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THE ESSENTIAL FACILITY DOCTRINE AND THE HEALTH CARE INDUSTRY

SCOTT D. MAKAR*

I. INTRODUCTION

THIS Article presents a critique of the antitrust essential facility doctrine and its application in the health care industry. The essential facility doctrine,1 a recent antitrust concept, requires the owner of an "essential facility" to provide its business rivals with equal or non-discriminatory use of, or access to, the facility on fair terms. The doctrine has been applied in a number of contexts, including formerly regulated industries that have remnants of unregulated market power.2 In recent years, physicians, non-physician health care professionals, and medical equipment suppliers have attempted to extend the doctrine to health care markets.3 The doctrine's application in the health care field raises a number of issues because of the competitive and regulatory tensions health care providers confront.4

The Article begins with an overview of the development of the essential facility doctrine. The first section provides the legal background of the doctrine and a critique of the current essential facility

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1. The essential facility doctrine is also termed the "bottleneck" doctrine. Note, Unclogging the Bottleneck: A New Essential Facility Doctrine, 83 COLUM. L. REV. 441, 441 (1983). The "bottleneck" refers to an entry barrier that can arise where entry at multiple levels of production is necessary for entrants to effectively compete with vertically integrated incumbent firms. ROGER D. BLAIR & DAVID L. KASEMAN, ANTITRUST ECONOMICS 314-16 (1983) (discussing concept of vertical integration as a barrier to entry).


4. See generally H. E. Frech, The Long-Lost Market in Health Care: Government and Professional Regulation of Medicine, in A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE 44, 45 (Mancur Olson, ed., 1981) (noting that "medicine is, in fact, so heavily regulated that it may be the most completely regulated sector of the economy").
test. The legal foundation of the essential facility doctrine is based upon the metaphor that firms controlling "essential facilities" or "bottlenecks" must provide access to their competitors on fair and reasonable terms. This broad legal metaphor, however, has yet to find support in any one explanatory theory. Commentators have urged broad and narrow economic interpretations of the doctrine but no consensus has formed.

Next the Article discusses the application of the doctrine to the health care industry, focusing primarily on whether hospitals, staff privileges, or exclusive supply contracts may be considered essential facilities. Although such facilities may be "essential" to persons who demand health care, courts have generally rejected claims that such facilities are "essential" in an antitrust sense. These decisions are consistent with the prevailing view that an "essential facility" must exhibit the characteristics of a natural monopoly that rivals cannot replicate and to which mandatory access is necessary in order to compete. They are also consistent with traditional monopolization theory which mandates access only as a remedial measure in those circumstances where access will increase long-run economic efficiency.

I THE ESSENTIAL FACILITY DOCTRINE

A. Legal Development of the Doctrine

Although predicated on the early United States Supreme Court case **United States v. Terminal Railroad Ass'n**, the essential facility doc-

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6. Phillip Areeda, *Essential Facilities: An Epithet in Need of Limiting Principles*, 58 Antitrust L.J. 841, 852 (1990) ("There is no general duty to share. Compulsory access, if it exists at all, is and should be very exceptional."); James R. Ratner, *Should There Be An Essential Facility Doctrine?*, 21 U.C. Davis L. Rev. 327, 367 (1988) (discussing broad and narrow approaches and suggesting that a successful essential facility claim requires that denial causes "welfare-harmful output reduction" or "will increase or maintain the facility's market power."); David J. Gerber, *Rethinking the Monopolist's Duty to Deal: A Legal and Economic Critique of the Doctrine of "Essential Facilities"*, 74 Va. L. Rev. 1069 (1989) (arguing that doctrine should apply to exceptional cases involving long-term, anti-competitive exclusions and natural monopolies); Gregory J. Werden, *The Law and Economics of the Essential Facility Doctrine*, 32 St. Louis U. L.J. 433, 476, 479-80 (1987) ("A facility probably should be deemed essential only if it is a natural monopoly;"") legislative or administrative agencies, rather than the judiciary, should regulate industries and the doctrine as an antitrust cause of action should be eliminated); John Cirace, *An Economic Analysis of Antitrust Law's Natural Monopoly Cases*, 88 W. Va. L. Rev. 677, 727 (1986) ("phenomena described by the [essential facility] doctrine are more accurately analyzed by the theory of natural monopoly).

