COMMENT

Patient Coercion by Hospitals: A Comparison of Antitrust Standards in *Hyde* and *Rumple*

INTRODUCTION

This Comment concerns the potential impact of the Supreme Court's decision in *Jefferson Parish Hospital District No. 2 v. Hyde*[1] on the Indiana case of *Rumple v. Bloomington Hospital*,[2] with respect to the Supreme Court's analysis of tying arrangements[3] between hospitals and health care professionals. The issue reflects a recent and growing trend in the application of antitrust law to the health care industry. Because the Indiana antitrust statute is patterned after the federal antitrust statute, the standards and tests set forth by the federal courts are particularly applicable to Indiana cases. Further, the Supreme Court decisions will affect the policies of hospitals and other health care institutions in the state.

This Comment initially considers the health care industry and the application of the antitrust laws to the industry. Against this background, the tests enunciated by the Supreme Court in *Hyde* are applied to the hospital policy in *Rumple* for an analysis of the tying arrangement. As a result of the analysis, this Comment proposes less restrictive alternative policies for the hospital and concludes that the factual situation, as presented in *Rumple*, should be deemed an illegal tying arrangement under the standards of *Hyde*.

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1. 104 S. Ct. 1551 (1984).

2. 422 N.E.2d 1309 (Ind. Ct. App. 1981), *transfer denied*, 429 N.E.2d 214 (Ind. 1981).

3. The tying arrangement must include four elements to sustain an antitrust violation: (1) two separate products (tying product and tied product) must be present; (2) the seller must have sufficient market power in the tying product to coerce purchase of the tied product; (3) a not insubstantial amount of interstate commerce must be involved; and (4) anticompetitive effects in the market must be shown. Bob Maxfield, Inc. v. A.M.C., 637 F.2d 1033, 1037 (5th Cir. 1981). *See* United States Steel Corp. v. Fortner Enters., 429 U.S. 610 (1977); Fortner Enters. v. United States Steel Corp., 394 U.S. 495 (1969); Northern Pac. Ry. v. United States, 356 U.S. 1 (1958).

The Supreme Court in Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738 (1976), largely eliminated the interstate commerce defense as a mechanism for health care providers to avoid antitrust scrutiny. The third requirement does not warrant further discussion in the text. The Court held that the requisite substantial impact on interstate commerce could be based upon a hospital's receipt of Medicare and Medicaid reimbursement. Any hospital receiving such reimbursement payments would have the nexus required for the application of the Sherman Act. *See* Rich, *Medical Staff Privileges and the Antitrust Laws*, 2 WHITTIER L. REV. 667, 674 (1980); Note, *Antitrust—Implied Repeal of the Antitrust Laws by the National Health Planning Act*, 56 TUL. L. REV. 749, 752 (1982) [hereinafter cited as Note, *Antitrust—Implied Repeal*].

I. Background

The health care industry is big business, accounting for 10.5% of the 1982 gross national product.[4] National health expenditures in 1981 reached almost $300 billion[5] and recent projections suggest that by 1990 $750 billion will be spent on health care annually.[6] The health care industry is reportedly the country's second largest employer.[7] Both the rapid rise in the cost of medical care [8] and the growth of the health care industry have led to increasing antitrust scrutiny. Most antitrust challenges in the health care industry are brought under section one of the Sherman Act.[9] Since Indiana's antitrust statute[10] is patterned after the Sherman Act, state courts must consider decisional law under the Act in construing the Indiana statutes.[11]

For several years, the medical and legal professions maintained that their practice was a public service and not a "trade" within the language of the Sherman Act. The professions claimed to be exempt from the statute as a result of this interpretation. To support the exemption argument, the professions relied upon the dicta in several cases where the Supreme Court distin-

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4. Pankau, *Health Law: How Should Medical Care Be Provided?*, 58 FLA. B. 135 (1984).

5. Weller, *The Primacy of Standard Antitrust Analysis in Health Care*, 14 TOLEDO L. REV. 609 n.1 (1983).

6. Halper, *The Health Care Industry and the Antitrust Laws: Collision Course?*, 49 ANTITRUST L.J. 17, 18 n.5 (1981).

7. *Id.* at 18.

8. The cost-reimbursement system has been blamed for the rising costs. *See* Waxman, *Keynote Address: National Concerns for the Future of Health Care*, 2 WHITTIER L. REV. 635 (1980); Wood, *The Chairman's Corner*, HEALTH LAW., Fall 1983, at 2. "The natural incentives of these payment programs have been characterized by an absence of negative constraints on intermediate products by the patient population." *Id.* at 2. The lack of cost control incentive has resulted in excessive and unnecessary tests and procedures. *See, e.g.*, Rumple v. Bloomington Hosp., 422 N.E.2d 1309 (Ind. Ct. App. 1981). This inefficiency has led to higher overall consumer costs. Note, *Health Law—The Conflict with Antitrust Law—* National Gerimedical Hospital & Gerontology Center v. Blue Cross of Kansas City, 18 WAKE FOREST L. REV. 591 n.1 (1982) [hereinafter cited as *Health Law—The Conflict*]. However, a DRG (diagnosis related groups) reimbursement system for Medicare hospitalization costs could have a major impact on cost control efforts. The limit on reimbursement creates an incentive to hold down unnecessary expense by eliminating superfluous tests and lengthy hospitalizations. Ward, *Washington Watch*, 26 RES GESTAE 554 (1983).

9. *See* 15 U.S.C. §§ 1-7 (1982). The purpose of the Sherman Act is "to prevent and control combinations made with the view to prevent competition, or for the restraint of trade, or to increase the profits of the producer at the cost of the consumer." Speech by Senator Sherman before the United States Senate (Mar. 21, 1890). Section 1 of the Sherman Act declares illegal any "contract, combination,. . . or conspiracy, in restraint of trade or commerce. . . ." 15 U.S.C. § 1 (1982). Section 2 of the Act prohibits monopolization or attempts to monopolize a relevant area of commerce. 15 U.S.C. § 2 (1982).

10. In pertinent part, IND. CODE § 24-1-2-1 (1982) provides: "Every scheme, contract, or combination in restraint of trade or commerce. . . is illegal . . . ."

