at trial that without nurse anesthetists only 10-20% of the current level of care could be provided in New Orleans, and that their elimination would result in tremendous increases in the cost of service. 5-15 a.m. Tr. 65-66; 5-15 p.m. Tr. 41, 80-81.

more complex matters. It is wise to conserve the most highly-trained specialists for the cases where they are needed, using other professionals when their skills match the job's requirements. That is what the Hospital has done by encouraging the use of nurse anesthetists. As the Solicitor General put it, "the antitrust laws were promulgated to promote, not frustrate, the entry of competitive alternatives. The antitrust laws should not be transformed into a tool that allows competitors to prevent competition by competent, state-licensed, non-physician health care providers" (US Br. in Support of Cert. 10 n.11).

Finally, the court denigrated the efficiencies by saying that the exclusive arrangement was not the least restrictive way to obtain them (Pet. App. 13a-14a). It recommended, for example, closer supervision by other personnel (*id.* at 15a).[15] The court erred in consigning all benefits to the least restrictive alternative dustbin. Nothing ever passes the least restrictive alternative test, because one can always *imagine* some less restrictive rule that, in a hypothetical world, produces benefits without corresponding costs. "A judge would be unimaginative indeed if he could not come up with something a little less 'drastic' or a little less 'restrictive' in almost any situation" (*Illinois Election Board v. Socialist Workers Party*, 440 U.S. 173, 188 (1979)

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15. The court apparently thought, contrary to all of the evidence in the record, that the process of checking the credentials of physicians applying for membership on the staff would ensure high-quality service. The evidence discussed elsewhere in this brief shows, however, that the Hospital wants more than minimally-credentialled staff; it wants staff working in an environment, and under incentives, that assure high quality of work as well as high paper achievements.

(Blackmun, J., concurring)). The degree of economic integration is variable in any business. Some pen manufacturers make their own ink, while others buy ink from specialty firms. Some hospitals have "open" departments of anesthesiology, while most have "closed" departments.

A "least restrictive alternative" approach stifles beneficial innovation in the delivery of professional services. No other court takes such an approach to antitrust matters.[16] One cannot show that any given arrangement is perfect or costless. Nonetheless, the benefits of the arrangement — including most particularly the supervision of the nurse anesthetists — lie at the heart of the case. They illustrate why the Hospital used exclusive arrangements rather than an open department. A court cannot sweep them aside as irrelevant (except to a defense that can never be made out) without missing the whole point of tie-in doctrine. Courts call some practices tie-ins because of a belief that putting odd products together in a package hardly ever serves a purpose besides restricting competition. They call other practices (such as selling cars with motors already in them and ball point pens with refills in them) not tie-ins because the gains produced by such prepackaging are apparent. The savings to be had from a practice are pertinent both to the characterization of the practice as a tie-in and to the question whether the

16. See *Continental T.V., Inc. v. GTE Sylvania Inc.*, 694 F.2d 1132, 1138 n.11 (9th Cir. 1982) (rejecting least restrictive alternative approach, in reliance on *Continental T.V., supra*, 433 U.S. at 58 n.29).

practice, so characterized, must be held unlawful per se. Cf. *Continental T.V., Inc. v. GTE Sylvania Inc.*, *supra*; *Broadcast Music, supra.*

The benefits in this case are the same as those of selling cars with motors. They are the benefits of economically-integrated production. They are the sort of gains from coordination that any firm achieves by hiring workers and putting them together in teams. Boeing hires its engineers, rather than subcontracting each specialized task or allowing engineers to roam the halls looking for work in an "open" engineering department. The benefits from coordination are why firms grow and prosper. They are why, as the Court said in *Arizona v. Maricopa County Medical Society, supra*, 102 S. Ct. at 2480, complete medical coverage by cooperating doctors in a clinic would be "perfectly proper."

E. *The Hospital Lacks Market Power*

If the Court accepts the argument to this point, the case is over. Whether or not the Hospital possesses market power, the packaging of anesthesia with operations cannot be an *exercise* of that market power. It cannot harm patients (the Hospital bills them no matter what) or other hospitals (which can copy the arrangement if they wish). Its only effect is to help patients if, as the district court found, it enables the Hospital to deliver better service at lower cost. No matter what the Court makes of these arguments, though, the Hospital does not possess market power, and *Fortner II* requires a decision in its favor.

1. The Hospital has no Power vis-a-vis Patients

The district court found that the Hospital cannot charge higher prices to its patients, because they can go elsewhere (Pet. App. 33a-34a). The record supports this finding.

There are at least 31 hospitals in the New Orleans metropolitan area (the Census SMSA). The Hospital's patients may choose among them, and there are at least 12 more hospitals on the fringes of the Census SMSA.[17] (The data summarized here, and their sources, are presented in more detail in Appendix B to this brief.) The Hospital is the fourth-largest of these 31 or 43 hospitals.

If the area of practical choice open to patients is the SMSA, then the Hospital's market share is uniformly less than 10%. By the standard of total patient admissions, the Hospital draws about 7.1%. It has 5.4% of the beds (440 of 8144 available). It logs about 6.2% of the patient days (reflecting a higher average bed occupancy, which attests to competive success and high quality rather than monopoly power). If, as the district court assumed, the area of choice is the smaller "East Bank" portion of Jefferson and Orleans Parishes (the city of New Orleans proper), these figures rise to 9.0% of admissions (8211 of 91084), 7.1% of beds (440 of 6231), and 7.7% of average daily occupancy (353 of 4559). If one narrows it still further by counting only patients who live in East Bank Jefferson and Orleans, and use a hospital in these areas, the admissions figure is 10.7%.

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17. There are 43 hospitals in the service area defined by the Health Systems Agency (5-16 Tr. 125; A. 36-38) and 345 in the state of Louisiana (5-15 p.m. Tr. 73).

