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Peter J. Hammer
Assist. Prof, University of Michigan Law School

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Peter J. Hammer

I. Introduction

Professionalism does not exist in a vacuum. Professions exist within a complicated web of social and economic relations, with social structures serving often underappreciated economic roles. Guilds, for example, with, among other things, their strict membership control, apprenticeship requirements, and non-competition arrangements, provide a method to package and distribute information and technical expertise as a commodity itself. Physicians (and other professionals) can also be viewed as bundles of information and, radical as it may seem, hospitals can be thought of

* Assistant Professor, University of Michigan Law School. Professor Hammer received his J.D. and Doctorate in Economics from the University of Michigan. A recipient of a Robert Wood Johnson Foundation Health Policy Investigator Award, Professor Hammer's scholarship interest involves antitrust law and the health care industry. He is also the founder and director of the Program for Cambodian Law and Development at the University of Michigan.

1 See Kenneth J. Arrow, Uncertainty and the Welfare Economics of Medical Care, 53 AM. ECON. REV. 941 (1963). Arrow contends that "institutional organization and the observable mores of the medical profession" should be included as "data to be used in assessing the competitiveness of the medical-care market." Id. at 944. Unfortunately, the call to engage in a richer economic/institutional analysis of professional relations has gone largely unheeded.

2 As Arrow Observed:

But the demand for information is difficult to discuss in the rational terms usually employed. The value of information is frequently not known in any meaningful sense to the buyer; if, indeed, he knew enough to measure the value of the information, he would know the information itself. But information, in the form of skilled care, is precisely what is being bought from most physicians, and, indeed, from most professionals.

Id. at 946.
primarily as economic firms arranging for the provision of medical services. At the same time, most observers would concede that physicians are more than simply vessels for the commodification of information, and hospitals are more than just methods for organizing the means of medical production. Further complicating matters is the fact that health care is influenced by an elaborate array of government regulations, public subsidies, market failures, and various traditions of self-regulation. These forces form the backdrop against which medical antitrust disputes are litigated and decided.

This essay seeks to inform understandings of antitrust and the professions at the millennium by juxtaposing judicial treatment of hospital-physician exclusive contracting cases with judicial treatment of dealer termination cases as a form of vertical non-price restraints. In the typical exclusive contract, a hospital will enter into a relationship with a group of physicians, such as radiologists or anesthesiologists, to be the sole provider of a package of services to the hospital. This contrasts with the traditional "open" medical staff model characteristic of most other hospital-physician relations, where basically any qualified physician is extended the "privilege" of practicing at the hospital. In the typical manufacturer-distributor relationship, on the other hand, a manufacturer of a product enters into a contract with a retailer for the distribution of the commodity. The contract often imposes a variety of obligations and restrictions controlling the behavior of the distributor.

Many themes emerge from the antitrust comparison of doctors and distributors. As a descriptive matter, doctors are functioning more and more as passive distributors of health care. Viewing doctors

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3 As others writing in medical antitrust can appreciate, it is not uncommon to get what you think is a fresh insight into a question, only to find that Clark Havighurst has already written about the topic, sometimes decades earlier. This is no exception. See Clark C. Havighurst, Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships, 1984 DUKE L.J. 1071, 1144-57 (1984) (exploring the analogy between antitrust treatment of vertical contracting and physician-hospital contracting). Havighurst explores the analogy between hospital exclusive contracting and vertical non-price restraints, but also stresses the limitations of such a comparison. Id. at 1146 n.243.

4 From a theory of the firm perspective, contracting is an alternative to single firm ownership and control through vertical integration. A manufacturer could simply build and own its system of distribution, as many do. A persistent puzzle in antitrust law is how to deal with conduct that when done "in house" raises no serious antitrust issues in the absence of monopoly power policed by section two, but when made the object of contract is subject to stricter antitrust scrutiny and potential liability under section one of the Sherman Act.
as distributors highlights the loss of special status and autonomy physicians enjoy as they become increasingly viewed as inputs into the process of health care production. Changes in the law often track changing facts on the ground. This particular antitrust transformation tracks the trajectory outlined by Henry Maine: a movement away from status-based professional distinctions to antitrust distinctions based upon contractual relations. The contracts focus of contemporary medical antitrust law is suggestive of the power of the economic forces reshaping the organizational structure of how medical services are provided and financed. But in these still evolving markets, it is important to strike a cautionary note. While antitrust analysis has moved from status to contract, the realm of contracts is itself highly contestable. As the health services research literature indicates, the physician’s ultimate role in the “firms” providing medical services is yet to be determined. Whether (and to what degree) doctors end up as distributors, employees, co-owners, or risk-bearing purveyors of health insurance remains to be seen.

This essay cuts through many different layers of antitrust law as to which, depending upon the specific legal question, I have fairly conflicted views. The following can serve as a compass for the reader. First, although I remain critical of the Supreme Court’s underdeveloped analytical treatment of the efficiency attributes of vertical relations, I find the judicial framing of health care relations as “vertical” to be helpful to the extent that it focuses attention on the nature of the contractual relations themselves, rather than the professional or quasi-professional status of the parties. From this perspective, the move from status to contract is a step in the right direction. Second, while the economics of hospital-physician relations can be complicated, the analysis of most forms of hospital

5 “[W]e may say that the movement of the progressive societies has hitherto been a movement from Status to Contract.” Henry Maine, ANCIENT LAW 182 (Sir Frederick Pollock ed., 1930). In Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975), the Supreme Court finally confronted and rejected the status-based claim that the learned professions were not engaged in “trade” as regulated under the Sherman Act. The progressive realignment of antitrust treatment of hospital contracting practices with the antitrust standards governing contracting practices elsewhere in the economy simply works to complete the Goldfarb revolution.

6 While antitrust doctrine is fond of categorical distinctions between “horizontal” and “vertical” relations, it is doubtful that health care markets will ever be able to fit neatly into such a frame. Too many actors are involved, engaging in too many complicated transactions, encompassing both sophisticated medical services and the allocation of competing types of risk over time. For example, individuals, on behalf of themselves and their families, but acting typically through
exclusive contracting that have been litigated to date is relatively straight-forward and generally supports the procompetitive role that courts attribute to these arrangements. As such, most antitrust courts are reaching the correct outcome in upholding these exclusive agreements. However, professionalism is not an empty vessel and, as Arrow reminds us, social institutions can play underappreciated economic roles. Therefore, it is important that the superficial reasoning that often follows legal categorization of a relationship as "vertical" not infect the ability of courts to appreciate the underlying complexities that health care cases may often present. As antitrust treatment of the professions moves from status to contract, it highlights the need for more sophisticated economic analysis of contracting practices more generally, and of the professions in particular.