11. Photovest Corp. v. Fotomat Corp., 606 F.2d 704 (7th Cir.), *cert. denied*, 445 U.S. 917 (1979); Orion's Belt, Inc. v. Kayser-Roth Corp., 433 F. Supp. 301 (S.D. Ind. 1977).

guished a "profession" from a "trade" as used under Sherman section 1.[12] Giving due consideration to the dicta, the federal courts formulated a "learned professions" exemption.

The virtual absence of antitrust enforcement in the health care field[13] substantially contributed to the illusion that special treatment of the profession was warranted.[14] In fact, immunity from antitrust laws is not generally favored,[15] and public policy dictates a narrow construction of antitrust law exemptions.[16] The Supreme Court follows public policy by narrowly construing the learned professions exemption[17] and, as a result, continues to scrutinize the health care industry under antitrust law.[18]

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12. People v. Roth: *Should Physicians Be Exempt from New York Antitrust Law?*, 2 PACE L. REV. 273, 275 n.20 (1982) [hereinafter cited as *New York Antitrust Law*].

13. *But see* American Medical Ass'n v. United States, 317 U.S. 519 (1943) (in which the Supreme Court did not accord doctors special treatment in antitrust analysis, rather they affirmed the conviction of the AMA for suppressing competition).

14. Weller, *supra* note 5, at 613.

15. Note, *Antitrust—Implied Repeal, supra* note 3, at 754.

16. St. Paul Fire & Marine Ins. Co. v. Berry, 438 U.S. 531, 551-52 (1978). *See* Note, *Antitrust—McCarran Act*, 49 GEO. WASH. L. REV. 426, 431-32 n.43 (1983).

17. *See* Goldfarb v. Virginia State Bar, 421 U.S. 773, 787 (1975) (holding that the "nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act" and that the "public-service aspect of professional practice" is not determinative of the coverage of the antitrust law); National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 688 (1978) (dismissing the hope provided by footnote 17 of the *Goldfarb* case that the learned professions would be treated differently due to the public service nature of the professions. The Court held that the "central principle of antitrust analysis" nevertheless remains the same for the professions: unreasonable restraints of trade are illegal, and the focus of the question of "reasonableness" must be upon the "restraint's impact on competitive conditions," not upon professional policies which the restraint may help to promote).

The Fourth Circuit Court of Appeals has also been particularly active in applying antitrust analysis to the health care profession. In Ballard v. Blue Shield of S.W. Va., 543 F.2d 1075 (4th Cir. 1976), the court applied *Goldfarb* to the medical profession by ruling that the professional status of doctors alone did not exempt them from the Sherman Act. In Virginia Academy of Clinical Psychologists v. Blue Shield of Va., 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981), the court, relying on *Professional Eng'rs* declaration that "it is not the function of a group of professionals to decide that competition is not beneficial in their line of work," 435 U.S. at 690, held that anticompetitive conduct is not to be condoned "upon an incantation of 'good medical practice.' " 624 F.2d at 485.

18. National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City, 452 U.S. 378 (1981). The National Health Planning and Resources Development Act did not "create a 'pervasive' repeal of the antitrust laws as applied to every action in response to the health-care planning process." *Id.* at 393. *But see id.* at 393 n.18 (where the Court again limits the holding to "not foreclose future claims of antitrust immunity in other factual contexts"). The National Health Planning and Resources Development Act is found at 88 Stat. 2225 (codified as amended at 42 U.S.C. § 300k (1982)). The goal of the NHPRDA is "the strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve . . . to advance the purposes of quality assurance, cost effectiveness, and access." 42 U.S.C. § 300k-2(a)(17) 11 (1982).

For other sources scruntinizing the health care industry under antitrust law see Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551 (1984) (applied antitrust principles to an exclusive contract between the hospital and an anesthesiologists' group in the context of a tying arrangement); Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982) (application

II. Special Features of the Health Care Industry

The primary objectives of the health care industry are to provide quality care and to encourage the containment of otherwise exorbitant costs.[19] Critics charge that the health care system is "inflationary, and rewards waste, inefficiency, duplication of services [and] overutilization."[20] One explanation is that the economic structure of the health care industry operates in a dysfunctional market.[21] The supply and demand for health care services are artificial.[22] Price competition among physicians, hospitals and other providers is the crucial missing link in the market structure.[23] Competition among doctors, if any, is based on quality.[24] No price competition exists among hospitals because the patient delegates to the physician the authority to determine the patient demand for medical service and limits the provider of the services to the hospital where the physician has staff privileges.[25]

Reasoning that competition in the atypical health care market may not have the same effect as in other commercial markets,[26] two commentators argue that the health care industry should be accorded special antitrust standards.[27] In fact, a congressional report concluded that the "health care industry does not respond to classic market place forces."[28] The Supreme Court in *Arizona v. Maricopa County Medical Society,* however, held that the argument that "the health care industry was . . . far removed from the competitive model" did not justify unique antitrust rules.[29]

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of the *per se* rule to price fixing in the health care industry); Weller, *supra* note 5, at 615. *But see* Halper, Hospital Medical Staff Cases Under the Antitrust Laws: A Status Report 1, 4 (Feb. 2, 1984) (Paper presented at the A.B.A. Joint Program on Competition, Economic Change and Antitrust Issues in the Health Care Industry available from the A.B.A).

19. Halper, *supra* note 6, at 19.

20. Merriman, *Private Initiatives and Concerns in Health Care Cost Containment,* HEALTH LAW., Fall 1983, at 6.

21. Note, *Health Law—The Conflict, supra* note 8, at 597.

22. Shapiro, *Cost, Containment in the Health Care Field and the Antitrust Laws,* 7 AM. J.L. & MED. 425, 434 (1982).

23. Weller, *supra* note 5, at 619.

24. Norris & Szabo, *Communication Between the Antitrust and the Health Law Bars: Appeals for More Effective Dialogue and a New Rule of Reason,* 7 AM. J.L. MED. iii (1982).