By any standard, these are not large market shares, even when the geographic and patient-origin base is narrowed. On a SMSA basis, the share of all beds in the four largest hospitals is 34.0%, and the Herfindahl-Hirschman Index is 564. (The Antitrust Division's 1982 Merger Guidelines explain the computation and use of the Index, which must reach 1000 before a market is deemed even slightly concentrated.) Other methods of computing share yield higher numbers (App. B, *infra*), but none shows any significant risk of market power. In case after case, markets of substantially greater concentration have been found to lack any market power.[18]

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18. See Landes & Posner, *Market Power in Antitrust Cases*, 94 Harv. L. Rev. 937 (1981), for the theory of market power and a collection of the cases. See also, e.g., *Fortner II* (U.S. Steel lacks market power in housing and credit markets); *Northern Pacific* (a grocery store in a small town lacks market power if other stores are available); *United States v. E.I. DuPont de Nemours & Co.*, 351 U.S. 377 (1956) (sole maker of cellophane lacks market power because of competition from other flexible wrappings); *Spartan Grain, supra* (sole aeller of a chicken-grain package lacks market power because other firms could copy the arrangement); *Dimmitt Agri Indus., Inc. v. CPC International Inc.*, 679 F.2d 516 (5th Cir. 1982), cert. denied, No. 82-1347, Apr. 18, 1983 (25% share insufficient as a matter of law); *Broadway Delivery Corp. v. United Parcel Service of America, Inc.*, 651 F.2d 122 (2d Cir. 1981) (firm with almost 50% of package deliveries lacks market power because it cannot exclude new entry); *Kingsport Motors, Inc. v. Chrysler Motors Corp.*, 644 F.2d 566, 571 (6th Cir. 1981) (firm with at least a 10% share of the concentrated mid-sized car market lacks market power); *Yentsch v. Texaco, Inc.*, 630 F.2d 46, 57-59 (2d Cir. 1980) (Texaco lacks market power in concentrated gasoline market because it did not dominate the market); *In re Data General Antitrust Litigation*, 529 F. Supp. 806 (N.D. Cal. 1981) (second-largest seller of minicomputers lacks power as a matter of law; contrary jury verdict overturned).

The court of appeals recognized that the district court had applied "a traditional method of economic power analysis" (Pet. App. 8a) and apparently thought that in most cases the sellers in such a market would have no power (*id.* at 9a). Nonetheless, it held, the Hospital has power as a result of a concatenation of "market imperfections" (*ibid.*). The public prefers nonprofit hospitals, the court thought; moreover, "the prevalence of third party payment of bills eliminates a patient's incentive to compare the relative cost" of hospitals (*ibid.*), and there is "a lack of complete information regarding the quality of medical care offered" (*ibid.*). Finally, patients prefer "to select the hospital closest to home" (*ibid.*; see also *id.* at 7a-8a). The court thought these things, taken together, so dulled patients' sensitivity to price that the Hospital could exploit them. The court is wrong. Neither singly nor in concert do its assertions justify setting aside the district court's findings.

No evidence in the record supports the view that the medical care industry is generically noncompetitive, and this cannot be the subject of judicial notice. This Court's decision in *Arizona v. Maricopa County Medical Society, supra*, is based on a belief that the provision of medical care is ordinarily competitive.

The court of appeals' "evidence" of imperfect competition concerned the lack of complete information, the prevalence of insurance, and other features present in most markets to some degree. Lack of perfect information is endemic in consumer goods markets. Competition nonetheless exists because some people search and tell others what they found, and some producers

advertise.[19] Those who search protect the others, because firms must set the competitive price to attract the searchers. Similarly, surgeons and other knowledgable people almost always choose the hospital and anesthesiologists for surgery, again protecting patients from overreaching.

As for insurance: this exists in the housing and auto markets too. The insurance in medical markets is incomplete. Many policies have coverage limits or require "copayments" (such as a 20% contribution toward all costs incurred) that make patients sensitive to cost. In 1981 at least 9% of all hospital revenues came directly from patients' pockets. *Socioeconomic Issues of Health 1981*, Table 42 (AMA 1981). Insurance companies and governmental agencies have established cost-containment systems that serve in part as replacements for patients' price-searching incentives that are diminished by insurance.[20] Even if insurance dulls patients' sensitivity to price, it does not reduce (and may even enhance) their desire to obtain the highest quality care. There will be keen competition among hospitals to serve the demand for quality medical care.

A court thus cannot take ignorance and insurance as establishing market power without proof. It probably

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19. See Schwartz & Wilde, *Intervening in Markets on the Basis of Imperfect Information*, 127 U. Pa. L. Rev. 630 (1979), for a comprehensive discussion.

20. For some examples, see *Arizona v. Maricopa County Medical Society*, *supra*, 102 S. Ct. at 2477-78 & nn. 26, 28; *Union Labor Life Insurance Co. v. Pireno*, 102 S. Ct. 3002 (1982); *National Gerimedical Hospital v. Blue Cross*, 452 U.S. 378 (1981).

cannot use them as indicia of market power at all without holding that all sellers in all markets have market power.

The fact that people who live near the Hospital prefer to use its services also does not establish market power — at least not unless every corner grocery has market power as a matter of law. A small grocery draws most of its customers from its neighborhood even if it is in the shadow of a large supermarket and even if 95% of the people in the neighborhood use the supermarket. The origin of its customers would prove nothing about market power. The same is true here. There is no proof that the Hospital could charge elevated prices because of this preference (or any preference for nonprofit institutions). The district court found that it could not (Pet. App. 34a, 38a-39a). The preference of neighbors probably reflects the Hospital's good service and competitive prices rather than monopoly power.

Finally, everything the court of appeals said about this Hospital would be true of every other hospital in New Orleans and the nation as a whole. The Hospital has no power relative to other hospitals, no advantage they lack, and thus no market power within the meaning of *Fortner II*.