The first section outlines antitrust treatment of vertical restraints in the context of standard manufacturing relations. The second section explores the economics underlying hospital-physician relationships. The third section constructs a composite judicial approach from the hospital exclusive contracting cases that illustrates how doctors are indeed being treated as distributors for antitrust purposes. The final section concludes by examining what future contracting and antitrust trends in health care might look like, and what implications this may have for antitrust law and the professions.

the agency of their employers, purchase insurance to cover the costs of medical services that they hope they will never need. Moreover, the insurance and medical service components of health care are being combined in an increasing variety of packages. Managed care represents a complicated system for the joint production of medical services and insurance, and therefore embodies agents acting as both buyers and sellers within an array of real and potential conflicts of interest. See Lawrence Casalino, Managing Uncertainty: Intermediate Organizations as Triple Agents, 26 J. HEALTH POL., POL'Y & L. 1055 (2001) (Special Issue, Kenneth Arrow and the Changing Economics of Health Care) (eds. Peter J. Hammer, Deborah Haas-Wilson, and William M. Sage). It is difficult, if not impossible to completely untangle this web into distinct sets of relations that are "vertical" and others that are "horizontal" for antitrust purposes. The fact that many courts try and do just that is itself an interesting fact. In the end, such efforts must be met with some level of skepticism. Moreover, one should be open to exploring what lessons the limitations that these classification exercises face in health care markets may have for antitrust doctrine in other sectors of the economy.

7 See generally Arrow, supra note 1.
II. A Fabled Antitrust Story of Vertical Relations

The revolution in judicial treatment of vertical non-price restraints just pre-dates the transformation of health care markets. In *Continental T.V. v. GTE Sylvania Inc.*, the Supreme Court overturned its previous *per se* condemnation of vertical non-price restraints, declaring that restraints arising from vertical forms of contracting would be subject to more lenient rule of reason analysis. Under rule of reason analysis, judges were instructed to balance potential losses attributed to reductions in intra-brand competition against possible gains in terms of enhanced inter-brand competition. Motivating the Court was the belief that manufacturer-imposed restrictions on intra-brand competition could strengthen the competitiveness of the brand and thereby increase the vitality of inter-brand competition. In theory, the existence of sufficient inter-brand competition will act as a self-policing mechanism to discipline manufacturers who impose restraints that do not enhance the value of their product in the eyes of consumers. In *Business Electronics Corp. v. Sharp Electronics, Corp.*, however, the Court moved substantially beyond simply suggesting that the effects of intra- and inter-brand competition must be balanced against each other, to asserting what amounts to a near legal presumption in favor of the efficiency of manufacturer-imposed vertical restraints (in the absence of market power).

The modern vertical restraints cases track the ascendancy of Chicago school law and economics as a force shaping antitrust law.

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9 *Id.* at 58.

10 *Id.* at 54-55.

11 *Id.* at 52 n.19.


13 *Id.* at 725-26. *Monsanto Co. v. Spray-Rite Serv. Corp.*, 465 U.S. 752 (1984), completes the vertical restraints trilogy by imposing substantial evidentiary hurdles of plaintiffs seeking to prove the existence of an anticompetitive agreement among suppliers and distributors on the basis of circumstantial evidence. If the evidence purporting to prove the existence of an agreement is as consistent with procompetitive business justifications as it is with anticompetitive conduct, then the plaintiff must introduce additional evidence that tends to exclude the possibility of independent action on the part of the manufacturer. *Id.* at 761-63. The burden of this requirement increases in direct proportion to the scope of procompetitive benefits that courts presume to associate with vertical contracting practice.
These cases also represent a shift away from the social, political, and economic values that animated early judicial hostility towards manufacturer attempts to interfere with the autonomy and independence of small retailers and distributors. Part of this shift is ideological – competing beliefs about the virtues of small versus big business, fairness versus efficiency, and trust in private versus public forms of control.\(^\text{14}\) Part of the shift in contemporary antitrust law’s treatment of vertical restraints represents underlying changes in the economics of national and increasingly international markets – economies of scale dictate larger sizes of operation, the costs of information and monitoring determine prevailing patterns of private contracting, and the geographic heterogeneity of consumer preferences influences the appropriate degree of local versus centralized control of price and non-price decision making.\(^\text{15}\)

It was not long before changes in judicial treatment of vertical relations among manufacturers and distributors began to influence antitrust treatment of health care. Still, the analogy between vertical non-price restraints and hospital-physician contracting was and is not perfect. I characterize the story of how doctors became distributors as a fable in vertical relations. There are pronounced differences between the economics of physician-hospital relations and vertical systems of manufacturer-distributor relations. Physician-hospital relations have much stronger overtones of joint production.\(^\text{16}\) This

\(^{14}\) Indeed, Justice Holmes 1911 dissenting views in Dr. Miles, which substantively resonate with the precepts of modern Chicago School teachings, sounds as much in deeply held social as it does economic beliefs.

Dr. Miles Medical Company knows better than we do what will enable it to do the best business. . . . I cannot believe that in the long run the public will profit by this court permitting knaves to cut reasonable prices for some ulterior purpose of their own and thus to impair, if not to destroy, the production and sale of articles which it is assumed to be desirable that the public should be able to get.


\(^{15}\) But economics alone can only push so far. In the end, economics and ideology are infinitely contestable. The fact that efficiency will never completely trump notions of fairness, even as an antitrust consideration, can be seen in the fact that dealer termination cases continue to have jury appeal, no matter how skeptically they are viewed by economists, and the fact that dealer protection statutes continue to be popular in political markets.

\(^{16}\) See Havighurst, supra note 3, at 1144 n.243. For further discussion of limitations in the analogy between doctors and distributors, see infra notes 25-26 and accompanying text.
calls the tightness of the economic analogy between doctors and distributors into some degree of question. In addition, and perhaps more importantly, judicial treatment of vertical restraints has a fabled character all its own. Rather than developing a rigorous analysis of the efficiency and cost-benefit implications of various vertical contracting practices, as might have been expected after *Sylvania* and as called for by Justice Stevens’ dissent in *Business Electronics*, the efficiency of vertical restraints is largely accepted as received judicial wisdom. In this manner, categories such as “vertical” and “horizontal” in antitrust law, and the assertion of the “procompetitive” benefits of vertical restraints often represent legal conclusions rather than declarations of economically proven fact. The rhetoric of vertical relations frequently eclipses any substantive economic analysis.