7. 224 U.S. 383 (1912). See David Reiffen & Andrew N. Kleit, *Terminal Railroad Revis-
trine is a relatively new antitrust theory that utilizes elements of both the law of monopolization and refusals to deal. Over the past fifteen years, plaintiffs increasingly have invoked the doctrine as a supplemental theory of antitrust liability in two situations. The first involves attempts by rivals to access or use some "essential" facility or resource that a vertically-integrated firm controls. The claim is that the rivals cannot compete effectively or enter the marketplace without access to the essential or monopolized facility. The second involves a group of firms who collectively produce or control some resource or facility to which excluded rivals desire access. The claim is that the group has collectively refused to deal with the excluded rivals and has thereby unreasonably denied them the "essential" resource.

1. Monopolization

The first type of essential facility claim is in most respects a traditional monopolization claim. Monopolization is based on a firm's development and willful maintenance of "monopoly" power over a particular product or service within a defined geographic market. The antitrust laws do not condemn the structure of monopoly itself. Instead, the laws condemn illegitimate business conduct that firms use to achieve or maintain monopoly power. For example, a firm that achieves monopoly power through superior operating efficiencies does not violate the antitrust laws. Similarly, a firm that survives the competitive process in a market where only one firm can economically sur-

ited: Foreclosure of an Essential Facility or Simple Horizontal Monopoly?, 33 J.L. & Econ. 419, 437 (1990) (concluding that courts have misinterpreted the Terminal Railroad case and that the essential facilities doctrine "may discourage efficient behavior without a corresponding benefit in terms of deterring anticompetitive conduct."); Boudin, supra note 5, at 398 (stating that "Supreme Court decisions commonly cited for the doctrine by lower courts . . . do not offer much support.").

8. See Areeda, supra note 6, at 841.

11. The Sherman Act, section 2, states that "[e]very person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize" shall be guilty of a felony. 15 U.S.C. § 2 (1988).
12. Monopoly power alone is not sufficient to establish a monopolization claim; there must also be anticompetitive conduct evidencing a general intent to monopolize (i.e., willful maintenance or acquisition). United States v. Grinnell Corp., 384 U.S. 563, 570-11 (1966); Lawrence Anthony Sullivan, Handbook of the Law of Antitrust § 33, at 94 (1977).
13. Judge Learned Hand noted that "[a] single producer may be the survivor out of a group of active competitors, merely by virtue of his superior skill, foresight and industry." United States v. Aluminum Co. of Am., 148 F.2d 416, 430 (2d Cir. 1945).
vive does not violate the antitrust laws (i.e., a natural monopoly).\textsuperscript{14} Thus, monopoly power that results from either superior efficiency or natural monopoly is lawful.\textsuperscript{13} To prevail on a monopolization claim, a plaintiff must satisfy a two-part test which requires that the defendant (1) have sufficient market power in the relevant product (or service)\textsuperscript{15} and geographic markets, and (2) engage in anticompetitive conduct that creates, protects, or perpetuates this power.\textsuperscript{17} In essential facility cases, the market allegedly monopolized is the "essential facility" itself.

Under the first part of the monopolization test, the traditional proxy for economic power is market share analysis (i.e., definition of the relevant market and a determination of the defendant's market share in that market).\textsuperscript{18} Upon demonstrating a defendant has the requisite level of market power, the plaintiff must show the defendant engaged in anticompetitive conduct designed to maintain or expand such power.\textsuperscript{19} The defendant can justify its actions by establishing that legitimate business reasons motivated its actions.\textsuperscript{20} Attempt to monopolize claims require proof of a dangerous probability of monopolizing a particular market and the specific intent to monopolize.\textsuperscript{21}

2. Refusals to Deal

The second type of essential facility claim is a refusal to deal, also termed a boycott.\textsuperscript{22} Unilateral refusals to deal occur when a single firm, often an alleged monopolist, refuses to deal with other firms or customers. The current law generally grants individual firms the freedom to deal or refuse to deal with whomever they choose, unless the refusal supports an illegal restraint or constitutes illegal monopoliza-

\textsuperscript{14} See Union Leader Corp. v. Newspapers of New England, 284 F.2d 582, 589-90 (1st Cir. 1960), cert. denied, 365 U.S. 833 (1961). The court noted that a defendant who intends to succeed in ousting an incumbent natural monopolist through legitimate business practices does not have the "exclusionary" intent necessary to establish a monopolization claim. \textit{Id.} at 589-90.