2. The Appropriate Market Perspective is the One in which Anesthesiologists Compete to Sell their Services to and Through Hospitals

Ultimately the question whether the Hospital has market power vis-a-vis its patients is irrelevant. We have explained above that the Hospital's exclusive arrangement with Roux neither augments nor exercises such power. Moreover, so far as patients are concerned, either "open" or "closed" departments restrict the

choice of anesthesiologists to those admitted to practice in the hospital. The difference between open and closed departments therefore affects only the market in which hospitals secure, and physicians sell, anesthesiology. It is a physician, after all, and not a patient, who brought this case. The physicians' market — the one in which respondent sought employment, the one to which the Hospital turned to staff its department — is the one that matters. See *Dos Santos, supra*, 684 F.2d at 1354.[21] See also *RCM Supply Co. v. Hunter-Douglas, Inc.*, 686 F.2d 1074, 1076-77 (4th Cir. 1982).

This position follows not only from the nature of the competition affected by the contract but also from *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320 (1961). In *Tampa* an electric utility signed a 20-year exclusive contract for coal. This Court sustained the contract under the antitrust laws because, it held, the contract affected only a minuscule portion of the relevant market. There were two possible markets in *Tampa*: the electric service market, in which Tampa Electric had a monopoly (corresponding to the market in which the Hospital serves patients), and the coal market, in which sellers of coal competed to sell to utilities. The Court selected the latter, because that was the one affected by the contract. The buyers of electricity

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21. "The patient... receives the services but does so without making any significant economic decision. It may thus be more appropriate for antitrust purposes to treat the *hospital* as the purchaser, in view of the hospital's responsibility for assuring the availability of anesthesia services for its patients.... If the hospital... is regarded as the purchaser, the relevant market could be defined as the area... in which the [hospital] (rather than the patient) can practicably turn for the alternative provision of anesthesia services."

did not care how the utility got its coal. See also *United States v. General Dynamics Corp.*, 415 U.S. 486 (1974) (analyzing competition in the market to sell contracts for coal delivery). The same principle applies here. If one wants to analyze whether the exclusive anesthesiology arrangement affects competition, one must look at where and how anesthesiologists compete.

3. There is a National, Competitive Market among Anesthesiologists for Placement in Hospitals

There is a national market in anesthesiology. Many anesthesiologists are born in one city, receive their medical training in a second, are residents in a third, and practice in several more over the course of their lives. The American Society of Anesthesiologists (ASA) maintains a national placement service, as do other medical specialties. The national medical journals carry placement ads. Respondent received his undergraduate education in San Diego, his graduate education in New Orleans, and practiced in Miami before returning to New Orleans (A. 29). He is licensed in California as well (A. 30). Respondent was the placement chairman of the Louisiana chapter of the ASA, and he testified that he received a "fair number" of inquiries from anesthesiologists in other states seeking to relocate to New Orleans (5-16 Tr. 92-93). Respondent's two associates came from Florida (5-16 Tr. 69). Dr. Roux did his internship and residency in Minnesota (5-15 p.m. Tr. 39).

Mobility is common because anesthesiologists are selected by hospitals and surgeons rather than patients. They rarely build up the sort of personal practice that ties general practitioners to a single location. As Dr. Adriani, respondent's expert, said: "Anesthesiologists...are like nomads. They can pick up and leave

and go to another community. They don't have an office and the clientele . . . . So it's very simple for an anesthesiologist to say, well, I'm going to move to Florida, or I'm going to move to California" (5-16 Tr. 49; see also A. 52-53, 64 for Dr. Adriani's history of migration). Census data place physicians as a whole among the most mobile professional groups. See U.S. Census, Mobility for States and the Nation 38-44 (PC(2)2B) (1970 data).

Surely respondent's "foreclosure" from obtaining one of the four positions at the Hospital does not affect competition in any discernable fashion. He competed for the position at the Hospital in 1971, and he lost out (5-16 Tr. 195). He was (and is) fully employed at another hospital (5-16 Tr. 66). He has the rest of the Nation in which to sell his services. The Hospital has the rest of the Nation and much of the world from which to secure anesthesiologists, too. Respondent's current inability to obtain the Hospital's work, case-by-case, is immaterial in this larger perspective.

Moreover, as *Tampa*, *General Dynamics*, and many other cases[22] hold, there is no inconsistency between long-term contracting and competition. Quite the contrary, as the district court observed, exclusive contracts "serve to benefit competition among anesthesiology groups if the terms of the contracts are not for unreasonable periods of time. Such a system would serve to encourage anesthesiologists to improve the quality of their services in order to obtain these contracts with hospitals" (Pet. App. 34a). Competition for the contract

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22. E.g., *United States v. El Paso Natural Gas Co.*, 376 U.S. 651 (1964); *Dos Santos, supra*; *Fleer Corp. v. Topps Chewing Gum, Inc.*, 658 F.2d 139 (3d Cir. 1981); *Omega Satellite Products Co. v. City of Indianapolis*, 694 F.2d 119 (7th Cir. 1982).

is as vital as competition for "spot" sales. See 5-15 a.m. Tr. 86 (testimony of Hospital's administrator). It may be more vital still, because it requires rivals to focus their energies on improving their quality or reducing cost in order to impress hospitals that can make detailed inquiries, while "open" departments do not entail such concentrated scrutiny. See 5-16 Tr. 203.

Respondent understood this very well. He testified that he did not want to bid for an exclusive contract, because: "[T]hat gets to practice by the lowest bidder. And I think that's not our intent in the practice of medicine." 5-16 Tr. 76. Perhaps antitrust law does not *require* "practice by the lowest bidder." It is simply flabbergasting to be told, however, that antitrust is offended by competition with this result.

Competition for the contract is common in industry. Every year General Motors puts up for bids the contracts to supply tires. If Firestone wins in 1984, a court would not listen to Goodyear's complaint that it had been "foreclosed" from selling to GM in that year, or that competition had been diminished. There was competition aplenty. Similarly, there was competition to supply the engines for the Boeing 727, the largest-selling commercial airplane ever. Boeing picked Pratt & Whitney's JT-8D engine, which powers every 727. General Electric could not complain that this is an antitrust violation. The fact that Pratt & Whitney held the Boeing contract for so long does not show a lack of competition. It shows, and the success of the 727 attests, the power of competition for the contract in producing better products at lower prices. Thus the court of appeals' decision to ignore this form of competition because Roux has held the Hospital's position for 10 years (Pet.