III. The Economics of Hospital-Physician Relations

The organization of hospital-physician relations has always presented a puzzle for economists. In the early 1970s, there was a discrete body of literature exploring different possible models of hospital behavior. Newhouse, for example, postulated that hospitals acted as joint maximizers of quality and quantity. Lee, on the other hand, argued that hospital behavior was best modeled in terms of maximizing the individual utility of hospital administrators. Alternatively, Pauly and Redisch argued that hospitals were best characterized as physician cartels, organized and operated to maximize the profits of the medical staff. It is not surprising that these modeling exercises had a limited life in the literature. Competing models of hospital behavior make sense only if hospitals have substantial discretion as to how they can behave. With Medicare’s introduction of prospective payment in 1983 and the cost consciousness triggered by double-digit medical inflation ushering in

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17 *Business Electric*, 485 U.S. at 748-57 (Stevens, J., dissenting).
the managed care revolution, less and less discretion existed in
hospital markets. In this environment, one would expect non-profit
hospitals to act more like their for-profit counterparts. It is also in this
new environment of cost consciousness that hospitals started
exercising greater control over their medical staffs and began
experimenting with exclusive contracts for various sub-groups of
physicians.

The majority of hospitals, even today, are non-profit
organizations. The typical non-profit hospital consists of a Board of
Trustees, a group of hospital administrators, and the medical staff –
an independent body of the physicians who have privileges to work at
the hospital.\(^\text{22}\) Whether and when a hospital should be treated as a
single, well-defined economic firm raises its own important antitrust
issues under \textit{Copperweld}.\(^\text{23}\) The resolution of the \textit{Copperweld}
question is largely determined by the degree of structural autonomy
afforded the medical staff as an entity, and a practical inquiry into
whether there is a legitimate unity of interest between the Board and
the medical staff. The trend over the past two decades has been
towards organizing and operating hospital structures in a manner that
makes them look and act more like rationally integrated firms. Under
such circumstances, most courts generally hold that hospitals are

\[^{22}\text{The court in} \textit{Ezpeleta v. Sisters of Mercy Health Corp.}, 621 F. Supp. 1262
(N.D. Ind. 1985), provides a nice description of the basic structure of most non-
profit hospitals and their relationship with physicians and the setting in which
exclusive contracts are entered.}\]

\[^{23}\text{Copperweld Corp. v. Independence Tube Corp.}, 467 U.S. 752 (1984).\]
An appreciation of the complexities of hospital-physician relations begins to suggest some of the limitations in the analogy between doctors and distributors. Rather than standing at distinct levels of production, physicians and hospitals are, in many respects, joint producers of medical services. One implication of the joint nature of hospital-physician production is that one would ordinarily expect these services to be provided in an integrated fashion. A second insight is that the nature of such integration will be heavily dependent upon the type of physician service in question and its economic relationship to the provision of hospital services. There is a range of services that physicians can provide independent of hospitals, and the technological trend has been to increase the scope of services available on an out-patient or free-standing basis. There is another range of services for which the physician component (professional expertise) is primary and the hospital component (primarily physical capital and supportive services) is secondary. Finally, there is a range of hospital-based practices where the hospital component is primary and the physician service is secondary. Hospital-based practices consist primarily of pathology, anesthesiology, radiology, and emergency room services. Here, the patient’s choice of physician is largely ancillary to their choice of the

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24 To minimize antitrust liability under Copperweld, the hospital must limit the independence of the medical staff and subordinate the interests of physicians to the independent and distinct interests of the hospital. See, e.g., Oksanen v. Page Mem. Hosp., 945 F.2d 696, 703-04 (4th Cir. 1991) (holding no Sherman Act § 1 claim can be based upon the revocation of the plaintiff’s staff privileges because under Copperweld a hospital cannot conspire with itself); Canady v. Providence Hosp., 903 F. Supp. 125, 127 (D. D.C. 1995) (granting defendant’s motion to dismiss finding no concerted action in light of the Copperweld doctrine); Purgress v. Sharrock, No. 91 Civ. 0621, 1992 U.S. Dist. LEXIS 17057, at *9 (S.D.N.Y Nov. 9, 1992) (holding as a matter of law that the hospital was incapable of conspiring with members of its medical staff).

25 It is seldom economically rational for complementary services to be provided by economically independent entities. See Peter J. Hammer, Medical Antitrust Reform: Arrow, Coase and the Changing Structure of the Firm, in THE PRIVATIZATION OF HEALTH CARE REFORM (G. Bloche ed., Oxford Univ. Press) (forthcoming 2002). The joint nature of hospital-physician production argues in favor of greater integration and raises a number of questions about the function and structure of hospital-physician relations in the context of competing theories of the firm. The fact that one would predict that integration is likely to occur, however, says little about how such integration is likely to take place in practice. See discussion of the health services research literature infra notes 75-77 and accompanying text.
hospital as a provider. Not surprisingly, this last category represents the strongest economic case for "vertical" integration on the part of the hospital and has been the area where hospitals have been most active in entering into exclusive contracts with discrete sets of providers. In this domain, the hospital has a strong incentive to integrate and the economic position of the hospital will likely dominate that of the physician.

IV. The Antitrust Response: Doctors As Distributors

In the face of transformations within health care markets, hospitals have tried to obtain tighter control over their medical staffs and to implement exclusive contracts with hospital-based practices. These efforts have generated substantial antitrust activity. A recent

26 While the analogy between hospitals entering into an exclusive contracts with physicians and manufacturers contracting with distributors is useful in building bridges between two areas of antitrust law, other structural analogies can also be invoked. Some courts have classified hospitals as the "buyer" of physician services. See, e.g., Dos Santos v. Columbus-Cuneo-Cabrini Med. Ctr., 684 F.2d 1346 (7th Cir. 1982).

Because the patient generally takes no part in the selection of a particular anesthesiologist (the surgeon makes the choice), and because the expense of anesthesia services to the patient is ordinarily at least partially insured or otherwise payable by a third party, it might be somewhat anomalous to treat the patient as a buyer. The patient in these circumstances receives the service 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, its incentive to maximize the use of its surgical facilities and its potential liability for negligent rendition of anesthesia services in its operating rooms. If the hospital rather than the individual patient is regarded as the purchaser, the relevant market could be defined as the area in which Associates operates and in which the Medical Center (rather than the patient) can practicably turn for alternative provision of anesthesia services.

Id. at 1354. Alternatively, for certain other services courts have suggested that the physician might more appropriately be viewed as an employee of the hospital.