\textsuperscript{15} The oft-cited proposition that "[t]he successful competitor, having been urged to compete, must not be turned upon when he wins" applies in these situations as well as those involving the essential facility doctrine. \textit{See Aluminum Co. of Am.}, 148 F.2d at 430.

\textsuperscript{16} References to product markets in this Article include service markets unless otherwise indicated.


\textsuperscript{18} SULLIVAN, \textit{ supra} note 10, §§ 12-32, at 41-93.

\textsuperscript{19} \textit{Id.} §§ 33-39, at 94-105.


\textsuperscript{22} Concerted refusals to deal are also termed group boycotts. E. THOMAS SULLIVAN & JEFFREY L. HARRISON, UNDERSTANDING ANTITRUST AND ITS ECONOMIC IMPLICATIONS § 4.13, at 105 (1988).
tion.23 Even a monopolist has no general duty to cooperate with its business rivals.24 The general absence of a duty to deal with competitors, however, does not necessarily mean that a refusal to deal cannot be used as evidence to support a monopolization claim.25 For example, a monopolist's decision to end a joint marketing arrangement with its competitors can be evidence of anticompetitive conduct perpetuating the monopolist's power.26

Collective or concerted refusals to deal, however, have traditionally been classified as per se antitrust violations.27 These types of refusals occur when two or more competitors agree to exclude another competitor from access to some competitive advantage the group shares. For instance, a group of competitors might attempt to increase its own collective profits by increasing the costs of competing firms, resulting in a reduction of competitive pressures as the higher cost firms leave the marketplace.28 Some scholars, however, have criticized the per se label because it can repress legitimate efficiency-enhancing activities.29 In recent years, the Supreme Court has softened the per se label's harshness by requiring antitrust plaintiffs to demonstrate that a challenged concerted refusal to deal is predominantly anticompetitive before applying the per se label.30

3. The Essential Facility Doctrine: An Antitrust Hybrid

The essential facility doctrine is an antitrust hybrid that combines elements of monopolization and refusals to deal. The doctrine's reliance on these two concepts raises the question whether the doctrine is

24. 472 U.S. at 600-01.
25. Id. at 601.
26. Id. at 600-05.
28. This concept is termed raising rivals' costs and is developed more fully in Thomas G. Krattenmaker & Steven C. Salop, Anticompetitive Exclusion: Raising Rivals' Costs To Achieve Power over Price, 96 YALE L. J. 209 (1986) and Steven C. Salop & David T. Scheffman, Recent Advances in the Theory of Industrial Structure: Raising Rivals' Costs, 73 AMER. ECON. REV. 267 (1983). A common example is a group collectively controlling some asset other competitors need to enter the marketplace. See, e.g., Gamco v. Providence Fruit & Produce Bldg., Inc., 194 F.2d 484 (1st Cir.), cert. denied, 344 U.S. 817 (1952).
29. See BORK, supra note 23, at 330-44. Bork notes that some boycotts, so-called naked and disguised naked boycotts, have no efficiency benefits and should be illegal. Id. at 334-37. However, certain ancillary boycotts which contribute to the efficiency of a cooperative economic activity should be permissible. "In such cases one must look to the underlying restraint in order to learn the efficiency potential of the boycott." Id. at 338.
redundant. A forceful argument exists that essential facility claims can be analyzed under existing monopolization or refusal to deal law without developing a new antitrust theory that combines elements of both. Nonetheless, the essential facility doctrine has become well-established in many jurisdictions.