App. 12a n.9) gets things backwards. That the arrangement has lasted so long — through year-to-year renewals and a second round of bids in 1976 — illustrates the success, not the failure, of this competition.

F. *Anesthesia and Operating Rooms are One Product*

We have assumed throughout this brief, as the court of appeals held, that "we are dealing with two distinct services" (Pat. App. 5a) to which tie-in principles apply. The court thought they are two products because they can be supplied separately. In a sense this is true: operating rooms are not at all "like" anesthesiology, and the two are not combined (as buttons are combined with cloth) to produce a single recognizable entity. There is nothing inevitable about their joint provision. At hospitals with "open" departments they are supplied by different parties, and dentists supply anesthesia without surgery.

Nonetheless, this does not mean that anesthesiology and operating rooms are different products for *antitrust* purposes. The definition of a product is inevitably arbitrary. Every component of an automobile's engine can be and is sold separately to auto repair shops, yet we have no difficulty recognizing an assembled engine as a single product. Anesthesiology and operating rooms are a single product in the same sense. They are a product because it is often more economical to supply them together than to supply them separately.[23]

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23. Respondent argues (Br. in Opp. 16) that we did not preserve in the Fifth Circuit the argument that there is only a single product. We agree with respondent that the argument was not made there as unmistakably as we make it here. But petitioners did argue, and the district court held, that the combination of anesthesia and operating rooms is beneficial and cost-reducing. The court

The challenged arrangement *creates* a unified medical service, which the Hospital furnishes to patients.[24] The fact that the Hospital could conduct its business so as to multiply the number of products is irrelevant. What makes a tie is the fact that two items, each *independently* useful, are put together and the customer coerced to take both even though he needs but one. What makes a single product is the fact that the package sold is conveniently used as a unit. Many cases hold that there is no tie if the products are frequently used together; surely there is none, they say, if the products are not sold in separate markets.[25]

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of appeals addressed these arguments. As we argue in the text, these are the criteria that define a single product. Thus the argument was presented in functional terms.

24. Respondent says (Br. in Opp. 16-17) that it is impermissible to treat the Hospital as furnishing medical care to its patients because only the surgeons, anesthesiologists, and other professionals are licensed to practice medicine. This is a wholly formal response. Only attorneys are licensed to practice law, yet it is quite appropriate to think of a law firm, a collective and perhaps corporate entity, as the seller of legal services. The Hospital furnishes medical care in the only senses that matter for antitrust: it is the locus of competition against other hospitals, and it is the place patients go when they seek care. (If this is important, though, Louisiana law makes the Hospital responsible for the quality of all care furnished there. E.g., *Dillon v. Hospital Affiliates*, 407 So.2d 493, 496 (La. App. 1981), holding a hospital responsible for ensuring that its patients receive "due care under the circumstances" from the medical staff.)

25. See, e.g., *Times-Picayune*, *supra*; *Hirsh v. Martindale-Hubbell, Inc.*, 674 F.2d 1343 (9th Cir. 1982), cert. denied, Nov. 1, 1982, No. 82-570; *Klamath-Lake Pharmaceutical Ass'n v. Klamath Medical Service Bureau*, 701 F.2d 1276, 1288-90 (9th Cir.

Under the standard adopted by these cases, the arrangement at issue here is not a tie-in. Operating rooms and anesthesia are used as a unit. The utility of one depends on the supply of the other. There is no market for operations without anesthesia; no patient thinks himself "coerced" if told that anesthesia comes with surgery; no patient has complained to the Hospital that he received an unwanted service. Moreover, operating rooms and anesthesia are packaged in fact, no matter how the hospital's medical staff is organized. A patient contracts for "surgery" and depends on the hospital or the surgeon to secure space, blood, oxygen, drugs, nurses, anesthesia, and the other essential ingredients of medical care. The hospital always excludes some potential suppliers deemed inferior to those admitted to practice. The patient inevitably sees the transaction as a package deal.[26] See, e.g., *United States*

1983); *Krehl v. Baskin-Robbins Ice Cream Co.*, 664 F.2d 1348 (9th Cir. 1982); *Principe v. McDonald's Corp.*, 631 F.2d 303 (4th Cir. 1980), cert. denied, 451 U.S. 970 (1981).

26. Respondent may reply that operating rooms and anesthesiology are separate products because they are priced separately on patients' bills. This cannot be the legal test of multiple products, though. A law firm prices partners' time, associates' time, and expenses separately, yet no one thinks of legal services as a tie-in. Hospitals price oxygen and blood separately, but no one would seriously argue that the joint provision of patients' rooms and oxygen is a tie-in. Hospitals' pricing practices are designed to fulfill the cost accounting and cost containment requirements of those (insurers and governmental agencies) who pay most bills and to encourage patients who pay their own charges to conserve in their demands on the hospitals' services. See *United States v. Jerrold Electronics Corp.*, 187 F. Supp. 545, 559 (E.D. Pa. 1960), aff'd mem. 365 U.S. 567 (1961) (package not a tie despite separate pricing). Cf. *Krehl, supra* (package not a tie despite fact that different parts were furnished by different entities).

v. American Society of Anesthesiologists, 473 F. Supp. 147, 160 (S.D.N.Y. 1979): "Anesthesiologists rarely have contact with patients prior to their surgery. . . . In fact, patients have little input into the selection of their anesthesiologists. . . . There is no evidence of competition between anesthesiologists insofar as patients are concerned; in fact, there is unrefuted evidence that the patient is not truly a customer of the anesthesiologist."

Because almost anything can be disassembled into components, the definition of a product is a matter more of convention than of logic. The only useful approach is to ask whether the particular aggregation threatens competition on the merits. If a given package is — as this one is — just a method by which the seller competes with other sellers, free to design their own packages, there is no reason for antitrust intervention.

