No. 82-1031

In the Supreme Court of the United States

OCTOBER TERM, 1983

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

REPLY BRIEF FOR THE PETITIONERS

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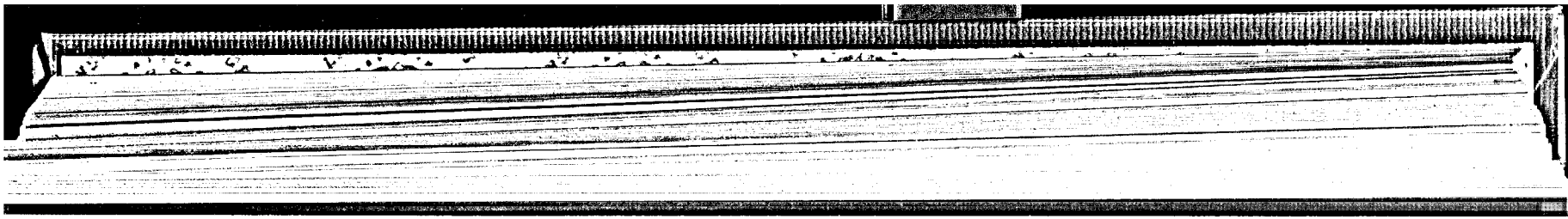

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I. THE ARRANGEMENTS AT ISSUE SHOULD BE VIEWED FROM THE PERSPECTIVE OF A MARKET FOR PROFESSIONAL SERVICES, NOT FROM THE PERSPECTIVE OF A SINGLE PERSON SEEKING WORK

The parties' briefs in this case barely engage. Petitioners discuss the contracts at issue here from the perspective of the entire process of providing medical services. Anesthesiologists compete to secure positions at hospitals; hospitals shop the nation for qualified medical professionals. Hospitals compete to design methods of delivering services that will make them-

selves attractive to patients; patients and surgeons shop among hospitals to find desirable combinations of facilities and services. From such a perspective the contract between one hospital and a few anesthesiologists affects a tiny, almost invisible, portion of the market. It is understandable not as restraint of trade but as one of many decisions by which a hospital assembles services and continuously tailors its internal arrangements to compete.

Respondent, on the other hand, discusses the contracts from the perspective of a single physician seeking work in a given hospital. For this physician, whose residence may be fixed by extrinsic factors (perhaps spouse and children make movement impractical), the contractual arrangements have a great influence. They appear as "restraints". For respondent, working at the Hospital may be his most desired opportunity. The arrangements foreclose an option (a joint practice among several hospitals) that respondent desires. They do not make *his* patients better off. They do not aid physicians and patients who want *him* to be their anesthesiologist in the Hospital. Thus, respondent argues, they should be condemned.

Respondent's submission may well be right as a factual matter. It is also irrelevant. Respondent argues in effect that the antitrust laws protect his interests as a provider of services—in other words, as a competitor. They do not. The antitrust laws are designed for the benefit of "competition, not competitors." *Brunswick Corp.* v. *Pueblo Bowl-O-Mat, Inc.*, 429 U. S. 477, 488 (1977). See also *Continental T.V., Inc.* v. *GTE Sylvania Inc.*, 433 U. S. 36, 53 n. 21 (1977) (antitrust laws do not prohibit "restrictions on the autonomy of independent businessmen").

A. The arrangements are not tying contracts

Our arguments start with the premise that competition is what counts. Emphasizing this larger picture, we argue that the exclusive anesthesiology contract is a method by which the Hospital secures services that its patients need. Whether this is best portrayed as a vertical exclusive dealing contract (similar to the methods by which the Hospital acquires wheelchairs, gauze, food and drugs) or as an employment contract (similar

to the methods by which the Hospital acquires nurses, residents, and others) does not matter very much. Once it is understood that the Hospital's value lies in assembling the inputs of many professionals in order to create "surgery" and other "medical care", it becomes clear that the arrangements respondent challenges cannot restrain competition. They are no more objectionable than the decision of large law firms to have full time partners (rather than to permit a lawyer to be a part-time practitioner at several firms simultaneously) or the decision of a large public utility to acquire all of its coal by an exclusive contract rather than by multiple short-term purchases. See *Tampa Electric Co.* v. *Nashville Coal Co.*, 365 U.S. 320 (1961). The law of tying arrangements is not pertinent.