[T]he vast majority of work performed by pathologists involve laboratory tests and analyses that require the pathologist to rely a great deal upon the hospital’s physical facilities and equipment. Thus, it is easy to see the pathologist as similar to an employee of the hospital rather than an independent contractor hired by the hospital for each specific task he must perform.

survey of medical antitrust litigation I conducted with Bill Sage revealed that roughly one-third of all healthcare antitrust cases between 1985 and 1999 consisted of staff-privilege disputes, while another one-third consisted of disputes over exclusive contracting. This finding is rather startling. Conflicts over hospital-physician relationships dominate medical antitrust litigation. While common, these antitrust suits were not even mildly successful. Our survey indicated that plaintiffs received favorable outcomes in approximately 9% of staff privilege cases and only a slightly higher 16% of exclusive contract cases.

When one examines the exclusive contracting cases as a whole, certain patterns emerge. Most hospital exclusive contract cases involve hospital-based practices – emergency room, anesthesiology, pathology, radiology and to a more limited extent cardiology. Almost every exclusive contracting case tries, usually unsuccessfully, to fit itself within the frame of an established category of per se type illegality – group boycotts, tying agreements, exclusive dealing arrangements. These are confused areas of antitrust law outside health care, and judicial treatment of hospital exclusive contract cases has done little to clarify these concepts. More frequently, judicial efforts to escape the plaintiff's per se frame simply create more doctrinal confusion. For example, some courts will invoke the alleged special status of health professions to justify rule of reason instead of per se analysis. As will be argued later, this move is neither necessary, nor very helpful. Alternatively, many


28 Only 17% of the cases in the survey involved antitrust disputes over managed care. Id.

29 In calculating outcomes, we only coded significant dispositions. We considered a disposition to be “significant” if it determined or substantially influenced the overall outcome of the dispute between the parties. Minor procedural rulings in favor of one party were not considered “significant.” We counted the denial of a summary judgment motion made by the defendant as a plaintiff victory, because it imposes potentially large trial costs on defendants even if they eventually prevail, and therefore promotes settlement. As such, the standard we employed is likely to overstate plaintiff victories. We also counted a significant outcome in district court as a plaintiff (or defendant) victory, even if it was subsequently reversed on appeal. Id.

courts invoke the antitrust injury doctrine as a means of short circuiting the substantive antitrust analysis. Antitrust injury claims were invoked in 45% of the opinions addressing exclusive contracting claims.\(^{31}\)

While not invoked in all cases and not even the dominant form of judicial analysis, one can create an interesting composite approach to hospital exclusive contract cases that maps surprisingly well onto the template of manufacturer-dealer vertical restraints outlined earlier. Within this composite, courts expressly characterize the hospital-physician relationship as “vertical” and invoke the rule of reason standard in light of an appreciation of the procompetitive benefits associated with exclusive contracts. Furthermore, within this vertical realm, intra-firm restraints are viewed as efficiency-enhancing and credited with stimulating greater competition in the “inter-brand” market of hospital competition. Consistent with contemporary beliefs about the efficiency of vertical contracting, courts express agnosticism about particular private contractual forms, and reject invitations to judicially pre-determine the type or timing of competition that should take place in the market. One can add within the vertical composite a place for suspect forms of horizontal collusion. These horizontal issues, however, take the form of a residual concern about dealer boycotts, rather than the central focus that characterizes traditional per se frames of reference.

A. Composite: The Vertical Nature of Hospital-Physician Relations

Antitrust law maintains a strong affinity for tight binary distinctions, for example, \textit{per se} versus rule of reason analysis, or vertical versus horizontal relations. In crossing the divide separating horizontal from vertical relations, one also crosses a rhetorical divide that typically opens the door to more lenient rule of reason evaluation and often affords an effective presumption in favor of the reasonableness of the conduct in question. Given the joint nature of most forms of hospital-physician production, the “vertical” label is more contestable here than it is in traditional manufacturer-distributor relationships. Nevertheless, many courts feel comfortable discussing hospital exclusive contracts as “vertical,” or as sufficiently close to make the analogy judicially persuasive.

The following cases illustrate the point. \textit{Leyba v. Hartmut}

\(^{31}\) See Hammer & Sage, \textit{supra} note 27.
Renger Anesthesia Specialists\textsuperscript{32} was brought in the wake of a merger between an allopathic and an osteopathic hospital. The merged entity entered into an exclusive contract with the MD anesthesiologists, and the excluded DO anesthesiologists brought an antitrust suit. The court classified the relationship between the hospital and the physicians as being vertical in nature, stating:

The evidence shows that St. Joseph [hospital] is not at the same market level as either Dr. Renger or ASA, and is not in competition with either of these parties for the provision of anesthesiology services. Hence the relationship is not horizontal. If anything, the evidence shows that the relationship between the defendants is vertical.\textsuperscript{33}

At the same time, the court noted some discomfort with the analogy: "It is not clear from the case law whether the vertical restraint concept would be directly applicable in this situation, in light of the fact that this is not a classic ‘product distribution’ case."\textsuperscript{34}

Often times, given the more overtly contractual and arms-length relationships between providers in managed care networks, the analogy between exclusive contracting and vertical non-price restraints is easier for courts to recognize. Capital Imaging Associates, P.C. v. Mohawk Valley Medical Associates, Inc., \textsuperscript{35} for example, involved a radiologist suing over his exclusion from the defendant’s independent practice association ("IPA") model HMO. The court cited the alleged vertical nature of the relationship as a means of avoiding application of the \textit{per se} rule. "Plaintiff has alleged that defendants’ activities constitute an illegal group boycott and an illegal tying agreement. However, the defendants’ type of exclusivity practices are vertical, nonprice restraints that are analyzed not under the \textit{per se} rule, but under the ‘rule of reason’ standard."\textsuperscript{36} For authority, the court cited directly to the Supreme Court’s decision in Sylvania.\textsuperscript{37}

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\textsuperscript{32} 874 F. Supp. 1229 (D.N.M. 1994).
\textsuperscript{33} \textit{Id.} at 1240.
\textsuperscript{34} \textit{Id.}
\textsuperscript{35} 725 F. Supp. 669 (N.D.N.Y.).
\textsuperscript{36} \textit{Id.} at 677.
\textsuperscript{37} \textit{Id.} (citing Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36 (1976)).
In Reddy v. Good Samaritan Hospital,\textsuperscript{38} plaintiff anesthesiologist left the primary group providing anesthesiology services at the hospital to start his own sole proprietorship. The difficulties working with multiple independent providers led the hospital to demand that all physicians form a single group that it could work with. Plaintiff refused to rejoin the group and sued under the antitrust laws to enjoin the hospital from entering into an exclusive contract with his former employer. Citing the Supreme Court's recent decision in NYNEX,\textsuperscript{39} the court held that the exclusive contract was vertical in nature and therefore could not form the basis of a \textit{per se} illegal group boycot.\textsuperscript{40} Then, citing Sylvania and Business Electronics, the court held that non-price vertical restraints, such as the allocation of customers, would be subject to rule of reason analysis.\textsuperscript{41}

The final case within our composite treating hospital-physician relations as fundamentally vertical is Smith v. Northern Michigan Hospital, Inc.\textsuperscript{42} Smith arose after the merger of two hospitals in Petoskey, Michigan. The merged entity consolidated emergency rooms to one facility and decided to staff the emergency room via an exclusive contract with full-time emergency room physicians. Plaintiffs, who had previously helped staff the emergency room on a part-time basis at one of the pre-merged hospitals, sued alleging antitrust violations. The Sixth Circuit rejected the plaintiffs' theory of a horizontal conspiracy.