Whether the judicial response to competitive package-selection is to say "one product" or to say "two products but lawful" is important because tie-in doctrine forces a two-product package to struggle under a substantial burden of justification. Putting firms to the task of providing this justification in litigation increases the costs of competition and, in the long run, reduces the amount of competition. We therefore agree with the Solicitor General's argument (US Br. in Support of Cert. 8-12) that whenever multiple sellers can compete by putting any items together in a package — when they can "Go ye and do likewise" — the case should be dismissed without further ado on the ground that there is but one "product." Under that standard, petitioners were entitled to judgment on the pleadings.

G. *The Anesthesiology Contract is not Different from an Ordinary Employment Contract*

The Solicitor General suggests that this case should be analyzed as a vertical exclusive dealing contract by which the Hospital obtains needed inputs. On this approach, the Rule of Reason applies, and the contract is sustained because the exclusive contract affects only a trivial fraction of the anesthesiology market.

We think the Solicitor General's analogy is not quite right. This case is about employment relations. The Hospital employs a staff of nurses. A freelance nurse cannot come into the Hospital and work with individual patients. A nurse who claimed an antitrust right to be employed by the Hospital, or to roam the halls waiting for physicians to designate patients for him or her to attend, would be laughed out of court. There is no good reason why the arrangement by which the Hospital secures anesthesiology services should be treated differently.

The arrangement by which the Roux anesthesiologists are retained is functionally equivalent to employment. They work full-time at the Hospital.[27] They are compensated at the Hospital's discretion. (They receive a fixed percentage of the anesthesiology department's revenue, but the Hospital has control of the department's charges. A. 25-27.) The device of an exclusive services contract is useful for purposes of the tax and pension laws. It also enables the Hospital to discharge the Roux group more easily than it could discharge

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27. The fact that they may engage in limited teaching or outside practice (A. 25) does not undermine their status as employees. Full-time teachers sometimes engage in practice too.

regular employees (5-15 a.m. Tr. 60; 5-16 Tr. 161-63). We have emphasized that this right to dismiss Roux is an important source of competitive pressure.

For antitrust purposes, though, there is no difference between employment and the exclusive contract. No matter how the Hospital secures anesthesiologists, the patient seeking an operation is limited to the anesthesiologists the Hospital permits to practice there. Not everyone will be admitted, and the choice of anesthesiologists will be limited. That "vice," if vice it be, does not depend on whether the Hospital has four full-time anesthesiologists and a "closed" department or twelve part-time anesthesiologists and an open department. That doubtless explains why the plaintiff in this case is an anesthesiologist seeking employment rather than a patient complaining of enhanced prices.

Antitrust law has never been used to patrol employment opportunities. Even if Boeing employed half of all the aerospace engineers in the United States, it would be free to hire whom it wanted and turn others away. If Boeing instead chose to subcontract particular engineering tasks to outside firms, it need not run the antitrust gantlet. The losing bidders for the work would have had their competition. This case presents the same problem. There is *competition for the position* of being an anesthesiologist at the Hospital. Respondent competed and lost (5-16 Tr. 195). If the Hospital may hire anesthesiologists for indefinite periods, it may acquire anesthesia by contracts of indefinite duration.

The perspective we offer here is one in which the Rule of Reason, not the per se rule, supplies the governing standard. And because the employment market is at least as big as the nation, no firm has a monopoly or

monopsony. There is no possibility of market power, no possibility of harm to consumers. Whether these medical exclusive contract cases are filed as tie-in complaints, as boycott complaints (the physician claims that the rest of the physicians in the hospital are boycotting him by refusing to work with him), or as exclusive dealing cases (after the fashion of *Tampa Electric*), there is no need for litigation. If there is competition in the national employment market, which there always is, the plaintiff is destined to lose the case no matter how it is pleaded.

Defendants have won every exclusive medical contract case except this one. See note 8, *supra*. Many of the cases, including this one, have required extended proceedings and costly trials. If the plaintiff cannot win, summary judgment or dismissal on the pleadings is in order. *First National Bank of Arizona v. Cities Service Co.*, 391 U.S. 253, 289-90 (1968). Antitrust litigation is notoriously expensive, and "[i]t is a gratuitous cruelty to parties and their witnesses to put them through the emotional ordeal of a trial when the outcome is foreordained." *Mason v. Continental Illinois National Bank*, No. 81-2893 (7th Cir. Apr. 1, 1983), slip op. 10.

Although this case should have been dismissed under Fed. R. Civ. P. 12(b)(6) for failure to state a claim, it was nonetheless tried. The trial produced convincing evidence, and the district court found, that the contract did not restrain trade. With the per se rule out of the way, this case can be returned to the lower court for enforcement of the district court's judgment.

CONCLUSION

The judgment of the court of appeals should be reversed. The case should be remanded with instructions to affirm the district court's judgment in petitioners' favor.

Respectfully submitted.

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May 13, 1983

APPENDIX A

FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

OFFICE OF THE SECRETARY

February 24, 1983

Robert E. Nord, Esq.
Hinshaw, Culbertson, Moelman,
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69 West Washington Street
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Chicago, Illinois 60602

Dear Mr. Nord:

This is in response to your request for an advisory opinion concerning a contract by which Burnham Hospital has granted to a physician group the exclusive right to provide radiology services to patients in the hospital. You have asked whether any law enforced by the Commission would be violated if Burnham, acting pursuant to the contract, determines that a physician not affiliated with that group should not be given access to its radiology facilities or authorization to provide radiology services to Burnham's patients.

Based on the information you have supplied, it is the Commission's understanding that Burnham Hospital is a nonprofit general acute care hospital located in Champaign, Illinois. Among the services Burnham offers to the public are diagnostic radiology services. The hospital owns radiology laboratory facilities and employs approximately 20 radiology technicians. Throughout its history, Burnham has provided radiology services either through a radiologist employed by the hospital or a radiology group under exclusive contract with it.

You have explained that in 1980 the hospital, after receiving and considering proposals from other radiology groups, entered into a contract with a group of radiologists practicing under the name Prairie Professionals ("Prairie") that gives Prairie the exclusive right to operate the hospital's radiology laboratory and to render radiology services to patients at the hospital. Prairie is responsible for providing radiology services as needed; supervising and discharging the radiology technicians who are employed by the hospital; consulting with the hospital on the selection and replacement of equipment; and participating in educational and scientific activities at the hospital, including the training of radiology technicians. In addition, Prairie is to designate a radiologist to function as department chief, who will be responsible for operating the department and helping the hospital to control the department's budget. The contract has a term of three years; thereafter it is renewable for one-year periods and may be terminated by either party on 180-days notice. The hospital bills patients for the use of its radiology facilities. Prairie bills the patient separately for its professional services on a fee-for-service basis.

