forms of economic credentialing can affect hospital services markets as well. For example, where a hospital implements an economic-credentialing decision that denies privileges to physicians who invest in a facility that competes with the hospital (such as a single-specialty hospital), the policy may adversely affect the hospital market, or some of the services provided by hospitals. In this situation, even if the policy is adopted unilaterally by the hospital, it can raise issues under Section 2 of the Sherman Act. That issue is discussed in more detail below.32

2. Exclusive Contracts Between Hospitals and Hospital-Based Physicians

Hospitals and other health care facilities frequently use exclusive contractual arrangements with a single physician group for anesthesia, radiology, pathology, and other specialized physician services that are integral to the hospital’s delivery of its own services. These types of hospital-based medical services typically entail use of equipment located at and owned by the facility, as well as use of the hospital’s employees. In some cases, a practitioner’s privileges to practice at the hospital terminate automatically with termination of the exclusive contract. Disappointed rivals of a group with an exclusive contract who also wish to provide those services at the hospital frequently assert antitrust claims challenging the exclusive contract and the denial or termination of related medical staff privileges as an unlawful tying or exclusive dealing arrangement, a group boycott, or monopolization or attempted monopolization. These claims, for the most part, have failed.

Although exclusive contracts between hospitals and hospital-based physicians inherently foreclose other practitioners from serving patients at a given facility, they may be an effective means of maintaining efficiency and quality of patient care.33 Hospital-based services typically entail use of the facility’s own medical equipment and require close interaction between the physicians with the exclusive contract and the hospital’s nursing and technical staff. Exclusive arrangements may facilitate and smooth this relationship, as well as facilitate scheduling

29. E.g., Gordon v. Lewistown Hosp., 423 F.3d 184, 204 (3d Cir. 2005) (explaining that court would not “substitute its judgment for that of health care professionals and the governing body of the Hospital as to whether [plaintiff’s] conduct either did or could have an adverse impact on patient health or welfare”); Lee v. Trinity Lutheran Hosp., 408 F.3d 1064, 1073 (8th Cir. 2005).

30. See American Medical Association Policy H-230.975, available at http://www.ama-assn.org/ama1/pub/upload/mm/475/811.doc (“Economic credentialing is defined as the use of economic criteria unrelated to quality of care or professional competency in determining an individual’s qualifications for initial or continuing hospital medical staff membership or privileges.”). For a discussion of the antitrust ramifications of economic credentialing, see Mark J. Horoschak, Economic Credentialing as Exclusionary Conduct Under the Sherman Act, ABA SECTION OF ANTITRUST LAW HEALTH CARE CHRONICLE, Oct. 2005, at 28.

31. See Little Rock Cardiology Clinic, P.A. v. Baptist Health, 573 F. Supp. 2d 1125, 1137-38 (E.D. Ark. 2008), aff’d 591 F.3d 591 (8th Cir. 2009); see also infra ch. V.E.

32. See infra ch. V.E.

and full-time coverage, permit better departmental management, improve resource utilization and quality assurance, promote teamwork, and control costs. These benefits promote both higher quality care and greater efficiency in the delivery of services. Courts have also upheld exclusive arrangements when demand for the relevant service would support only one practitioner, and, absent the exclusive arrangement, the service would not be provided at all. Courts, thus, have treated exclusive arrangements between hospitals and hospital-based physicians leniently under the antitrust laws.

Exclusive contracts between hospitals and hospital-based physicians are challenged most often as tying arrangements in which the hospital allegedly ties the purchase of physician services from the group with the exclusive contract (the tied service) to the sale of some type of hospital service (the tying service)—for example, requiring a patient to use the hospital’s exclusive radiology group to interpret radiological tests as a condition to the hospital’s selling the patient the technical component of radiology services such as use of the hospital’s X-ray equipment, CT scanner, and radiology technicians. Or, for example, anesthesiologist excluded from practicing at the hospital because of an exclusive anesthesia contract may allege that the hospital conditions the sale of use of its operating room to its patients’ purchase of anesthesia services from the anesthesiologists with the exclusive contract.