25. Waxman, *supra* note 8, at 637; *see* Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346, 1355 (7th Cir. 1982).

26. Some aspects of competition in the health care market will lead to an increase in hospital charges. For example, proprietary hospitals want to compete, but only to maximize profits, not to maintain costs. Note, *Health Law—The Conflict, supra* note 8, at 608 n.148.

27. *See Hyde,* 686 F.2d 286; Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738 (1976).

28. S. REP. No. 1285, 93d Cong., 2d Sess. 4, *reprinted in* 1974 U.S. CODE CONG. & AD. NEWS 7842, 7878.

29. Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 350 (1982).

III. Antitrust Law Application to the Health Care Industry

The courts uniformly have employed two basic analyses,[30] the per se rule and the rule of reason, in determining whether the Sherman Act has been violated.[31] In *Northern Pacific Railway Co. v. United States*[32] the Supreme Court explained the per se violation:

> [T]here are certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use . . . . Among the practices which the courts have heretofore deemed to be unlawful in and of themselves are price fixing; division of markets; group boycotts; and *tying arrangements.*[33]

A tying arrangement is defined as "an agreement by a party to sell one [tying] product but only on the condition that the buyer also purchases a different [tied] product . . . ."[34] Although the Court announced a strict per se treatment of tying arrangements, consideration of market power and amount of commerce, plus recognition of some defenses, transform the rule against tying into a "near" per se rule.[35] The Court, by a bare majority, continues to hold the "near" per se rule applicable to tying arrangements.[36]

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30. In Veizaga v. National Bd. for Respiratory Therapy, 1977 Trade Cas. (CCH) ¶ 61,274 (N.D. Ill. 1977), the court suggests a two-step analysis involving, first, a determination whether the challenged activity, by its nature and character, is "commercial," and second a determination of the appropriate approach. If the activity is commercial, a per se approach may be taken. If it is noncommercial, the rule of reason should apply. Halper, *supra* note 6, at 28.

31. Justice Brandeis in Chicago Bd. of Trade v. United States, 246 U.S. 231, 238 (1918), provided the classic statement on the rule of reason standard:

> The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and predict consequences.

32. 356 U.S. 1 (1958).

33. *Id.* at 5 (emphasis added).

34. *Id.*

35. Comment, *The Single Product Issue in Recent Tying Litigation,* 1980 Ariz. St. L.J. 871, 872.

36. Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551 (1984). Justices Stevens, Black, and White in the opinion of the Court and Justices Brennan and Marshall in their concurrence, adhere to the precedent that "tying arrangements are subject to evaluation for *per se* illegality under § 1 of the Sherman Act." *Id.* at 1569. While concurring in the judgment of the Court, Justices O'Conner, Powell, and Rehnquist and Chief Justice Burger argue that the *per se* rule should be abandoned in favor of the rule of reason. *Id.* at 1569 (O'Connor, J., concurring).

In *Jefferson Parish Hospital v. Hyde,* the Court presents the issue as a two-step analysis. The first step is to consider whether the exclusive contract gives rise to a per se violation of section 1 of the Sherman Act. If not, the second step is to determine whether the contract is nevertheless illegal because it unreasonably restrains competition.[37] The second step, the rule of reason, has been applied to the health care field in order to consider the substantial benefit and pro-competitive justifications.[38]

Hyde is the most recent Supreme Court case applying the antitrust laws to tying arrangements between health care professionals and hospitals. The case involved Hyde, a board-certified anesthesiologist, who applied for admission to the medical staff of East Jefferson Hospital. The credentials committee and the medical staff executive committee recommended approval, but the hospital board denied the application because the hospital was a party to a contract providing that all required anesthesiological services be performed by one specific firm of anesthesiologists. Hyde then commenced an action seeking a declaratory judgment that the contract was unlawful and further sought an injunction ordering the hospital to appoint him to the hospital staff. The district court denied relief, finding under a rule of reason analysis that the anti-competitive consequences of the contract were minimal and were outweighed by benefits of improved patient care.[39] The Fifth Circuit Court of Appeals reversed, holding that the hospital had sufficient market power in the tying product, (its operating rooms), to coerce the purchase of the tied product, (anesthesiological services); therefore, its exclusive contract with the professional medical corporation was rendered an illegal tying arrangement under a per se analysis.[40] The Supreme Court reversed, holding that the record contained no evidence that the hospital forced any services on unwilling patients and therefore did not give rise to a per se violation.[41] The Court further held that there was insufficient evidence to prove an unreasonable restraint of competition.[42]

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37. *Id.* at 1554.

38. *See, e.g.,* Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982); Stone v. William Beaumont Hosp., 1983-2 Trade Cas. (CCH) ¶ 54,681 (E.D. Mich. 1983); McElhinney v. Medical Protective Co., 549 F. Supp. 121 (E.D. Ky. 1982); Smith v. Northern Michigan Hosps., 518 F. Supp. 644 (W.D. Mich. 1981). The dissent in *Maricopa* argued that "the *per se* label should not be assigned without carefully considering substantial benefits and procompetitive justifications". Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 364 (1982) (Powell, J., dissenting). *See also* Tripoli Co. v. Wella Corp., 425 F.2d 932 (3d Cir.), *cert. denied,* 400 U.S. 831 (1970) (quality of care justifications in health care, as in other areas of antitrust law, may help avoid *per se* treatment).

39. 513 F. Supp. 532 (E.D. La. 1981).

40. 686 F.2d 286 (5th Cir. 1982).

41. 104 S. Ct. at 1567.

42. *Id.* at 1568. There was no evidence that the price, quality or supply or demand for either the tying product or the tied product had been adversely affected by the exclusive contract, and no showing that the market as a whole had been affected at all by the contract.