Prairie physicians are members of Christie Clinic ("Christie"), a large multispecialty physician group. Pursuant to a separate contract with Burnham, Christie purchased a full-body computed tomographic ("CT") scanner which it installed on hospital premises. Under the contract, Christie designates the physicians who may use the scanner.

You state that a physician has requested to practice radiology independently at Burnham notwithstanding the exclusive agreement with Prairie. Burnham would like to deny this physician access to its radiology facilities in order to adhere to, and retain the benefits of, the contract with Prairie.

According to your letter, Burnham believes that the contract is in the hospital's ecomonic interest and that it improves the quality of services provided at the hospital.

Specifically, the hospital believes that the contract creates cost efficiencies in procuring radiological services for its patients, operating and maintaining its equipment, and supervising its radiology technicians.

In addition to Burnham Hospital, there are three other general acute care hospitals in the Champaign-Urbana area from which Burnham draws patients. Burnham has 214 beds, Mercy Hospital has 255 beds, Carle Foundation Hospital has 281 beds, and Cole Hospital has 65 beds.[1] Thus, Burnham has about 26 percent of the beds in what Burnham describes as the relevant area. Carle is associated with a clinic, and only members of the clinic are permitted to have privileges at that hospital. Mercy and Cole each has an exclusive contract with a different group of radiologists; Carle has a closed staff in all its departments. The radiology contracts at both Cole and Burnham have changed hands in recent years.

Your letter states that Burnham offers no facilities or services not available in at least one of the other area hospitals. Both Carle and Burnham have full-body CT scans, the one at Burnham being owned by Christie Clinic rather than by the hospital. Both Carle and Mercy offer therapeutic radiological services that are not available at Burnham.

You also state that some Champaign-Urbana radiologists provide services to hospitals in surrounding communities. Radiology services are also available outside the hospital from independent radiology laboratories. Burnham accepts radiological studies from other hospitals or from independent laboratories at the discretion of the attending physician.

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[1] There are three other hospitals in the Champaign-Urbana area that do not seem to be in substantial competition with the four mentioned above. McKinley Memorial Hospital has 31 beds and is affiliated with the University of Illinois. Herman Adler Mental Health Center is a state-run long-term care facility for children with 46 beds. The hospital at Chanute Air Force Base has 55 beds, but apparently is not open to the general public.

Antitrust analysis of hospital exclusive contracts can be complicated because the contracts create relationships among hospitals, physicians, and patients that have no clear parallels in commercial practice and that are difficult to characterize. The contract occurs at one level — between the hospital and the physician — while the direct financial transaction occurs at a different level — between the physician and the patient, with payment usually made by an insurer. Some court decisions suggest that in analyzing exclusive contracts the patient should be considered the buyer and the hospital and the physician group the sellers of the service in question.[2] Another court has suggested that the hospital rather than the patient should be considered the buyer of the service, and the physician group the seller, in cases where the patient generally does not make a personal decision to obtain the service and does not personally select the provider.[3] The Commission is of the opinion that each approach may be helpful in some circumstances, because exclusive contracts may affect both competition among physicians and hospitals for patients and competition among physicians to market their services to hospitals. Accordingly, antitrust analysis should be flexible enough realistically to take into account the impact of these contracts on hospitals, physicians, and patients.

An exclusive contract for radiology services can have both procompetitive and anticompetitive aspects. The contract grants exclusivity within the hospital to a particular radiologist or group of radiologists and thereby limits the ability of the patient and the attending physician to choose among competing radiologists. It may also, if radiologists

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[2] Robinson v. Magovern, 521 F. Supp. 842, 885 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 842 (3d Cir. 1982), *cert. denied*, 51 U.S.L.W. 3340 (U.S. Nov. 1, 1982) (No. 82-415); Hyde v. Jefferson Parish Hosp. Dist. No. 2, 513 F. Supp. 532 (E.D. La. 1981), *rev'd on other grounds*, 686 F.2d 286 (5th Cir. 1982), *petition for cert. filed*, No. 82-1031 (Dec. 17, 1982).

[3] Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982).

contract in groups, make it more difficult for individual physicians to enter the market since a physician may have to join an existing group or form a new group in order to practice in the area.

A contract of reasonable duration does not, however, eliminate competition among radiologists or prevent entry. Instead, it shifts the focus of competition among both established and entering radiologists to the securing of the contract. The exclusive contract may also have procompetitive effects by providing a number of benefits to hospitals and to their patients. There is reason to believe that in some circumstances at least, the use of exclusive contracts in certain hospital departments can facilitate efficient delivery of services in a number of ways. It can increase the hospital's control over operation of the department, ensure full-time availability of services, lower costs through standardization of procedures and centralized administration of the department, permit better scheduling of the use of facilities, facilitate maintenance of equipment, improve supervision of support staff and working relationships between the staff and physicians, and improve the quality of services by assuring that physicians perform enough procedures to maintain their proficiency, have an incentive to upgrade their skills, and are effectively subject to hospital standards of quality.[4] To the extent that these objectives are realized, a hospital is better able to compete with other hospitals.