To prove an unlawful tying arrangement, a plaintiff (a competitor of the group with the exclusive contract, a payor, or a patient) must prove (1) that the two services are separate and distinct rather than a single service; (2) that the hospital has market power in the relevant market for the service it sells—the tying product or service, which means the patient must prove the relevant market for that service; (3) that the hospital conditions the sale of its services on its patients’ or payors’ purchase of the complementary services from the group with the exclusive contract; and, (4) in most cases, that the hospital has a direct economic interest in the sale of the physicians’ services—for example, in the case of an exclusive contract for radiology services, that the hospital shared in the radiologists’ fees for the professional component of the services. Some courts, especially in more recent tying decisions, require the plaintiff to prove foreclosure of, or an anticompetitive effect in, the market for the tied service. And although tying arrangements are often said to be per se unlawful, many cases permit the defendants to present procompetitive justifications for the arrangement, thus requiring an almost full-blown rule of reason analysis. Rarely have plaintiffs challenging exclusive arrangements between hospitals and hospital-based physicians been able to sustain all these requirements.

40. E.g., E & L Consulting v. Doman Indus., 472 F.3d 23, 31 (2d Cir. 2006) (noting that “anticompetitive effects in the market” is an essential element); Reifert v. S. Cent. Wis. MLS Corp., 450 F.3d 312, 319 (7th Cir. 2006) (“The tying claim must fail absent any proof of anticompetitive effects in the market for the tied product.”).
41. See, e.g., PSI Repair Servs. v. Honeywell Inc., 104 F.3d 811, 815 n.2 (6th Cir. 1997).
42. See BCB Anesthesia Care v. Passavant Mem’l Hosp. Ass’n, 36 F.3d 664, 667 (7th Cir. 1994) (noting the “thousands of pages” of decisions discussing physician exclusions from hospitals that “almost always came to the same conclusion: the staffing decision at a single hospital was not a violation of Section 1 of the Sherman Act”); Hager v. Venice Hosp., 944 F. Supp. 1530, 1537 (M.D. Fla. 1996) (“Courts throughout the country have interpreted the federal antitrust laws as allowing hospitals to enter into exclusive service provider contracts. A staffing decision at a single hospital based on an exclusive contract is not violative of antitrust laws.”).

34. See, e.g., Four Corners Nephrology Asso’s., P.C. v. Mercy Med. Ctr. of Durango, 582 F.3d 1216, 1224, 1225 (10th Cir. 2009).
35. See, e.g., Nilavar v. Mercy Health Sys., 244 F. App’x 690, 700 (6th Cir. 2007) (“There is extensive circuit precedent, including our own, that has upheld hospital-based exclusive provider agreements as not violative of the antitrust laws. Although the reasons vary for the decisions, they offer support for the finding that a hospital’s decision regarding staffing, including privileges, is not anticompetitive.”).
37. E.g., id. at 7, 16-18 (finding that hospital lacked market power where 70% of area patients used other hospitals); McMorris v. Williamsport Hosp., 597 F. Supp. 899, 912-13 (M.D. Pa. 1984); Burnham Hosp., 101 F.T.C. at 995.
The courts have held that most hospital-based physician services (with the possible exception of pathology services) are separate services from hospital services for purposes of tying analysis. But some courts have found the hospital lacked the requisite market power in the tying product market, while others have found that the hospital did not coerce its patients to purchase the tied product. And perhaps most frequently, courts have found that the hospital lacked the necessary direct economic interest in the sale of the tied product because the hospital and physicians billed for their services separately and the hospital obtained no part of the physicians’ professional fees. The direct-economic-interest requirement would be met, however, where the physicians in question are hospital employees and the hospital receives the remuneration for their services.