B. The Essential Facility Test

The essential facility test actually involves two tests, a monopolization test for unilateral conduct and a concerted refusal to deal test for cooperative conduct. The monopolization test generally requires that four elements be established:

1. control of the essential facility by a monopolist;
2. a competitor's inability to practically or reasonably duplicate the essential facility;
3. the denial of the facility's use to a competitor; and
4. the feasibility of the owner's provision of access to the facility.

Some courts have recognized various defenses to essential facility claims such as a valid business reason for the denial of access. The concerted refusal to deal test incorporates a fifth element:

5. an agreement between the owner of the facility and some of the potential entrant's competitors that prevents an equitable sharing of the facility.

This element provides the concerted action required to establish a group boycott claim.

31. See, e.g., Ratner, supra note 6, at 327. The United States Supreme Court's decision in Aspen Skiing Co. v. Aspen Highlands Skiing Corp. is instructive. 472 U.S. 585 (1985). The plaintiff in Aspen Skiing Co. prevailed on its monopolization claim without reliance on the doctrine. In fact, the Supreme Court expressly avoided addressing the essential facility claim because existing antitrust theory was sufficient to prove liability. Id. at 611 n.44.


33. See, e.g., Aspen Skiing Co., 472 U.S. at 595-599. The trial court's jury instructions in Aspen Skiing Co. Court stated "a company which possesses monopoly power and which refuses to enter into a joint operating agreement with a competitor or otherwise refuses to deal with a competitor in some manner does not violate Section 2 if valid business reasons exist for that refusal." Id. at 597.

Courts have applied different analytical labels to the essential facility doctrine. Some courts categorize the doctrine under a per se test, while others regard the test as a rule of reason approach. A strong argument exists for a rule of reason. First, the essential facility doctrine is primarily based on the law of monopolization which uses a rule of reason analysis. The law of monopolization does not condemn the existence of a monopoly acquired by lawful means, nor should it condemn a firm's creation of, or control over, an "essential" facility acquired by lawful means. Further, the law of monopolization recognizes a "business justification" defense which would have no purpose under a per se analysis.

Second, the elements of the essential facility tests require economic balancing of the pro-competitive and anti-competitive effects of exclusion. This type of balancing approach is inconsistent with a per se analysis. In addition, the essential facility tests contain a number of different elements that require a detailed analysis of market structure. The structural analysis embodied in the test makes it difficult for a court to condemn exclusion outright without a thorough and thoughtful economic analysis. A rule of reason approach, therefore, is most appropriate.

Finally, a rule of reason—or at least a modified per se test—should apply to essential facility claims based on a concerted refusal to deal theory. This approach requires that a court make a detailed examination of the relevant market to determine, for example, whether the defendants have monopoly or market power, whether entry barriers exist, and whether there are legitimate business reasons for the alleged exclusion. This approach stems from the trend in group boycott theory that requires close scrutiny of whether the group of defendants


36. One prominent health care antitrust expert has stated the doctrine is a rule of reason test. See Clark C. Havighurst, Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships, 1984 DUKE L.J. 1071, 1112 (doctrine is "essentially a subcategory of the rule of reason that applies to all competitor collaboration").

37. This modified per se approach stems from the decision in Northwest Wholesale Stationers, Inc. v. Pacific Stationary & Printing Co., 472 U.S. 284 (1985), in which the Supreme Court held that the per se rule does not apply in concerted refusal to deal cases unless an antitrust plaintiff demonstrates that the cooperative from which the plaintiff was excluded "possesses market power or unique access to a business element necessary for effective competition." Id. at 298.
collectively has that level of market power necessary to make their exclusion of rivals "predominantly anticompetitive.""38

C. The Essential Facility Tests: Discussion of the Elements

1. Owner Must Monopolize and Control the "Essential Facility"

The first element of the essential facility test requires that a facility's owner be a monopolist.39 This requirement is fundamental to the proper application of the doctrine. A plaintiff must prove the facility owner has the degree of monopoly power over the "essential facility" that is required to establish an antitrust violation.40 For example, the court in Consul, Ltd. v. Transco Energy Co.41 rejected the contention that an essential facility claim does not require a threshold showing of market power.42 Instead, the court held that an essential facility plaintiff must utilize traditional market share analysis in establishing that the facility owner is a monopolist.43