Hospitals must assure that radiology services are available as needed and of acceptable quality if they are to attract attending physicians and their patients. When the decision to use an exclusive contract to staff a hospital-based department is made unilaterally by a hospital in order to promote efficient operation of the department, when the hospital lacks significant power in the relevant market, and when the

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[4] *See, e.g.*, Foster, *Exclusive Arrangements Between Hospitals and Physicians: Antitrust's Next Frontier in Health?*, 26 St. Louis U.L.J. 535, 540-41 (1982); M. Thompson, *Antitrust and the Health Care Provider* 151-52, 154 (1979).

contract is of reasonable duration or terminable by the hospital on reasonable notice, the contract would not generally be likely to have a substantial anticompetitive effect in any market.[5]

Several courts considering antitrust challenges to exclusive contracts for hospital services have treated the agreements as vertical restraints subject to rule of reason analysis.[6] In balancing the procompetitive and anticompetitive effects of the contracts in the hospital and physician services markets, the courts have considered such factors as the characteristics of the market, particularly the market power of the hospital in question; the purpose of the contract; its duration; the manner in which the decision was made to use an exclusive arrangement; and the procompetitive benefits of the contract. These courts have not found that the exclusive contracts considered had significantly anticompetitive effects, and they have found that the contracts resulted in significant competitive benefits to the hospitals.

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[5] A different case would be presented if the hospital joined a conspiracy among members of the medical staff to restrain competition among hospital-based physicians. *See* Robinson V. Magovern, 521 F. Supp. 842, 906 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 824 (3d Cir. 1982), *cert. denied*, 51 U.S.L.W. 3340 (U.S. Nov. 1, 1982) (No. 82-415); State of Maryland v. The Medical Staff of Harford Memorial Hospital, Circuit Court for Harford County, Equity No. 27734 (Oct. 29, 1981) (assurance of discontinuance obtained from hospital staff that allegedly threatened to refuse to deal with any but a specified group of radiologists in an attempt to coerce the hospital into contracting with the group on terms demanded by it). In addition, different questions would be raised under the antitrust laws if a large proportion of the specialists in a market formed a group and negotiated jointly with a number of hospitals in the area.

[6] Hyde v. Jefferson Parish Hosp. Dist. No. 2, 513 F. Supp. 532 (E.D. La. 1981), *rev'd*, 686 F.2d 286 (5th Cir. 1982), *petition for cert. filed*, No. 82-1031 (Dec. 17, 1982); Smith v. Northern Michigan Hospitals, Inc., 518 F. Supp. 644 (W.D. Mich. 1981), No. 81-1513 (6th Cir. argued Oct. 21, 1982). *See also* Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982); Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981), *aff'd mem.* 688 F. 2d 824 (3rd Cir. 1982), *cert. denied*, 51 U.S.L.W. 3340 (U.S. Nov. 1, 1982) (No. 82-415).

One recent decision, however, held that an exclusive contract for anesthesia services constituted a per se illegal tying arrangement. *Hyde v. Jefferson Parish Hospital District No. 2*, 686 F.2d 286 (5th Cir. 1982), *petition for cert. filed*, No. 82-1031 (Dec. 17, 1982). The court in that case construed the contract as tying the sale of the hospital's chosen anesthesia service to the use of its operating rooms, found that the hospital had appreciable economic power in the township in which it was located, and concluded that the contract restrained, and indeed eliminated, competition among anesthesiologists in the hospital.

The Commission is of the opinion that the per se rule of illegality for tie-ins is not applicable to Burnham's contract with Prairie Professionals. Although radiology services are physically separable from other services and facilities supplied by Burnham, mere separability is not a sufficient basis for characterizing an arrangement as a tie-in. Instead, the function of the aggregation must be examined to see if the restraint represents the forced purchase of a second distinct commodity to leverage power from one market to another in order to avoid competition on the merits.[7] The purposes and effects of the contract in question are very different from such a classic tie. Rather than avoiding competition on the merits, Burnham is attempting to compete with other hospitals by obtaining efficiencies and a desired level of quality and service in its radiology department, according to the submission. Using a form of vertical integration to combine functionally related services, the hospital is apparently seeking to improve the array of health care services that it offers to the public. Moreover, the case law indicates that no tie-in should be found to exist where, as here, the hospital derives

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[7] *See* Times-Picayune Publishing Co. v. United States, 345 U.S. 594, 614 (1953); Hirsh v. Martindale-Hubbell, Inc., 674 F.2d 1343 (9th Cir. 1982), *cert. denied*, 51 U.S.L.W. 3340 (U.S. Nov. 1, 1982) (No. 82-570); Krehl v. Baskin-Robbins Ice Cream Co., 664 F.2d 1348 (9th Cir. 1982); Principe v. McDonald's Corp., 631 F.2d 303 (4th Cir. 1980), *cert. denied*, 451 U.S. 970 (1981).

no direct or exploitative financial benefit from requiring that all diagnostic radiology services in the hospital be provided by a particular group of physicians.[8] In short, the contract is not the type of pernicious, naked restraint of trade to which the per se rule of illegality applies.

The Commission believes that Burnham's contract is most closely analogous to a requirements contract, a type of exclusive dealing arrangement, that should be judged under the rule of reason in a fashion similar to that for more traditional vertical restraints.[9] The Commission's analysis of the contract focuses on whether its effects on competition among radiologists and among hospitals are on balance harmful or beneficial. Factors relevant to the analysis include the proportions of the hospital and physician services markets involved in the contract, the purposes of the contract, its duration, the extent to which it deters entry, the benefits the hospital and the public derive from it, and the extent of competition for the contract.[10]

Based on the information available to the Commission, it does not appear on balance that Burnham's adherence to its contract with Prairie Professionals would violate the Federal Trade Commission Act or any other law enforced by the Commission. You report that the contract was intended to, and does, facilitate efficient operation of the radiology department. The Commission understands that the decision

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[8] *See, e.g.*, Boddicker v. Arizona State Dental Ass'n, 1982-2 Trade Cas. (CCH) ¶64,812 (9th Cir. March 24, 1982); Keener v. Sizzler Family Steak Houses, 597 F.2d 453 (5th Cir. 1979); Kentucky Fried Chicken Corp. v. Diversified Packaging Corp., 549 F.2d 368 (5th Cir. 1977); Rodrique v. Chrysler Motor Corp., 421 F. Supp. 903 (E.D. La. 1976); Crawford Transport Co., Inc. v. Chrysler Corp., 338 F.2d 934 (6th Cir. 1964); Rumple v. Bloomington Hospital, 422 N.E. 2d 1309 (Ind. App. 1981).