Rumple v. Bloomington Hospital[43] is the leading Indiana case in the construction and application of the Indiana antitrust statute to such tying arrangements. Rumple was injured in an accident and was taken to Bloomington Hospital for x-rays and treatment. Dr. Doster examined x-rays of his wrist, reduced the fracture, and placed the wrist in a cast. Dr. Hammer, a radiologist, reviewed the x-rays that evening, after Rumple had gone home, and made an official interpretation confirming Dr. Doster's diagnosis. The review of the x-rays by Dr. Hammer was done pursuant to Bloomington Hospital's policy that each x-ray taken must be interpreted by a radiologist. All radiologists practicing at the hospital were members of the Southern Indiana Radiological Association (SIRA), a medical corporation. Radiologists do not order x-rays to be taken, but rather interpret x-rays ordered by other physicians. Accordingly, SIRA billed Rumple for Dr. Hammer's interpretation of the wrist x-rays. Rumple refused to pay the bill and sought a declaratory judgment of nonliability for payment. The court held that Bloomington Hospital's policy requiring the interpretation of x-rays by a radiologist was reasonable.[44] It also held that SIRA did not maintain a monopoly on the interpretation of x-rays at Bloomington Hospital.[45] In affirming the lower court's decision, the Indiana Court of Appeals found no violation of Indiana's antitrust statute. The hospital's policy, according to the court of appeals, did not establish an illegal monopoly, and the relationship between the hospital and the association was not an illegal tying arrangement.[46] The Indiana Supreme Court denied petition to transfer.[47]

The hospital policy, requiring that, in addition to the interpretation of the attending physician, there must be an official interpretation by a radiologist of all x-rays,[48] forces the patient to buy services he might not otherwise purchase. This appears to be an example of a classic tying arrangement. The hospital agrees to sell the tying product (the x-rays and reading by the physician), only on the condition that the patient purchase the tied product (reading of the x-rays by the radiologist). This policy results in higher, often unnecessary, costs to the patient. It also forces the patient to purchase the radiologist's additional interpretation of the x-ray in order to receive the medical treatment at the hospital.[49]

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43. 422 N.E.2d 1309 (Ind. Ct. App.), *transfer denied,* 429 N.E.2d 214 (Ind. 1981).
44. 422 N.E.2d at 1311.
45. *Id.*
46. 422 N.E.2d at 1309.
47. 429 N.E.2d 214.
48. 422 N.E.2d at 1318.
49. For a more detailed analysis of the harms of tying arrangements, see *infra* notes 69-87 and accompanying text.

IV. Application of *Hyde* to *Rumple*

The existence of a tying arrangement is determined by characterizing the transaction as involving dual products and attributing economic power to the seller. If the transaction is defined as involving a single product, then by definition, no tying has occurred and the analysis stops. If the transaction is defined as involving dual products, then the analysis continues to determine the economic power of the seller. This power must be shown in order to establish the coercion of the consumer.

A. Two Products

The characterization of the transaction as single or dual products is a threshold question which can determine the outcome of the litigation. This determination is particularly difficult in the health care industry since the provider market is fragmented.[50] The hospital's position is that only one product, a functionally integrated package of services, is provided.[51] This single product embraces everything that occurs in the hospital from the arrival of a patient until he leaves. The services by subspecialists, such as radiologists, pathologists, and surgeons are also included in this package of services. The patient's contrary position is that two products exist: the hospital's services and the subspecialists' services.

The Supreme Court in *Hyde* utilized the test provided in *United States v. Jerrold Electronics Corp.*[52] The *Jerrold* test examines market practices to

50. *See* Weller, *supra* note 5, at 620; Payton, A Theory and Model of Non-Price Competition Among Hospitals 5 (Feb. 3, 1984) (Paper presented at the A.B.A. Joint Program on Competition, Economic Change and Antitrust Issues in the Health Care Industry available from the A.B.A.). "Although doctors and hospitals produce complementary products and are functionally integrated, they are not economically integrated; nor do they function quite, or only, as buyers and sellers of services to one another. . . . Since doctors function as purchasing agents for patients, from the hospital's point of view the doctor is both labor and consumer." *Id.*

51. *See* Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551, 1561 n.27 (1984) (Physical facilities include operating room, the recovery room, and the hospital room where the patient stays before and after the operation. The services include those provided by staff physicians, such as radiologists or pathologists, and interns, nurses, dietitians, pharmacist and laboratory technicians); McElhinney v. Medical Protcctive Co., 549 F. Supp. 121 (E.D. Ky. 1982) (the product market was the furnishing of medical services and supplies by the hospital and the individual doctors as a joint venture); Panaro v. Palm Beach-Martin County Medical Center, No. 82-539 CA(L) 01 G (Palm Beach Cir. Ct. July 11, 1983) (a single product, including hospital and operating rooms, equipment, medical services, nurses and other ancillary health services, was provided by the hospital). *But see Hyde,* 104 S. Ct. at 1562 n.30 (where the Court cites to several examples of cases where arrangements involving functionally linked products were found to be tying devices).

52. 187 F. Supp. 545 (E.D. Pa. 1960), *aff'd per curiam,* 365 U.S. 567 (1961). The court in *Jerrold Electronics* stated:

> There are several facts presented in this record which tend to show that a com-

determine the existence of either single or dual products. The test instructs a court to first compare the practices of competitors offering similar products, either singly or in a package, to the challenged transaction. If competitors also offer similar products only in a package, the Court favors a single product determination. The test requires that a court then inspect the variation of components within the packages offered. If the same components are always offered in the packages, the provider is considered to offer a single product. The test further requires a court to audit the method of billing the purchaser, either by component or by entire package. If the purchaser is billed for the entire package, the result is a single product. Finally, the test instructs a court to investigate the extent to which the provider offered the component separately for sale. If the components are only sold in a package and not by themselves, a single product exists.[53]

The *Hyde* Court found that two products existed. The Court's conclusion was based on application of the *Jerrold* analysis. First, other hospitals permitted separate purchase of anesthesiological services, indicating an industry practice contrary to that of the defendant hospital. Second, the services provided by individual anesthesiologists were not exactly the same. The variation removed the services from the single product category. Third, the anesthesiological services were billed separately from the other hospital services indicating a separate charge for each of the two products. Finally, the hospital required that all purchases of anesthesiological services be from one firm, although other anesthesiologists were available to perform the same services.[54]

In *Rumple*, the issue confronting the Indiana Supreme Court should have been whether the hospital policy requiring a radiologist to read all x-rays constituted single or dual products. The hospital asserted that the x-ray and its interpretation constituted one product.[55] The patient's position, the correct one under the *Jerrold* test, was that the tying product consisted of the x-ray and its interprctation by the attending physician while the separate tied product was the second required x-ray interpretation by the radiologist.