The present case does not involve a group of horizontal competitors whose joint control over some essential facility produces an unreasonable restraint on trade. Rather, NMH, as the coordinator and supplier of an essential but limited public service, stands in a vertical relationship to both the

\textsuperscript{38} 137 F. Supp. 2d 948 (S.D. Ohio 2000).

\textsuperscript{39} NYNEX Corp. v. Discon, Inc., 525 U.S. 128 (1998) (limiting application of the per se rule against group boycotts to horizontal relations).

\textsuperscript{40} Reddy, 137 F. Supp. 2d at 968.

\textsuperscript{41} \textit{Id.} See also Dos Santos v. Columbus-Cuneo-Cabrini Med. Ctr., No. 81 C 4296, 1983 U.S. Dist. LEXIS 12377, at *9 (N.D. Ill. Oct. 25, 1983) ("[T]he Exclusive Contract between the Medical Center and Anesthesia Associates is a form of vertical combination which must be analyzed under the \textit{Rule of Reason}."); Coffey v. Healthtrust, Inc., 955 F.2d 1388, 1392-93 (10th Cir. 1992) (characterizing the relationship between the defendant hospital and its physicians as vertical in nature and therefore subject to rule of reason analysis).

\textsuperscript{42} 703 F.2d 942 (6th Cir. 1983).
Burns Clinic [the group awarded the exclusive contract] and the independent physicians in Petoskey.\textsuperscript{43}

The vertical frame sets courts up to analyze hospital-physician exclusive contracts largely in the same manner they would examine a manufacturer’s system of distribution.

**B. Composite: Hospital Exclusive Contracts Generate Substantial Procompetitive Benefits**

In the fabled realm of vertical relations, it is often difficult to discern whether an assertion of procompetitive benefits precedes or follows from an assertion of a “vertical” relationship. In most hospital exclusive contracting cases, however, the economic benefits of the arrangement are real and multifaceted. Courts have been quick to recognize a wide variety of benefits associated with hospital exclusive contracting. Justice O’Connor’s concurring opinion in *Jefferson Parish*\textsuperscript{44} set the mold for subsequent judicial analyses of these practices. *Jefferson Parish* involved an excluded physician’s challenge to a hospital’s exclusive contract with a firm of anesthesiologists to provide services at the hospital. The plaintiff attempted to characterize the contract as an illegal tie between inpatient surgical and anesthesiology services. In advocating upholding the legality of the exclusive contract under the rule of reason, O’Connor outlined the economic rationale behind the alleged tie:

The tie-in improves patient care and permits more efficient hospital operation in a number of ways. From the viewpoint of hospital management, the tie-in ensures 24-hour anesthesiology coverage, aids in standardization of procedures and efficient use of equipment, facilitates flexible scheduling of operations, and permits the hospital more effectively to monitor the quality of anesthesiological services...Given this evidence of the advantages and effectiveness of the closed anesthesiology department, it is not surprising that, as the District Court found, such arrangements are accepted practice in the majority of hospitals of New Orleans and in the health care industry

\textsuperscript{43} Id. at 953.

Comparable procompetitive benefits of exclusive contracting have been tallied by other courts. In *Balaklaw v. Lovell*, the court reasoned that "the [exclusive] contract appears to best meet the needs of the purchaser, the hospital, and by extension its patients, and therefore it is clearly justified on pro-competitive grounds." Other courts have reached similar conclusions. The court in *Dos Santos* noted: "The exclusive contract between Medical Center and Anesthesia Associates produces benefits to consumers—including a continuous and assured supply of the proper quantity and quality of anesthesiology services as well as other efficiencies referenced in the foregoing findings of this Court." The court in *Northern Michigan Hospital* stated: "The appellants have failed to present evidence which would contradict NMH's manifestly legitimate and well-supported justification that full-time specialists trained as emergency room physicians provide medical services superior to those of generalists who rotate on a part-time basis while maintaining full private practices."

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45 *Jefferson Parish Hosp.*, 446 U.S. at 43-44. O'Connor further argued that the exclusive contract provided specific benefits to patients.

Further, the tying arrangement is advantageous to patients because, as the District Court found, the closed anesthesiology department places upon the hospital, rather than the individual patient, responsibility to select the physician who is to provide anesthesiological services. The hospital also assumes the responsibility that the anesthesiologist will be available, will be acceptable to the surgeon, and will provide suitable care to the patient. In assuming these responsibilities—responsibilities that a seriously ill patient frequently may be unable to discharge—the hospital provides a valuable service to its patients. And there is no indication that patients were dissatisfied with the quality of anesthesiology that was provided at the hospital or that patients wished to enjoy the services of anesthesiologists other than those that the hospital employed.

*Id.*

46 14 F.3d 793 (2d Cir. 1994).

47 *Id.* at 799 n.13


C. Composite: Hospital Restrictions on Intra-Brand Competition Strengthen Inter-Brand Competition

There are two important steps in this analysis. First, courts maintain that the unilateral imposition of standards or qualifications by a hospital can increase the competitiveness of the hospital vis-à-vis its rivals. Second, courts express a belief that the standards not only stimulate competition, but competition, in turn, will discipline hospitals that set inappropriate internal restrictions. Some of the reasoning for this aspect of the antitrust composite is borrowed from staff privilege as well as exclusive contracting cases. In upholding a hospital’s right to contract only with physician anesthetists, thereby excluding nurse anesthetists, the Ninth Circuit reasoned “hospitals must make choices about the types of qualifications a practitioner must have to apply for staff privileges in various fields of practice. These restrictions help it provide more efficient, higher quality services in order to compete against other hospitals.” Similar reasoning is invoked to support a hospital’s right to strictly define its staff privilege policies: “[A] non-monopolist hospital’s policy of restricting staff appointments to very highly qualified applicants did not impose an unreasonable restraint on trade, because by building a high quality staff the hospital would improve its competitive posture, thereby increasing competition in the relevant market.” It is easy to extend this analysis to the adoption of exclusive contracts. “The contract with Anesthesia Associates enhances the Medical Center’s ability to compete with these hospitals by upgrading the quality of its anesthesia service. The contract may benefit competition among anesthesiologists by encouraging them to improve the quality of their services in order to obtain these contracts with hospitals.”