A few courts do not require a showing of monopoly power and instead merely require a showing that access to the facility is in some sense "essential."44 Under this approach, an owner of an "essential facility" who does not have sufficient market power to have monopolized or attempted to monopolize any identifiable market may nonetheless be exposed to liability. For instance, a plaintiff who demonstrates that a facility is "impractical" to duplicate and is thereby "essential" can sidestep the traditional market power requirement. This approach runs counter to the United States Supreme Court's recent reaffirmation of the principle that factual findings of a defendant's market power and the intent to misuse such power are fundamental underpinnings of an antitrust violation.45 For this reason, the essential facility doctrine's monopoly power requirement should be a fundamental prerequisite to establishing antitrust liability.

38. Id.
39. See, e.g., Tarabishi v. McAlester Regional Hosp., 951 F.2d 1558, 1568 n.14 (10th Cir. 1991) (no showing that hospital or physicians were monopolists), cert. denied, ___ U.S. ___, 112 S. Ct. 2996 (1992).
42. Id. at 493.
43. Id. at 494-96.
Despite some judicial confusion regarding the proper analytical technique for demonstrating monopoly power in essential facility cases, most courts and commentators form a consensus supporting the traditional market share approach. Under this well-developed and straightforward methodology, a plaintiff must demonstrate that the defendant has monopoly power in a relevant product and geographic market or submarket. Monopoly power is a function of the defendant's market share in the relevant geographic and product (or service) market, evidence of entry or exit barriers, and other factors such as the existence of government regulations. In essential facility cases, this market analysis focuses on defining the parameters of the relevant product (or service) and geographic markets that include the alleged "essential facility."

The "essential facility" plaintiff must also establish that the defendant has "control" over the facility from which the plaintiff is denied access. This element is easily satisfied where the defendant has actual ownership of the facility. In other situations, however, defendants may not have sufficient control to meet this requirement. For example, one of a number of defendants who collectively control access to a facility may not individually have "control" over the facility. Instead, one defendant may merely contribute to the denial of plaintiff's access to the facility. In these situations, an essential facility claim may be brought only against the party who can ultimately provide access to the facility.

In the health care context, excluded physicians often assert that a number of defendants prevented the physicians from acquiring access to an alleged essential facility (e.g., staff privileges). Under the theory that "control" means that each defendant must directly control access, competing physicians who individually do not control "access" may not be subject to antitrust liability. The hospital that actually controls access to staff privileges would be the proper defendant.

47. See, e.g., MCI Communications v. American Tel. & Tel., 708 F.2d 1081, 1132 (7th Cir. 1982), cert. denied, 464 U.S. 891 (1983).
49. See, e.g., Beverage Management, Inc. v. Coca-Cola Bottling Corp., 653 F. Supp. 1144, 1157 (S.D. Ohio 1986) (defendant beverage company does not control grocer's feature ads which competing beverage distributor alleged were essential facilities).
51. The question whether members of a hospital's staff can conspire with the hospital to unlawfully deny staff privileges is unresolved as indicated by the split among the courts that have considered the issue. Compare Nurse Midwifery Assoc. v. Hibbett, 918 F.2d 605 (6th Cir. 1990)
2. Essentiality, Inability to Practically or Reasonably Duplicate the Facility, and Feasibility of Access

The essential facility test also requires that the facility at issue be "essential," that it cannot be reasonably or practically duplicated, and that access to it is economically feasible. This Article considers these requirements collectively because they are all indicia of the degree to which a defendant has economic power through its control of the "essential facility." No bright line tests exist and none of these elements alone establishes the requisite economic power in the essential facility. Instead, these factors seem to merely rephrase the monopoly power requirement in different terms. The elements also seek to answer the question why others cannot replicate the facility themselves.

The first part of the test requires a showing that a facility owner controls a resource that is "essential." Little coherent judicial guidance exists as to what "essential" means. Certainly, a monopolized resource is more likely to be "essential" in some respects than a non-monopolized resource. But courts have yet to equate "essential" facility and "monopolized" facility. Instead, a few courts have said that to be essential "it is sufficient if duplication of the facility would be economically infeasible and if denial of its use inflicts a severe handicap on potential market entrants."52 This formulation, however, seems to merely make the "inability to practicably duplicate" element a means of concurrently establishing the "essentiality" element. Equating "inability to practicably duplicate" with "essentiality" can unjustifiably infer that an existing facility is "essential" simply because one competitor cannot "practically" duplicate it.