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munity television antenna system cannot properly be characterized as a single product. Others who entered the community antenna field offered all of the equipment necessary for a complete system, but none of them sold their gear exclusively as a single package as did Jerrold. The record also establishes that the number of pieces in each system varied considerably so that hardly any two versions of the alleged product were the same. Furthermore, the customer was charged for each item of equipment and not a lump sum for the total system. Finally, while Jerrold had cable and antennas to sell which were manufacturered by other concerns, it only required that the electronic equipment in the system be bought from it.

187 F. Supp. at 559.

53. Comment, *supra* note 35, at 879.

54. 104 S. Ct. at 1564 n.39.

55. 422 N.E.2d at 1314.

If a court finds affirmative answers to the questions of whether the policy requiring separate purchase of a radiologist's interpretation of x-rays is unique to the individual hospital and contrary to the general practice of Indiana hospitals; and whether the hospital sent a bill for the service of taking the x-ray and its interpretation by the attending physician, while the radiologist sent another, separate bill for the additional interpretation of x-rays, then the courts should give serious consideration to the existence of dual products and the possibility of a tying arrangement.[56]

B. *Economic Power*

Another essential element of a tying offense is that the seller possesses "appreciable economic power" in the market for the tying product.[57] The Supreme Court in *United States Steel Corp. v. Fortner Enterprises (Fortner II)* framed the inquiry as:

> Whether the seller has the power within the market for the tying product, to raise prices or *to require purchasers to accept burdensome terms that could not be exacted in a completely competitive market.* In short, the question is whether the seller has some advantage not shared by his competitors in the market for the tying product.[58]

The proper inquiry is whether the hospital has the power to force the patient to accept the tying product.

The essential query within the relevant market is whether the patient is the real purchaser of the ancillary medical services.[59] The hospital regards itself as the purchaser in view of its responsibility for assuring the availability of such services for patients and its potential liability for negligent rendition of such services in the hospital. The hospital further claims that while the patient receives the services, he does so without making any significant

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56. Given the factual context of *Rumple,* the courts might also want to consider whether the radiologist considers his services as separate from those provided by the hospital; whether the physician views the interpretation by the radiologist as an additional procedure; and whether the patient receives treatment before the interpretation by the radiologist, making it an unnecessary procedure.

57. United States Steel Corp. v. Fortner Enters., 429 U.S. 610 (1977). *See also* Note, *Hospital Shared Purchasing Agreements After* White & White Inc. v. American Hospital Supply Corp., 14 Loy. U. Chi. L.J. 305, 323 (1983) [hereinafter cited as *Hospital Shared Purchasing*].

58. *Hyde,* 686 F.2d at 290 (quoting *Fortner II,* 429 U.S. at 620-21) (emphasis added).

59. There is a split among the courts as to whether the patient or the provider is the buyer. For cases holding that the patient is the buyer, see Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981); Bartholomew v. Virginia Chiropractics Ass'n, 612 F.2d 812 (4th Cir. 1979), *cert. denied,* 446 U.S. 938 (1980). For cases holding that the provider is the buyer, see *Hyde,* 686 F.2d 286; Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982); United States v. American Soc'y of Anesthesiologists, Inc., 473 F. Supp. 147 (S.D.N.Y. 1979). The characterization of the economic relationships could alter the definition of the relevant market. *See, e.g.,* Twin City Sports Serv., Inc. v. Charles O. Finley & Co., 676 F.2d 1291 (9th Cir. 1982).

economic decision.[60] If the hospital is the purchaser of the radiological association's services, the purchase would be characterized as a vertical integration of services, rather than as a tying arrangement.[61] The correct analysis, however, is that the patient, as ultimate consumer, is the purchaser of the hospital and radiological services. Specifically, the patient is responsible for paying the bill, either through an insurer or out-of-pocket.[62]

An example of a consent form indicated that the hospital and physicians disclaim being the purchasers of radiological services, and place the patient in the position of purchaser. The typical consent form provides: "I understand that the . . . person or persons performing services involving pathology and radiology are not the agents, servants or employees of Bloomington Hospital nor of any surgeon, but are independent contractors and as such are the agents, servants, or employees of myself [patient]."[63] While the consent form was designed to avoid tort liability of the hospital and referral physicians for negligence on the part of subspecialists, in fact it also serves as an admission that the patient is the purchaser of such services.[64]

A clearer understanding of the patient as purchaser is gained by analogizing the pattern of consumption of medical services to car repairs. When a car needs servicing, an owner takes it to a repair shop. When a body is in need of repair the person goes to a hospital. A mechanic examines the car and indicates the repairs that must be made. A doctor likewise examines the patient and recommends a course of treatment. The mechanic serves as the car owner's agent in acquiring the necessary parts to repair the car. The physician functions as the agent for the patient in selecting medical subspecialists.[65] The car owner is the ultimate purchaser of the parts. Regardless of whether the mechanic has the parts on hand or must purchase them from a supplier, the owner views the repair shop as the seller of the service of repairing his car. The same view is true of the medical services provided by

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60. *Dos Santos,* 684 F.2d at 1354 (The patient does not make economic decisions because the doctor selects subspecialists and insurance pays the bill). *See* Note, *Federal Antitrust Law and Hospital Closed Staffs Through Exclusive Contracts: Will the Supreme Court Provide the Necessary Legal Guidance in Deciding* Jefferson Parrish Hospital District No. 2 v. Hyde?, 28 ST. LOUIS U.L.J. 511, 523-26 (1984) (policy discussion of hospital as purchaser distinguishing between ultimate consumer and primary consumer).

61. *See Hyde,* 104 S. Ct. at 1561; Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738 (1976). "If the product market is defined as the market for anesthesia services to a hospital, then there has been no tying, as the provider of services, here the physician group, has not conditioned the provision of the services on the hospital's acceptance of a tied product." Bates, *Exclusive Arrangements for In-Hospital Professional Services: Does Hyde Mark a Watershed?,* 14 U. TOL. L. REV. 639, 650 (1983).

62. *American Soc'y of Anesthesiologists,* 473 F. Supp. at 150-51.