50 Bhan v. NME Hosps., Inc., 929 F.2d 1404, 1412 (9th Cir. 1991) (citation omitted).


the opinion, the court noted that the “exclusive anesthesiology contract between the Medical Center and Anesthesia Associates is the result of competition, not a restriction on competition.”

Most judicial opinions do not expressly characterize their analysis of hospital exclusive contracting and staff privileges in terms of a relationship between intra- and inter-brand competition, and perhaps such a framing would not be entirely appropriate. Nevertheless, the logic underlying the courts’ reasoning in hospital cases directly parallels the logic underlying the Supreme Court’s opinions in Sylvania and Business Electronics. Again, the more overtly contractual relations underlying managed care make some of these parallels easier to observe. Doctor’s Hospital of Jefferson, Inc. v. Southeast Medical Alliance, Inc., involved a hospital suing a managed care preferred provider organization (“PPO”) network after the hospital’s membership was terminated. In dismissing the plaintiff’s antitrust claim, the court evaluated the PPO’s actions expressly in terms borrowed from the realm of vertical contracting.

Competition among managed-care plans checks any anticompetitive effects of market power achievable from aggregating providers of hospital services in much the same way as interbrand competition “provides a significant check on the exploitation of intrabrand market power because of the ability of consumers to substitute a different brand of the same product.”

Competition between hospitals is assumed to discipline individual hospital behavior, while stricter individual standards are assumed to strengthen inter-hospital competition.


54 123 F.3d 301 (5th Cir. 1997).

55 Id. at 308 (quoting Continental T.V., Inc. v. GTE Sylvania Inc., 433 U.S. 36, 51 n.19 (1977)). While beyond the scope of this essay, it is useful to pause and ask what type of conditions would be necessary in practice to generate forms of inter-hospital competition that would fulfill the theoretical role suggested by the courts. Hospital markets are predominantly local and vary greatly in their level of competitiveness. Competition in many markets is relatively thin. What level of competition is necessary to achieve a result that might justify the judicial invocation of the vertical restraints reasoning articulated in Sylvania? Are there other sources of market discipline that can substitute for the absence of active inter-hospital competition? These are some of the questions that would have to be addressed if a more sophisticated analysis of “vertical” contracting practices were to be brought to bear in health care.
D. Composite: Judicial Agnosticism about Corporate Form and the Structure of Competition

Businesses, even hospitals, have a right to determine with whom they deal.\textsuperscript{56} Consistent with this laissez faire ethic is the belief that competition should determine the level of quality and range of services available on the market, not professionals per se, and not the courts.\textsuperscript{57} In \textit{Giampolo v. Somerset Hospital Center for Health},\textsuperscript{58} the hospital had originally extended the plaintiff neurologist a limited monopoly in the ability to interpret certain radiology procedures such as electroencephalography ("EMGs"). Subsequently, the hospital altered its policy to permit radiologists to also interpret those procedures, at the option of the treating physician. Plaintiff sued for alleged antitrust violations, arguing, among other things, that permitting radiologists to perform the interpretation would reduce the quality of such services. The court rejected the argument, reasoning that the original limitation was a restriction on the market, and that a free market would be the ultimate arbiter of who was in the best position to interpret various procedures, even if the end result was to have fewer procedures interpreted by neurologists. The court noted:

Yet even if the hospital's decision did reduce the overall level of care, it did so in a way that did not implicate antitrust concerns... By Giampolo's reasoning, a health insurer could injure competition simply by declining, for reasons of cost control, to reimburse for any given medical procedure. Simply put, a reduction in supply which diminishes competition implicates antitrust policy; a reduction in demand which puts downward pressure on physicians' incomes does not.\textsuperscript{59}

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\textsuperscript{56} Ford v. Stroup, No. 3:94-0544, 1996 U.S. Dist. LEXIS 21004, at *57-*58 (M.D. Tenn. Feb. 22, 1996) ("As a general rule, hospitals possess the right to determine with whom they will deal."); Blue Cross & Blue Shield United v. Marshfield Clinic, 65 F.3d 1406, 1413 (7th Cir. 1995) ("Hospitals are not public utilities, required to grant staff privileges to anyone with a medical license. The Marshfield Clinic's reputation for high quality implies selectivity in the granting of staff privileges at hospitals affiliated with the Clinic.").


\textsuperscript{59} Id. at *19-*20.
At issue in the older dealer termination cases was the question of when competition should take place and in what form. Should competition take place at the point of dealer-customer interaction (with efforts to maximize the intensity of inter-dealer rivalry), or should competition take place at a different point, such as the consumer's choice between brands, with rivalry taking place at the level of dealer competition with each other for the right to be an exclusive purveyor of a particular brand of product? In Sylvania and Business Electronics, the Court opted for inter-brand competition as the primary focus of antitrust law, and expressed a fair degree of agnosticism about how a manufacturer might structure its choice of intra-brand contractual restraints, or its strategies to rely upon varying degrees of intra-brand dealer competition to pursue its objectives.

Many of these issues are being rehashed in the medical context. In Collins v. Associated Pathologists, Ltd., plaintiff pathologist was terminated by defendant Associated Pathologists ("APL"), the exclusive pathology contractor at St. John's hospital, and was not extended staff privileges to continue practicing at the hospital. Plaintiff argued that the exclusive contract weakened competition between pathologists in the market and that active competition at the point where pathology services were demanded by patients would reduce the price of pathology services and would increase their quality. The court characterized the plaintiff's argument as follows:

[T]he exclusive agreements prevented patients at St. John's Hospital from having their pathology work done by anyone other than an APL doctor, and they prevented pathologists who were not APL members from offering his or her services at St. John's. The plaintiff contends that the exclusive agreements had an adverse effect upon competition in the area of pathology services, because competition among pathologists would result in lower prices and/or increased quality of pathology work done for St. John's patients.\(^6^1\)

This argument is very similar to claims made in dealer termination cases, which allege that increased competition at the retail level will lead to lower retail prices and/or improved retail services for customers.