[9] *See* Tampa Electric Co. v. Nashville Coal Co., 365 U.S. 320 (1961); Twin City Sportservice Inc. v. Charles O. Finley & Co., 676 F.2d 1291 (9th Cir. 1982), *cert. denied*, 51 U.S.L.W. 3354 (Nov. 8, 1982).

[10] *See* Beltone Electronics Corp., FTC Docket 8928, slip op. at 34 (July 6, 1982).

to enter into the contract, and thus to deny radiology privileges to other physicians, was made unilaterally in the interest of the hospital, and was neither coerced by members of the medical staff nor taken in furtherance of a combination between the hospital and the medical staff or any of its members to restrain competition among physicians. Burnham competes with at least three other hospitals, and does not occupy a dominant position in the market. It is not a unique facility. The contract has an initial term of three years with one-year extensions thereafter, and is terminable on 180-days notice by either party. Thus, opportunities for competition among radiology groups to secure the contract are preserved, and there is evidence that some competition for contracts does occur. In addition, radiology can be practiced to at least some extent on an outpatient basis, and Champaign-Urbana radiologists apparently have some access to hospitals in the surrounding area. In addition, there is no reason to believe that effectuation of the contract would result in higher prices for radiology services. Based on these factors, it appears that the contract does not unreasonably restrict competition among radiologists and that it may facilitate competition among hospitals.

Based on its understanding of the facts surrounding the decision to enter into the exclusive contract and the planned denial to other applicants of the right to practice radiology in the hospital, pursuant to that contract, as those facts are outlined above and further detailed in your submission, it is the Commission's opinion that Burnham Hospital's adherence to its grant to Prairie Professionals of the exclusive right to offer radiology services at the hospital would not violate the Federal Trade Commission Act or any other statute enforced by the Commission.[11]

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[11] By responding to Burnham's request for an advisory opinion concerning the described facts, the Commission takes no position on the presence or absence of any or all of the jurisdictional prerequisites to a law enforcement proceeding under Section 5 of the FTC Act, 15 U.S.C. § 45.

This advisory opinion, like all those issued by the Commission, is limited to the proposed conduct described in the petition being considered. Because by necessity it is based on factual representations by the hospital, it does not constitute approval of action taken by the hospital on any specific application for privileges that may become the subject of litigation before the Commission or any court, when those facts may be controverted. The conclusions stated in this letter are based on the Commission's understanding of present market conditions in the Champaign-Urbana area and in the health care field generally. The Commission retains the right to reconsider the questions involved or to rescind or revoke its opinion if the public interest so requires in accordance with Section 1.3(b) of the Rules of Practice.

By direction of the Commission.

BENJAMIN I. BERMAN
Acting Secretary

APPENDIX B
Local Hospital Statistics

Jefferson and Orleans Parish Hospitals Located on the "East Bank" (1)	Total Admissions (2)	Admissions from Jefferson and Orleans Parish (2)	Number of Beds (3)	Average Daily Census (3)
1. Charity	22,028	16,114	1,125	832
2. Southern Baptist	8,889	3,728	603	474
3. Ochsner Foundation	8,236	3,557	531	413
4. EAST JEFFERSON GENERAL	8,211	6,735	440	353
5. Touro Infirmary	8,132	6,822	509	395
6. Pendleton Memorial Methodist	6,328	3,834	318	211
7. Hotel Dieu	5,253	3,903	323	254
8. Lakeside	4,915	3,719	209	141
9. Veterans Administration	4,162	2,564	467	397
10. Mercy	4,063	3,363	240	195
11. Tulane Medical Center	N/A	N/A	235	190
12. St. Charles General	2,696	2,055	168	139
13. Flint-Goodridge	1,745	1,689	113	N/A
14. St. Claude General	1,698	1,583	136	81
15. Eye & Ear Institute	1,606	1,011	71	N/A
16. Montelepre Memorial	958	828	64	49

Local Hospital Statistics (continued)

Jefferson and Orleans Parish Hospitals Located on the "East Bank" (1)	Total Admissions (2)	Admissions from Jefferson and Orleans Parish (2)	Number of Beds (3)	Average Daily Census (3)
17. Children's	951	597	105	61
18. New Orleans Mental Health	488	363	237	165
19. Metairie	476	418	84	N/A
20. Coliseum House	156	99	168	140
21. River Oaks	93	44	85	69
22. US Public Health	N/A	N/A	N/A	N/A
SUBTOTAL	91,084	63,026	6,231	4,559
East Jefferson Percentage	9.0%	10.7%	7.1%	7.7%
"Top Four" Percentage	52.0%	53.3%	44.4%	46.4%
Herfindahl-Hirschman Index	1,096	1,137	804	872
Other Hospitals in New Orleans Metropolitan Area (SMSA) (1)				
23. West Jefferson	9,160	7,846	403	332
24. JoEllen Smith	4,383	3,789	356	174
25. Slidell Memorial	3,745	69	182	N/A

Local Hospital Statistics (continued)

Other Hospitals in New Orleans Metropolitan Area (SMSA) (1)	Total Admissions (2)	Admissions from Jefferson and Orleans Parish (2)	Number of Beds (3)	Average Daily Census (3)
26. Tammany	2,856	26	160	121
27. Chalmette	1,617	158	109	91
28. Southeast Louisiana	1,172	573	493	423
29. Highland Park	N/A	N/A	96	N/A
30. South Jefferson	704	604	75	23
31. St. Bernard	357	45	39	N/A
TOTAL	115,078	76,136	8,144	5,723
East Jefferson Percentage	7.1%	8.9%	5.4%	6.2%
"Top Four" Percentage	42.0%	49.3%	34.0%	37.4%
Herfindahl-Hirschman Index	785	911	564	658

Note: N/A = Not Available.

(1) Source: Ex. D-5 (New Orleans area hospital identification and locations).

(2) Admission data are for the period November 1, 1978 to April 30, 1979. Source: Ex. D-7.

(3) Source: American Hospital Assoc., *American Hospital Association Guide to the Health Care Field*, pp. A-91 to A-96 (1982).