63. Rumple v. Bloomington Hosp., 422 N.E.2d 1309, 1312 (Ind. Ct. App. 1981).

64. The language of the consent form also serves as evidence that the radiological services are a separate and distinct product from the services provided by the hospital in taking the x-rays and the attending physician in reading the x-rays.

65. Payton, *supra* note 50, at 5.

the hospital. The patient, as purchaser, pays the hospital for the medical services received and views the hospital as the seller of such services.

If a court finds the patient to be the real purchaser of medical services, the second level of inquiry is whether the hospital has market power. The hospital would be deemed to have sufficient market power if, within the market for the tying product (the x-rays and reading by the physician), the hospital requires the patient to accept the burdensome terms of the tied product (the reading of the x-rays by the radiologist), when a similar requirement could not be exacted in a completely competitive market. The *Hyde* decision provides no guidance in determining market power. While the court indicated that the existence of market imperfections[66] was insufficient to "generate the kind of market power that justifies condemnation of tying,"[67] such power might be inferred if the patient does not have the option of going to a competing hospital to avoid the tie. A patient, however, might not have the option of going to a different hospital if the policy is widespread; if the community in which the patient resides has only one hospital; or if an emergency requires care at the nearest hospital. This market-share analysis of a seller has been adopted by the Supreme Court to establish sufficient market power.[68]

Once a tying arrangement is said to exist, the court must decide if it is illegal. This decision requires an examination of the harms caused by the tying arrangement. Under the near per se rule, the court will balance these harms against the justifications given for the policy.

C. *The Nature of the Coercion*

There are two evils[69] inherent in a tying arrangement. First, the market forecloses competitors who, as a result, are denied access to customers in the tied product market.[70] Second, the buyer's free choice is pre-

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66. *See Hyde,* 686 F.2d 286 (The prevalence of third party payors in system; patients lack incentive to comparison shop; patients lack information about services they purchase; and patients choose hospitals by location, rather than by chance to avoid extra charges).

67. *Hyde,* 104 S. Ct. at 1566.

68. *See* United States v. Connecticut Nat'l Bank, 418 U.S. 656 (1974); United States v. DuPont & Co., 351 U.S. 377 (1956); Times-Picayune Publishing Co. v. United States, 345 U.S. 594 (1953).

69. The Chicago School views tying arrangements as nonproblems, arguing if one tries to prevent such arrangements, the hospital will be able to raise their prices due to their market power. The Chicago School concludes that the manner of exploitation is irrelevant. *See* R. POSNER, ANTITRUST LAW: AN ECONOMIC PROSPECTIVE 171-84 (1976); R. BORK, THE ANTITRUST PARADOX 365-81 (1978).

70. *Hyde,* 104 S. Ct. at 1568 n.51; International Salt Co. v. United States, 332 U.S. 392, 396 (1942): United States v. Loew's Inc., 371 U.S. 38, 45 (1962). Exclusive contracts between hospitals and subspecialists provide an opportunity for tying. The exclusive contract provides that only physicians who are parties to the contracts may be granted clinical privileges in a

cluded.[71] Both evils exist in the health care industry. The tying arrangement constitutes an unreasonable restraint on competition since it prevents other subspecialists[72] from entering that part of the service market controlled by the hospital. This artificially lowers the supply of subspecialists in the area and reduces the incentive for improving or initiating techniques or procedures.[73] More importantly, the tie eliminates the patient's choice of medical services at the hospital. This violates the goal of antitrust law, which is to allow the consumer to make buying decisions without being subject to economic coercion.[74]

In *Hyde,* the Court emphasized the importance of the coercion element:

> [T]he essential characteristic of an invalid tying arrangement lies in the seller's exploitation of its control over the tying product to force the buyer into the purchase of a tied product that the buyer either did not want at all, or might have preferred to purchase elsewhere on different terms . . . .[[75]] By conditioning his sale of one commodity on the purchase of another, a seller coerces the abdication of buyers' independent judgment as to the 'tied' product's merits and insulates it from the competitive stresses of the open market.[76]

The Court dismissed the idea that packaged sales are inherently anticompetitive. The arrangement must force the patient to purchase services as a

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given speciality. Walbot & Panaku, *Antitrust, Public Health-Care Institutions, and the Developing Law,* 1980 ARIZ. ST. L.J. 385, 404. Such arrangements take various forms, *e.g.,* employer/employee, independent contractor, and contain various financial provisions, *e.g.,* independent billing, fee for service, percentage of the gross. Fishman, Exclusive Hospital-Based Physician Contracts and Related Antitrust Considerations 1 (Oct. 3, 1983) (Paper presented at the National Lawyers Association Conference on Health Contracts). The collision of competition and exclusivity has resulted in numerous antitrust challenges. The exclusive contracts can have both procompetitive and anticompetitive aspects, and the fact situation governs. *See* FTC Advisory Opinion to Burnham Hosp., 101 F.T.C. 991, 993 (Feb. 24, 1983) (procompetitive benefits). While the *Hyde* case also involves an exclusive dealing contract, Justice Stevens indicates that "[t]he issue here is whether the hospital's insistence that its patients purchase anesthesiological services from Roux creates a tying arrangement." *Hyde,* 104 S. Ct. at 1561 n.28.

71. Fortner Enters. v. United States Steel Corp., 394 U.S. 495, 498-99 (1969) (quoting Northern Pac. Ry. v. United States, 356 U.S. 1, 5-6 (1958)); *Times-Picayune,* 345 U.S. at 605. This interest involves the patient's right to assemble a preferred array of practitioners, settings and services. The right to choose involves nothing less dramatic than the right to control what happens to one's body. Dolan & Ralston, *Hospital Admitting Privileges and the Sherman Act,* 18 HOUS. L. REV. 707, 721 (1981).

72. Subspecialists include the major departments of Emergency Room, Anesthesiology, Radiology and Pathology, and the lesser departments of Respiratory Therapy, Cardiac Catherization and Nuclear Medicine. *See* Fishman, *supra* note 70.

73. *See Hyde,* 686 F.2d 286. The market foreclosure argument is beyond the scope of this Comment.