\(^6^0\) 676 F. Supp. 1388 (C. D. Ill. 1987), aff'd, 844 F.2d 473 (7th Cir. 1988).

\(^6^1\) Id. at 1394-95.
The court in *Collins* rejected the plaintiff's argument. There are alternative ways to arrange competition, other than at the point of demand for individual pathology services. Competition can instead take place at the time that the exclusive contract is awarded or renewed.

The exclusive arrangement that APL has with St. John's Hospital was terminable by either party on 90 days notice, which suggests that St. John's can cancel the contract if another pathological service makes a better bid (in terms of prices and/or quality of services) to supply the package of pathological services which APL supplies. This approach indeed involves competition, not at the level of each individual lab test that must be performed for a patient, nor at the level of competition among individual pathologists for one or more job openings available at a hospital. This competition, rather, involves the right to provide the hospital with the entire package of pathological services which the Hospital (because of its patients) requires.\(^{62}\)

This redefined version of competition still affords patients with individual choice, but redefines the moment when that choice is exercised.

In the present case, even though the patients in St. John's Hospital do not have a choice of having doctors other than those from APL perform pathology work, they do have a choice prior to entering the hospital about which hospital they will enter, based upon factors such as price, quality, the type of services, and the staff members (including pathologists) of the hospitals in the relevant geographic market.\(^{63}\)

While not a hospital-physician exclusive contract case,

\(^{62}\) Id. at 1397. See also Dos Santos, 1983 U.S. Dist. LEXIS 12377, at *13 ("[The] exclusive anesthesiology contract between the Medical Center and Anesthesia Associates is the result of competition, not a restriction on competition. It is the result of a process of rivalry to be the hospital’s supplier of anesthesia services over a period of time."); Balaklaw v. Lovell, 14 F.3d 793 (2d Cir. 1994) (intensified physician competition for the exclusive contract itself improves quality and benefits patients).

\(^{63}\) *Collins*, 676 F. Supp. at 1404-05.
Ambroze v. Aetna Health Plans illustrates another parallel between health care and the antitrust laws governing vertical restraints. In Ambroze, physician anesthesiologists challenged aspects of their managed care contract that they argued interfered with their ability to provide quality care to their patients. The physicians' claims parallel those made by retailers and distributors asserting the right to establish the non-price terms of service free from manufacturer-imposed restraints. The court summarized the anesthesiologists’ argument as follows:

In plaintiffs’ view, “for physicians to compete effectively they must have the freedom to maximize the quality of patient care within the framework of current standards of medical care and medical necessity.” Because Aetna enrollees do not pay them directly for their services, Aetna physicians can only compete against each other on the basis of service. But competition among Aetna anesthesiologists is restrained, plaintiffs argue, because the effect of the Agreements is to undermine their independent, professional judgment regarding the nature and quality of services to offer enrollees. This is so because amendment and termination provisions in HMO contracts are the ultimate tools used by managed care companies to control physicians.

The court rejected the plaintiffs’ argument, although it did so by making an analogy to the managed care company’s role as an agent standing in the buyer’s shoes, rather than as a manufacturer asserting the right to establish intra-brand restraints upon its system of distribution.

The court argued that the managed care company was properly standing in the shoes of the patient, making price and quality decisions on the patient’s behalf. Relying upon the First Circuit’s decision in Kartell, the court held that establishing the standard of care would be left in the first instance to the economic exchange between the consumer and the managed care company itself. If that

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65 Ambroze, 1996 U.S. Dist. LEXIS 7274, at *14

market was incapable of safeguarding the patient’s interest, then recourse could be had to regulators or legislators. For antitrust purposes, however, physicians were disempowered from challenging the actions or decisions of the payor.

It is interesting to note how the same result in Ambroze could have been reached by application of the rules governing vertical restraints. In Albrecht v. Herald Co., the Supreme Court justified its per se rule against vertical maximum price fixing, in part, on the grounds that such prices could prevent dealers from providing their own levels of quality and non-price services in newspaper distribution. In reversing Albrecht’s per se approach, the Court in State Oil Co. v. Khan expressly privileged the manufacturer’s right to define the non-price dimensions of service over that of retailers and distributors. The rationale is the same as the basic intra-brand versus inter-brand logic motivating the Court in Sylvania.

The Albrecht Court also expressed the concern that maximum prices may be set too low for dealers to offer consumers essential or desired services. But such conduct,

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67 Ambroze, 1996 U.S. Dist. LEXIS 7274, at *21-*22 (citing Kartell, 749 F.2d at 929 n.7).

68 Upon remand from the Second Circuit, the district court considered and rejected the plaintiffs' amended complaint. The court made even more express its contention that hospitals and insurance companies function as appropriate surrogates for patients in these transactions:

In the instant case, the Hospitals and Aetna were jointly acting on behalf of the patients to purchase services from the plaintiffs for those patients. For their part, doctors have chosen to associate themselves with particular hospitals, accepting attendant conditions and standards of employment, and rely on payments from insurance companies for their income. By selecting the Hospitals as the location for their surgery and Aetna as their insurance company, patients in effect place those institutions in the position of joint agents for the patient to bargain with the anesthesiologists on their behalf regarding the terms and price of care they will receive. Charging the Hospitals and Aetna with conspiracy misses the point that there is no prohibition in these circumstances against the buyer and seller having more than a single intermediary in their negotiations with each other.


70 Id. at 152-53.

by driving away customers, would seem likely to harm manufacturers as well as dealers and consumers, making it unlikely that a supplier would set such a price as a matter of business judgment.\(^{72}\)

If the manufacturer makes inappropriate or incorrect decisions, it will be punished by inter-brand competition in the marketplace. While physicians may lay claim to be in a better position to independently assess the quality concerns of their patients than either gas station owners or the sellers of newspapers, the court in *Ambroze* was just as willing to trust the functioning of markets to faithfully communicate consumer quality demands as was the Court in *State Oil*.

E. Composite: Dealer Boycotts – The Vertical Placeholder for Horizontal Conspiracies

Examining the problem of hospital exclusive contracting through the fabled lens of vertical restraints highlights how competition in health care is similar to competition in other markets, and suggests the propriety of evaluating the legality of such restraints pursuant to the rule of reason. This is not to suggest that hospital cases raise no legitimate anticompetitive concerns. Even within the realm of vertical non-price restraints, one is still concerned about the problem of vertical restraints facilitating collusion between manufacturers or masking horizontally driven dealer cartels.\(^{73}\) This fear is more legitimate in the hospital setting than it is in most settings of product manufacturing and distribution. There are two sets of related concerns. First, the hospital structure itself may not be sufficiently integrated to justify the assumption of unitary action on the part of the hospital vis a vis the physicians receiving an exclusive contract. This is simply a version of the *Copperweld* problem that often gets raised in hospital antitrust litigation. The absence of sufficient unity of purpose between the medical staff and the hospital or Board would invalidate the basic premise that the exclusive contract is the result of an action by a single independent entity. Second, even if the board is structurally independent, it is still possible that competitor-physicians could co-opt or improperly

\(^{72}\) *State Oil*, 522 U.S. at 17 (citations omitted).