If the Court agrees, the case is over. Yet respondent essentially ignores these points. Respondent does argue (Resp. Br. 34) that the challenged arrangements are not employment contracts in fact. These formalities are irrelevant to antitrust analysis, though, if the consequences for consumers and competition are identical. In *Continental T.V.* the Court rejected the formal line (drawn by earlier cases) between distribution arrangements that entailed a transfer of "title" and those in which the manufacturer held "title." It did so because "[n]one of [the] key variables . . . is affected by the form of the transaction by which a manufacturer conveys his product to the retailers." 433 U. S. at 54. In this case, too, none of the pertinent variables is affected by whether the Roux anesthesiologists are employees or independent contractors. The employee-contractor distinction may be important for tax or for torts; it is meaningless in antitrust because it does not affect prices, output, or any other aspect of consumers' welfare.

Amicus American Society of Anesthesiologists makes a different argument in response to the employment analogy. The ASA says (Br. 17-18) that the arrangement is a "classic group boycott" because the Hospital arbitrarily excludes anesthesiologists from practice (and "delegates" this power to the Roux group). But it makes no more sense to call the exclusive arrangement a "boycott" than it would be to attach

that label to the hiring decisions of the Yale Law School. Yale's faculty votes on whether or not to hire a new professor. If the faculty votes no—whether on quality grounds or because it believes professors should not hold joint appointments with other law schools—this can be classified as either refusal to employ or as "boycott." Use of the pejorative boycott label adds nothing to the analysis. This Court has recognized in recent cases that the appropriate inquiry in the event a "boycott" claim is made is whether the activity *enforced* by the boycott is lawful. See, e.g., *National Society of Professional Engineers* v. *United States,* 435 U. S. 679 (1978) (scrutinizing objectives and effects directly in a case of restraints enforced by a boycott); *U.S. Trotting Ass'n* v. *Chicago Downs Ass'n,* 665 F. 2d 781, 787-90 (7th Cir. 1981) (en banc).

Respondent says that the arrangements are not vertical supply contracts because patients are charged for anesthesiology. Again, though, this elevates form over substance. Separate charges may be required for insurance purposes (see Pet. Br. 41 n. 26), but it is mysterious why this should influence antitrust analysis. The sticker on a new car will outline ten or more "separate" items and charges, but there can be no doubt that when General Motors acquires tinted glass to put into its autos it is engaged in a vertical arrangement, and that the auto-with-glass is a single product even though a separate charge for the glass appears on the bill.

Our final argument about the multiple-product inquiry is that any lingering doubt should be resolved by inquiring into the benefits of joint production and packaging.[1] At times

[1] See Pet. Br. 39-45. See also *Johnson* v. *Nationwide Industries, Inc.,* 715 F. 2d 1233 (7th Cir. 1983), in which the court used the analysis we advance in holding that a condominium unit and a management contract are a single product. The court observed that all condo units have *a* management contract (just as all operations have anesthesia), and that the question whether the seller of the condo should provide the management as well was properly to be resolved by letting the market determine whether that was a cost-beneficial arrangement. Thus the court declined to apply a per se analysis even though condos and management easily can be supplied separately. (The court also asked the district court to determine the "reasonableness" of the duration of the contract. We question the appropriateness of this inquiry, because a single seller of condominiums has no conceivable market power, but this refinement is not important here.)

respondent appears to deny that a court may look at the savings from joint production (e.g., Resp. Br. 49), but this cannot be taken seriously or it would require the dissolution into fragments of every product that *can* be so disassembled—that is, every product. The Court has said in *Arizona* v. *Maricopa County Medical Society*, 457 U. S. 332, 356-57 (1982), and other cases too numerous to count, that the savings of *integration* are indeed important to antitrust, even if savings cannot be advanced on behalf of "naked" restraints. Thus respondent's only proper answer here is that the exclusive arrangements harm consumers rather than help them. We return to that subject in Part II of this brief.

B. Any "tie" is harmless: The Hospital not only lacks market power but also seeks to reduce rather than increase the price of anesthesiology

We also have argued that even if this arrangement can be called a tie-in, it is harmless because the Hospital lacks market power. We made two principal arguments: first, that the right market is the national one in which anesthesiologists compete to find positions and to which hospitals turn to find anesthesiologists (Pet. Br. 34-39), and second, that the ability of other hospitals to copy the exclusive arrangement assures that the Hospital cannot be using the contract to create or exploit power (*id.* at 14-23).[2] See *United States Steel Corp.* v. *Fortner Enterprises, Inc.*, 429 U. S. 610, 619-22 (1977) (*Fortner II*).