74. *Id. See also* Blair & Finci, *The Individual Coercion Doctrine and Tying Arrangements: An Economic Analysis,* 10 FLA. ST. U.L. REV. 531 (1983); Craswell, *Tying Requirements in Competitive Markets: The Consumer Protection Issues,* 62 B.U.L. REV. 661 (1982); Flynn, *Antitrust Protection of the Consumer: Myth or Reality?,* 13 FORUM 939 (1978).

75. *Hyde,* 104 S. Ct. at 1558.

76. *Id.* (quoting *Times-Picayune,* 345 U.S. at 605).

result of the hospital's market power to have anticompetitive consequences.[77] Since every patient undergoing a surgical operation needs the services of an anesthesiologist, the hospital did not force any such services on unwilling patients.[78] It is clear, however, that not every patient having x-rays taken needs an additional interpretation by a radiologist before his doctor can treat him.

Certainly, if the hospital has a policy requiring a radiologist to read all x-rays,[79] then the purchase of the subspecialist's interpretation is compelled by the hospital. The radiologist has acquired the right to charge for interpreting every x-ray whether or not it is needed. The result has been to force a patient seeking medical services at the hospital to accept the additional reading of the x-rays. The wastefulness of this requirement is most pronounced when the attending physician reads the x-ray himself[80] and treats the patient without ever consulting the radiologist's report.[81]

The hospital policy should also be condemned from another economic perspective. It results in an "injury to the property" of the patient. In *New Jersey Chiropractic Society v. Radiological Society of New Jersey,*[82] consumers claimed they were required to make unnecessary expenditures to engage the services of a radiologist to take x-rays as a result of the alleged conspiracy of the radiological group to monopolize trade in this area of health.[83] The court concluded that the consumers were injured in their property as a direct result of the hospital's insistence upon the administration of x-rays by a radiologist.[84] The court relied on *Cleary v. Chalk*[85] to find that "[a] person whose property is diminished by a payment of money wrongfully induced is injured in his property."[86] The *Cleary* court also found this "injury to property" principle applied to both a consumer of services and a consumer of goods.[87] Under the *Cleary* analysis it is evident that the hospital policy requiring an additional reading of x-rays by radiologists wrongfully induces the patient to expend more for x-ray interpretation than is necessary, causing injury to the patient's property, and thereby justifying the condemnation of the policy.

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77. *Id.* at 1565.
78. *Id.* at 1567.
79. *Rumple,* 422 N.E.2d 1309.
80. The attending physician also bills the patient for reading the x-ray.
81. *Rumple,* 422 N.E.2d 1309.
82. 156 N.J. Super. 365, 383 A.2d 1182 (1982).
83. *Id.* at 368, 383 A.2d at 1184.
84. *Id.* at 371, 383 A.2d at 1185.
85. 159 U.S. App. D.C. 415, 488 F.2d 1315 (D.C. Cir. 1973).
86. *Id.* at 1319 n.17 (quoting Chattanooga Foundry & Pipe Works v. Atlanta, 203 U.S. 390, 396 (1906)).
87. *New Jersey Chiropractic Soc'y,* 156 N.J. Super. at 370, 383 A.2d at 1185.

V. JUSTIFICATIONS

The two most common justifications given as defenses for tying arrangements are quality control and efficient services. The Supreme Court has been reluctant to accept such "goodwill" defenses. The Court refused to allow a quality control justification when the use of contractual quality specifications was sufficient to protect quality without the use of a tying arrangement.[88] The Court has also refused to allow a technical maintenance justification of insuring satisfactory performance of products, when the only purpose or effect is to prevent the consumer from using the product of the competitor.[89]

From a hospital administrator's perspective, a flat rule concerning good medical practice is easier to administer. It is more efficient to compel all patients to adhere to the rule rather than making decisions regarding exceptions.[90] The hospital reasons that a flat rule will result in more efficient delivery of services.

> [A flat rule] can increase the hospital's control over operation of the department, ensure full-time availability of services, lower costs through standardization of procedures and centralized administration of the department, permit better scheduling of the use of facilities, facilitate maintenance of equipment [and] improve supervision of support staff and working relationships between the staff and physicians . . . .[91]

Certain rules, such as discharge of patients in wheelchairs, are standard practices for administrative efficiency. The hospital avoids the inconvenience of deciding the procedure for a patient's discharge on a case-by-case basis. There are, however, no economies in having a radiologist interpret all x-rays. The decision to have x-rays taken of a patient is already made on a case-by-case basis. Therefore, the hospital is not inconvenienced by an additional decision by the physician whether to request a confirmative reading by a radiologist. Most importantly, the patient and his physician will have a greater freedom of choice concerning the patient's medical treatment.

The quality argument given by the hospital to defend its policy is that the rule will generally reduce patient morbidity and mortality and assure accurate patient diagnosis and treatment, thereby increasing the quality of patient care.[92] In the *Hyde* decision, however, the Court in a footnote rejected

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88. International Salt Co. v. United States, 332 U.S. 392 (1947). *See also* Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551, 1565 n.42 (1984).

89. International Business Machs. Corp. v. United States, 298 U.S. 131 (1936).

90. An obvious example of a flat rule is the requirement that all patients must be discharged from the hospital in a wheelchair.

91. *Burnham Hospital*, 101 F.T.C. Dec. at 993.

92. Brief of Indiana Hosp. Ass'n, Amicus Curiae at 12, Rumple v. Bloomington Hosp., 422 N.E.2d 1309 (Ind. Ct. App. 1981).

the view that the legality of an arrangement of this kind turns on whether it was adopted for the purpose of improving patient care.[93]

Another quality argument given to defend the policy of having radiologists read every x-ray[94] is that it offers malpractice protection for the doctor and the hospital.[95] The patient, however, is not necessarily benefitting from this policy. The argument for quality control is moot if the precautionary measure is utilized long after the patient is gone, or never used at all by the doctor.[96] While the confirmative x-ray interpretation may aid the doctor in defending himself in a malpractice suit, it does not retroactively enhance the care received by the patient. If, on the other hand, the doctor waits to treat the paient until *after* reading the report, often filed a few days later,[97] negligence may result for failing to treat the patient promptly.[98] While admittedly there are instances where a confirmatory report is desirable, it is often an unnecessary expense to the patient.[99] The dissenting opinion in *Rumple* recognizes the uselessness of the mandatory policy requiring radiologists to read all x-rays. "Here the interpretation and report was but an empty institutional ritual performed in obedience to a sweeping rule. The [radiologist's] report was buried, unread, in a file, where it reposed until disinterred by a billing clerk."[100] When the physician proceeds with treatment before a second read-

93. *Hyde,* 104 S. Ct. at 1565 n.41.