\(^{73}\) *Business Electric*, 485 U.S. at 725-26 (limiting the antitrust concern justifying a *per se* rule against vertical price restraints to a concern over vertical agreements facilitating a manufacturer cartel or masking a horizontal dealer cartel).
influence the hospital’s decision making process. This problem has been acknowledged by some courts. Nevertheless, maintaining a vertical frame is still important. While concerns over physician led boycotts remain legitimate, they are likely to be the exception rather than the rule. As a result, they can be appropriately relegated to a secondary position and policed on a case-by-case basis under the rule of reason.

V. Looking Ahead: Health Care Contracting in the Future

Since the Supreme Court’s 1975 decision in Goldfarb, antitrust treatment of the professions has moved increasingly from status to contract. This might superficially appear to disadvantage physicians. While physicians can no longer claim special antitrust treatment as a matter of right, they can still exert substantial economic influence as to how health care markets and contracting practices will evolve. To date, hospital exclusive contracts have been limited primarily to hospital-based practices. In these arrangements, the hospital is typically the dominant party and there is often a fairly competitive labor market for physician services that can be regional if not national in scope. These types of practices are natural candidates for tighter integration. If one looks at non-hospital-based physician practices, however, the future of hospital physician contracting is much less clear. Making predictions in this area is dangerous. At early stages of managed care evolution, many people, including myself, were predicting the emergence of tightly integrated health plans. These plans, not unlike staff model HMOs, would combine the physician, hospital and payor function into a fairly seamless package. The more starry-eyed amongst us even predicted that these tightly integrated plans would begin to differentiate themselves in terms of practice style or allegiance to particular sets of clinical guidelines or practice protocols.

This did not happen. What emerged instead was the rapid

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74 See Collins, 676 F. Supp. at 1399 ("The court explained that because the M.D.s controlled the hospital’s admission decisions, the case was similar to the situation where a group of firms at one level of distribution, the doctors’ level, had used their existing relationship with a supplier to exclude their competitors from dealing with the supplier.") (citing Weiss v. York Hospital, 745 F.2d 786, 819-20 (3d Cir. 1984)). See also Oltz v. St. Peter’s Cmty. Hosp., 656 F. Supp. 760 (D. Mont. 1987) (upholding jury finding of an antitrust violation on the basis of evidence suggesting that the hospital board was pressured by physician anesthesiologist to adopt a policy banning nurse anesthetist from the facility).
growth of largely undifferentiated managed care plans. These plans were committed to loosely integrated, open networks of physicians that afforded consumers maximum choice of provider. Rather than tight integration, most physician groups contracted with multiple managed care plans. Managed care plans, in turn, seldom demanded any special allegiance from their providers. In this environment, very little plan differentiation took place.

There are a number of possible explanations for this pattern. Many economists would say this is simply evidence of what consumers want, a strong demand-driven preference for patient choice. There is substantial wisdom in this statement. Still, this preference for "choice" over the possible efficiencies of integration took place during a time of unprecedented national prosperity (at least for those Americans who enjoyed the benefits of employer-based health insurance), where sharper tradeoffs between costs and choice might be avoided. It remains to be seen if similar preferences will persist during an economic downturn. There are additional factors that have frustrated the causes of integration and differentiation. While antitrust treatment of the professions has largely shifted from status to contract, other areas of health law remain largely status-based. State regulatory structures are still premised on visions of uniformity and lock-step sameness. Moreover, the common law still approaches health care primarily through the lens of torts, with the imposition of unitary malpractice standards that constrain the type of contracting practices that would facilitate greater differentiation. If one believes that strong market forces have the power to move the common law, however, these are still fairly weak explanations for why stronger patterns of private ordering have not emerged in managed care markets.

One is left with something of a paradox. Coasian theories of the firm predict a fluid boundary between firms, contracts and markets. Nevertheless, all other things being equal, one would expect dominant patterns of contracting to emerge over time. They have not (or at least not yet). The work of people like Larry Casalino, Jamie Robinson and others has illustrated a great amount of experimentation leading mainly to patterns of herding and cycling, without the emergence of consistent patterns of private ordering.  

Within this disorder, there are lessons for health professionals. The private domain of contracts is highly contestable. There is no deterministic logic that hospitals must inevitably dominate physicians, or that payors will enslave providers. Indeed, the pattern in California was for physicians to merge into large multi-specialty groups and assume the lion’s share of managed care financial risk, even entering into sub-capitation agreements with hospitals. Many of these physician groups ultimately lost their shirts in the process, but the failure of their experiment against a backdrop of few clear successes need not be judged too harshly. An important object lesson remains. The physician, hospital and payor pieces of the health care firm can be put together in many different combinations, with ultimate success being determined by success in the market. The future is still very much up for grabs.

This being said, is it useful to view doctors as distributors? The move from status-based professional distinctions in antitrust law to a focus on the efficiency of contracting practices started with Goldfarb and continues in the hospital exclusive contracting cases of today. The “vertical” frame suggested by the composite of cases created in this essay is useful not because doctors are no different from distributors, or because all such vertical restraints should be upheld under the rule of reason, or even because it is particularly meaningful or accurate to classify relations in health care as being “vertical” in nature. Rather, the vertical frame is useful because it helps courts focus on the correct question: what is the economic rationale underlying the hospital-physician contractual relationship. Once the correct question is acknowledged, however, there is actually very little in the vertical label that provides insight into the correct answer.

In the future, antitrust courts are likely to see more complicated forms of hospital-physician contracting. The competitive effects of these arrangements will be harder to assess than the exclusive contracting cases of the past. Ideally, this would be viewed


77 Id.
as an opportunity, not an obstacle. The opportunity would be to start developing the tools necessary to identify and articulate the economic benefits and possible competitive threats of complicated forms of professional contracting. Therefore, it is important that the comparison between doctors and distributors not be used as an occasion to let legal categorization drive legal analysis. Health care and other professional markets are complicated, but it is a complexity that we can learn to live with and strive to understand. In the process, antitrust courts might even start pouring greater analytic content into the fabled law of vertical restraints than currently exists.