The plaintiff also may challenge the contract as an unlawful exclusive dealing agreement. Here, rule of reason analysis clearly applies. As a threshold matter, the plaintiff must define the relevant market and show that the contract forecloses a substantial share of the market to competitors of the group with the exclusive contract.

43. E.g., Collins v. Associated Pathologists, 844 F.2d 473, 477-80 (7th Cir. 1988).
47. E.g., County of Toulumne v. Sonora Cnty. Hosp., 236 F.3d 1148, 1157-58 (9th Cir. 2001); Beard v. Parkview Hosp., 912 F.2d 138, 142 (6th Cir. 1990); Kochert v. Greater Lafayette Health Servs., 372 F. Supp. 2d 509, 515 (N.D. Ind. 2004), aff’d, 463 F.3d 710 (7th Cir. 2006).
49. See, e.g., Imaging Ctr., 158 F. App’x at 420 (“The inquiry into exclusive dealing arrangements focuses on whether the arrangement forecloses competition among producers or suppliers in a substantial share of the relevant market in this type of vertical-foreclosure case should include all potential patients for the medical service in question.”);”}

52. E.g., Minn. Ass’n of Nurse Anesthetists, 208 F.3d at 661 (emphasizing the mobility of physicians and thus finding a national market); Collins v. Associated Pathologists, 844 F.2d 473, 479 (7th Cir. 1988) (national market for pathologists); Reddy v. Good Samaritan Hosp. & Health Ctr., 137 F. Supp. 2d 948, 969 (S.D. Ohio 2000) (explaining that “courts have concluded, in the context of a hospital entering into an exclusive contract...”).
is deemed the purchaser, the relevant geographic market is relatively local because patients typically are not willing to travel long distances for hospital-based physician services. The decisions are not in complete accord in answering this question, and several have held that both geographic markets must be analyzed for anticompetitive effects.

After defining the relevant market, the court examines the usual factors important in exclusive dealing analysis: (1) the percentage of the market foreclosed to defendant’s competitors by the contract, (2) the duration of the contract (including whether the contract can terminate the contract on short notice without cause), (3) the extent and coverage of other exclusive contracts in the market that would prevent the plaintiff and other actual and potential competitors from practicing in the market, and thus whether the plaintiff and other competitors could compete from other facilities, (4) the level of market concentration, (5) the market power of the group with the exclusive contract (and the likely effect of the contract on its market power), (6) entry barriers, (7) whether there was competition for the exclusive contract, and (8) any procompetitive effects resulting from the arrangement. The ultimate question is always whether the contract has resulted (or is likely to result) in higher prices or lower quality for consumers. Courts typically find no anticompetitive effect where the hospital merely substitutes one exclusive group for another and thus the number of competitors remains the same.

Many challenges to hospital-physician exclusive contracts have failed because the plaintiff has not been able to show the requisite anticompetitive effect on the price, quality, or output of physician services; the plaintiff physician could practice elsewhere in the market; or the arrangement generated substantial efficiencies in the delivery of care. Also relevant is that hospital services and physician services are economic complements, so all else equal, the hospital has no economic incentive to enter into arrangements with physician groups that permit them to exercise market power. Exercise of market power by physicians, as a theoretical matter, will decrease the quantity demanded of the hospital’s services.

---


61. See, e.g., Minn. Ass’n of Nurse Anesthetists, 208 F.3d at 662 (affirming summary judgment because “plaintiffs have failed to prove actual adverse effects on competition . . . such as increased prices for anesthesia services, or a decline in either the quality or quantity of such services available to surgery patients”); Verma v. Jefferson Hosp. Ass’n, 2007 WL 4468689, at *4 (E.D. Ark. 2007) (“Courts look to factors such as decreased output, increased prices, or reductions in the level of quality in a particular market in analyzing whether competition was harmed.”); cf. Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 29-30 (1984) (indicating that plaintiff must show an actual adverse effect on competition and that plaintiff failed to prove an adverse effect on quality or price).

---