94. *Rumple,* 422 N.E.2d at 1318. (The policy of the hospital does not foreclose the general practitioner from interpreting the x-rays of his or her patient. The policy merely requires that in addition to the interpretation of the general practitioner, there must be an official interpretation by a physician who possesses the necessary qualifications, i.e., a radiologist.).

95. *Rumple,* 429 N.E.2d 214 (Pivarnik, J., dissenting) (purpose of this confirmation radiology was to protect everyone in malpractice suits, which is not the duty nor responsibility of patient).

96. The doctor in *Rumple* said he did not need the confirmation report and never used it in his treatment of the patient. *Id.* The doctor in Alessio v. Crook, 633 S.W.2d 770 (Tenn. Ct. App. 1982), did not consult the x-ray report before discharging the patient.

97. *See Alessio,* 633 S.W.2d 770. The patient is taken to the radiology department to be x-rayed. The film is developed as soon as possible. The film is labeled with the patient's name and identification, date, and hospital number. The film is read and interpreted by one of the radiologists who dictates into a recorder his interpretation of the film. A stenographer then transcribes the recording and prepares an x-ray report. The radiologist reviews the report and initials it if he approves. After the report is initialed, it is ready to be filed in the patient's chart.

98. *See* Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974) (failure to give a glaucoma test in a timely manner was negligence). At a time when cost containment in medical practice is of major concern, decisions such as *Helling* could be expected to increase the amount of defensive medicine being practiced in all fields of medicine. Greenbaum, *Current Standards of Practice in Medicine: The Medical, Judicial, and Legislative Roles,* 7 W. ST. U.L. REV. 1, 7 (1979).

99. "While these readings by a radiologist were referred to as 'confirmative interpretations,' there is nothing in the record that they were ever consulted as such." *Rumple,* 422 N.E.2d at 1319 (Neal, P.J., dissenting). "A charge to a patient for a service not asked for by the treating surgeon, not used by the treating surgeon, or consulted by the treating surgeon, or anyone else" is an unnecessary expense. *Id.*

100. *Id.*

ing of x-rays is made, the required procedure has no impact on the quality of treatment given, rendering it wholly unnecessary. By permitting a case-by-case decision about confirmative reports by radiologists, unnecessary procedures will be reduced, resulting in decreased medical costs.

VI. Less Restrictive Alternatives

While the preservation of high quality health care is a desirable goal, there are less restrictive alternatives than the hospital's mandatory policy of a second reading of x-rays by a radiologist which will accomplish such a goal.[101] The alternatives to a mandatory policy will reduce unnecessary readings, thereby decreasing the cost to the patient. One such less restrictive alternative is to permit the attending physician to decide on a case-by-case basis when confirmatory radiological reports are necessary.[102] This gives the patient, through his doctor, a choice whether to purchase the independent radiological interpretation. This alternative allows the doctor to proceed with treatment based upon his own reading of the x-rays if he deems an additional interpretation unnecessary. In complicated cases, the doctor may seek a confirmatory report from the radiologist in order to guard against future malpractice actions. This alternative accomplishes two important objectives in that the hospital has met its burden of providing high quality medical service because such confirmatory interpretations are still available to the attending physician, while the patient's option to choose not to purchase unnecessary radiological services remains open.

A second less restrictive alternative would be to have a standard procedure whereby the radiologist reads all x-rays, unless the doctor indicates otherwise. The physician and patient could sign a form indicating that no other reading is necessary or desirable. While the end result of this second alternative is the same as the first alternative, the means are different. The first alternative requires an affirmative act on the part of the doctor for the radiologist to interpret the x-ray. The second alternative requires a negative constraint initiated by the doctor against the radiologist to prevent the additional interpretation of the x-ray. Both alternatives maintain a high standard of quality control as determined by the attending physician while allowing the patient an escape from a "forced" mandatory requirement.

A third less restrictive alternative would be to have a required reading of special types of x-rays. Such a system would predetermine the procedures[103]

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101. An illegal tying arrangement will not be excused if there is a less restrictive alternative to accomplish the end which the business justification purports to serve. Carpa, Inc. v. Ward Foods, Inc., 536 F.2d 39, 47 (5th Cir. 1976); *Hyde,* 686 F.2d at 292.

102. *See.* Waxman, *supra* note 8, at 637-38; Heitler, *Health Care and Antitrust,* 14 U. Tol. L. Rev. 577, 604 (utilization review to determine whether unnecesary care has been rendered).

103. Such procedures might include neck, back and head injuries, as well as special opthomological x-rays.

in which an additional radiological interpretation would be necessary. This alternative is less restrictive than a mandatory policy that requires all x-rays to be interpreted by a radiologist. The physician would, of course, still be able to acquire a confirmation report in other situations, when he so requested.

CONCLUSION

The health care industry's tremendous growth mandates increased application of antitrust law. The *Hyde* decision establishes the per se rule as the determinative test of legality of an established tying arrangement. In *Rumple,* hospital policy forces the patient to purchase the additional radiological interpretation (the tied product), incurring unnecessary expenses, in order to receive treatment at the hospital, to have x-rays taken and to have these read by the attending physician (the tying product). Such coercion of the purchaser is contrary to the goals of antitrust law and should be condemned. While the goal of providing quality health care is an admirable one, it can be better achieved by less restrictive alternatives. Such alternatives achieve the additional goal of cost containment without resulting in the anticompetitive effects suffered by the illegal tying arrangement. The hospital policy of requiring radiologists to read every x-ray is an illegal tying arrangement and should be denounced as a per se violation of the Sherman Act.

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