Respondent's emphasis on where and how *he* competes for patients causes him to bypass these points. He says nothing at all about the ability of other hospitals to compete by using similar contracts (save to brand all of them as anticompetitive). He mentions *Fortner II* only in passing. On the national market

[2] To put this slightly differently: Hospitals of all sizes and in all locations use exclusive arrangements; all *can* use such arrangements if they choose. If the arrangement is a method of seizing a monopolistic advantage, it can be countermanded by other hospitals' choosing the same method. That exclusive arrangements thrive in both one-hospital and multi-hospital cities—often alongside other hospitals that do not use exclusivity—strongly suggests that it is not monopolistic.

question, respondent concedes that anesthesiologists move and that hospitals shop (Resp. Br. 33-35). He discounts the movement because, he says, it is caused by anticompetitive conditions and because hospitals do not "buy" anesthesia. The first begs the question, and the second is wholly formal. Courts define markets to find out whether and to what extent firms can raise prices without competitive constraints. Neither of respondent's replies demonstrates any lack of competitive pressure that influences the Hospital's decision.[3]

Having put to one side the national market for anesthesiologists and the competition among hospitals to design better ways of serving patients, respondent emphasizes the degree to which patients prefer East Jefferson General Hospital. This is simply the wrong question to ask; it is like asserting in *Tampa Electric* that the market power requirement was satisfied because people who lived in Tampa got all of their electricity from Tampa Electric Co. Nonetheless, we deal with this further in Part III.

There is one final matter on which the parties have not engaged. Our opening brief contended that even if the Hospital has market power, and even if this arrangement is best characterized as a tie-in, there is no antitrust objection *at all* to it, let alone a per se objection, because it cannot conceivably amount to an *exercise* of market power (Pet. Br. 12-23). Because the Hospital is in privity with its patients and can charge them for anesthesia no matter how or by whom anesthesia is provided, the exclusive dealing arrangement cannot change the Hospital's ability to charge whatever price the

[3] Respondent also says that because the Hospital has dealt with Roux for 10 years, this national competition has been ineffective (Resp. Br. 34-35). The district court found the contrary as a fact (Pet. App. 34a). It is not the duration of the dealings between the Hospital and Roux that counts but, rather, whether the nature of exclusive contracts creates competitive pressure. Respondent's own citation to the record (Resp. Br. 35) shows that it does: respondent emphasizes that Dr. Roux signed the 1976 contract only after the Hospital put him under pressure by threatening to contract with another group. The use of the threat of termination to create competitive pressure is illustrated elsewhere in the record. See the citations at Pet. Br. 36-39.

market will bear. The Hospital doesn't want to jack up the price of anesthesiology, because if it does so it must reduce the price of its other services. The Hospital, just like the patients, wants lower costs and higher quality of anesthesiology. There is therefore no reason for a court to try to exercise medical judgment about the gains and losses of exclusive dealing. If the arrangement cannot increase or exercise market power, it is most sensible to understand it as procompetitive and beneficial. Respondent does not reply to this argument at all.[4]

We have surveyed the areas on which the parties do not come to grips in order to make a fundamental point. If the Court agrees with *any* of our submissions—no tie, no market power, or no effect on market power—it should reverse the judgment of the Fifth Circuit. Respondent has left unanswered several lines of argument that support our submissions, and respondent therefore has not supplied an adequate reason for affirmance.

II. THE EXCLUSIVE DEALING ARRANGEMENTS ARE PROCOMPETITIVE AND BENEFICIAL TO CONSUMERS

Our opening brief stressed the competitive benefits and efficiencies created by these arrangements both as an integral part of the consideration of the one-versus-two-product issue and as an aid to understanding why the Hospital undertook them. Respondents have devoted substantial argument (Resp. Br. 20-29) to the proposition that the arrangements are dele-

[4] *Amicus* American Society of Anesthesiologists, on the other hand, effectively concedes that hospital charges fall if anesthesiology charges rise and that the Hospital, with control of both, can set both no matter what arrangement it uses. See, e.g., ASA Br. 15-17. *Amicus* then argues that the function of the arrangement is to bilk insurers by making anesthesiology charges appear higher, and hospital charges appear lower, than they should be. This "fraud" explanation of exclusive contracts is of course irrelevant to an antitrust case; the Sherman Act was not designed as a cure-all for deceit. The explanation is also wrong. The ASA does not suggest how insurers, which are aware of exclusive contracts, can be taken in by them; it also does not explain why, if a hospital is intent on inflating its charges by reshuffling the categories in which they appear, an exclusive contract is a necessary instrument.

terious, and several *amici* make similar arguments. These arguments are largely foreclosed by the district court's findings of fact. The court concluded that the arrangements produce numerous benefits (Pet. App. 32a-34a; see also Pet. Br. 23-29). Although the court of appeals reversed one of these findings (*id.* at 11a. n. 7), it left the rest standing, and the two-court rule protects them now.

Because this is a dispute about the application of the per se rule, however, it is important to say more. The same exclusive dealing contract cannot be lawful in one case and illegal per se in another depending on a court's findings of fact. We think that respondent's arguments are *logically* fallacious, and they could not support a finding of "no benefit" under any circumstances. In saying this we rely essentially on our opening brief. We add only three observations.

First, a great deal of respondent's argument about the quality of service and competitive benefit rests on the proposition that exclusive arrangements lead to the substitution of "inferior" nurse anesthetists for the services of anesthesiologists (e.g., Resp. Br. 21, 24-25). Yet one must be careful about accepting the word of an anesthesiologist that a competitor[5] is not "good enough" and that arrangements allowing competitors to furnish their services will harm consumers. The appropriate judge of what level of quality is "best" is the market, not one of the contending suppliers. *National Society of Professional Engineers, supra.*

In a properly functioning market, the least-cost provider will supply any service. There is great benefit in having a job done by the person with the least training necessary to get it done well. Senior partners of law firms do not abstract depositions, and it is widely viewed as beneficial to use paralegals' or associates' skills to the maximum possible extent. It is the same in medicine. The more nurse anesthetists do, the lower the cost of service. That is unquestionably a competitive

[5] Nurse anesthetists are without question competitors of anesthesiologists. Their skills overlap with respect to many tasks, although only anesthesiologists are qualified to do other tasks.

benefit. Antitrust protects the right of hospitals to choose between the services of the competing anesthesiologists and nurse anesthetists. Some hospitals may choose unwisely, but if so they will suffer in the markets. It is unlikely that judges' medical judgment is superior to that of the hospitals themselves. Even if it were, it would be inappropriate to use antitrust law to "protect" sellers and customers from simple bad business judgment.[6]

Second, respondent maintains that the reduction in "choice" created by the exclusive arrangement will increase the price of service. Respondent insists that only "choice" at the door of the operating room counts. There are several problems in this line of argument. One is that "competition for the position" may be more effective than patient-by-patient competition in reducing price and increasing quality. Even if this is

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[6] Respondent's view that the contract leads to "excessive" use of nurse anesthetists is also difficult to square with the available data. Here is a table comparing the use of anesthesiologists at the Hospital with their use in all of Louisiana during 1979:

	East Jefferson	All Louisiana Hospitals
Patient Admissions	14,321	738,425
Average Patient Census	266	14,464
Anesthesiologists	3	149
Anesthesiology Coverage		
Admissions per anesthesiologist	4,774	4,956
Patients per anesthesiologist	89	97

Sources: American Hospital Ass'n, *Hospital Statistics* Tab. 6, p. 164 (1980 ed.); American Hospital Ass'n, *Guide to the Health Care Field* A98 (1980 ed.); American Medical Ass'n, *Physician Distribution and Medical Licensure in the United States* Tab. 9, p. 111 (1979 ed.).

These data show that the Hospital has a better ratio of anesthesiologists to patients than all Louisiana hospitals. Doubtless many things influence this, including the fact that large urban hospitals such as East Jefferson General have more surgical procedures per admission than do rural hospitals; as we have argued, it is likely that the Hospital would require even more anesthesiologists per admission than it does, if the exclusive arrangement did not exist. The data are sufficient, however, to refute any claim that the arrangements challenged here lead the Hospital to deprive patients of necessary anesthesiology.

wrong, as we have emphasized before, *any* method by which the Hospital selects its staff, including "open" departments, limits a surgeon's choice at the Hospital to the anesthesiologists who practice there. No method permits unlimited choice. Moreover, every method, including "closed" departments, presents patients with a great deal of choice. Everyone who lives in metropolitan New Orleans can use the services of any anesthesiologist. He need only arrange for referral to a hospital at which the anesthesiologist of choice practices.

Finally, the assertion that exclusive contracts stultify innovation (Resp. Br. 26) is devoid of either logical or evidentiary support. Why would it have this effect? We can think of three ways in which it *promotes* innovation, and there may be more.

(a) A group practice (e.g., the anesthesiologists serving the Hospital) permits specialization. One of the anesthesiologists in the Roux group may become expert at a new procedure, and because he can do *all* of these innovative procedures in the Hospital the acquisition of new knowledge will be worthwhile. An anesthesiologist who simply floated among hospitals without the benefit of a dedicated practice and the assurance of a minimum number of uses for the new procedure might be reluctant to learn the procedure or otherwise add to the skills that are useful for the less frequently used procedures.[7] (Again the analogy to a law firm is instructive. The solo practitioner usually is a generalist, while large firms have many specialists. The division of labor makes expertise possible.)

[7] This is close in spirit to the "free riding" concerns that informed this Court's decision in *GTE Sylvania*. When a group has the exclusive right to practice at a hospital, its members may spend time on coordinating activities with other hospital departments, in the education and training of other anesthesiologists and nurse anesthetists, and similar activities of general benefit. If anesthesiologists were compensated only for time spent assisting in surgery, however, there would be substantial problems in ensuring appropriate incentives. Because all anesthesiologists and the hospital would benefit from these activities, each anesthesiologist would have an incentive to avoid undertaking these time-consuming tasks. Within a "firm" of anesthesiologists the tasks can be parceled out in accord with the benefits.

(b) The substitution of nurse anesthetists for anesthesiologists is itself a form of innovation. It changes the contours of the "product" being furnished. It is no less "innovative" to furnish the same quality of service at lower cost than to improve the quality of service furnished at a given cost.

(c) Even if we assume that the Roux group acts like a monopolist, it will innovate because monopolists, no less than competitors, try to reduce their costs. If some beneficial professional innovation is available, a monopolist has every incentive to use it. A glance at firms with large market shares—Kodak, IBM, AT&T, and others have much market power even if they are not monopolists—does not turn up sluggards that shun innovation.

III. THE HOSPITAL LACKS MARKET POWER EVEN IF THE APPROPRIATE MARKET IS THE ONE IN WHICH PATIENTS SEEK HEALTH CARE

Respondent contends that the appropriate market is defined from the perspective of patients rather than, as we have argued, from the perspective of anesthesiologists and hospitals. Respondent emphasizes repeatedly that 70% of the Hospital's patients come from the East Bank of Jefferson Parish (e.g., Resp. Br. 38), and he infers from this that the Hospital has sufficient market power to support a finding of per se violation.[8] Once more, the district court found otherwise as a matter of fact (Pet. App. 33a-34a), concluding that whatever advantage the Hospital possesses is insufficient to allow it to charge supracompetitive prices. Our opening brief (Pet. Br. 30-34) shows why this is the correct conclusion (and why, as we maintained above, the patients' perspective is not the right one).

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[8] Respondent also points out (Resp. Br. 37), as did the court of appeals, that the Hospital is the only public hospital in the East Bank area. We do not see why this is pertinent. As Appendix B to our opening brief shows, the Hospital is not the only nonprofit hospital in the East Bank, and it is far from the only public hospital in the New Orleans area. Thus even if one hypothesizes that people have a preference for public or non-profit hospitals, it is hard to see how the Hospital can turn this preference into a monopoly price. The district court found that it could not (Pet. App. 34a).

Still, the "70% share" number is quite spectacular. It is therefore important to understand what it represents. Suppose there are two food stores in the Capitol Hill area of Washington, D.C. One is a supermarket with daily sales of $9,900. The other is a corner grocery with daily sales of $100. If you ask those who come in the door of the corner grocery where they live, you will find that 90% or more of them live in the Capitol Hill area. If respondent applied to the corner grocery the same method he applies to the Hospital, he would say that the corner grocery has a "90% share" and that it therefore has monopoly power. But if you ask *all* of the people who live in Capitol Hill where they shop, you will find that 99% go to the supermarket, not the corner grocery. The grocery has no power at all.

Respondent's emphasis on the fact that 70% of the Hospital's patients come from the East Bank of Jefferson Parish just diverts attention from more important questions. The most important of these is: where could people go for service if the Hospital raised its prices? The data in the record, summarized in Appendix B to our brief, show that the people who live in Jefferson Parish have a wealth of opportunities, and indeed that even now 70% of the people who live in the East Bank go to hospitals other than East Jefferson General (Pet. App. 33a). The Hospital faces ample competitive constraints.

CONCLUSION

For these reasons, as well as those given in our opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted.

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