Some courts have identified factors that indicate a facility is not essential. For example, a facility is not essential merely because it is better than or preferable to another.53 Similarly, facilities that competitors can "practically" or "reasonably" duplicate are not essential.54 These factors, however, provide little additional objective guidance such that the concept of "essentiality" remains somewhat open-ended and thereby provides courts with considerable discretion in its interpretation and application.

53. See, e.g., Fishman, 807 F.2d at 539.
54. See, e.g., Hecht, 570 F.2d at 992.
The fourth part of the test, the economic feasibility of access, refers to whether the facility's owner can share the facility without interfering with or depleting its own use of the facility, without causing congestion of the facility, and without incurring economic losses. Mandated access, requiring the owner to share its resources, may inhibit the owner's ability to serve its own customers or meet its own demands for the resources. For this reason, courts must consider the economic justifications of owners of essential facilities who include rivals. For example, simply because a firm has excess capacity does not mean it must share it with rivals if access would result in congestion, overuse or depletion of the resource. Similarly, firms that maintain an inventory of a purported "essential" resource should not have to make it available for consumption by others if they can demonstrate a valid "business justification."

3. Denial of Access to, or Use of, the Essential Facility

The essential facility test requires that the owner deny the plaintiff access to, or use of, the facility. This element parallels the exclusionary conduct requirement in monopolization actions. Under monopolization law, however, a refusal to deal or a denial of access is generally not actionable if made unilaterally as an independent business judgment. For this reason, the essential facility doctrine imposes greater obligations on owners of "essential facilities" than are generally imposed under other antitrust principles.

In the essential facility context, the term "access" means more than merely the right of access or admission to a facility. Instead, it means actual use and depletion of the facility (i.e. sharing and allocating the

56. The term "excess capacity" has both a rigorous and a common economic meaning. Rigorously defined, a firm is said to be producing with excess capacity if its output level is below that at which average costs are at a minimum. The more common usage refers to firms operating plant at a rate of utilization below that considered normal (e.g. at some percentage level of output that could be achieved).
57. This point is discussed infra in text accompanying notes 66-70.
58. See generally A. D. Neale & D. G. Gyder, The Antitrust Laws of the United States of America 59 (3d ed. 1980) ("where facilities cannot practicably be duplicated by would-be competitors, those in possession of them must allow them to be shared on fair-terms" (emphasis added)).
scarce resource among rivals). This distinction proves important because a connotation underlying a firm's refusal to grant "access" is that the firm acts unreasonably in doing so (perhaps because of an implicit assumption that the resource is abundant). Put in proper economic context, a firm's decision not to share or allow the use of its own resources with its business rivals has a less negative connotation and makes explicit that even purported essential facilities are resources subject to scarcity constraints.

The phrase "denial of access" is a term of art which can occur in a number of ways, some of which are innocuous. For example, a firm that refuses to even engage in negotiations with a competitor for use of a resource thereby denies that competitor access to the resource. This denial may have no anticompetitive effect even if the firm has some degree of market power. Some "denials of access" may also be justified based on scarcity. For example, a hospital may have a legitimate justification for limiting the number of physicians and non-physician professionals that have access to and use of its facilities. Denial of access in this context may have no meaningful economic ramifications.

A firm's unreasonable offer of access, however, can amount to a "denial" in some situations. For instance, if a defendant offers to provide its facility to the plaintiff at a price later determined to be unreasonable, a denial of access can occur.

Finally, the subjective motivations of owners of essential facilities who deny access appear to be irrelevant. Most essential facility cases set forth a multipart test that does include as one of its element that a denial of access be with "exclusionary intent." For this reason, a

60. See Neale & Goyder supra note 58, at 59.

61. For example, in Ferguson v. Greater Pocatello Chamber of Commerce, 848 F.2d 976 (9th Cir. 1988), an owner of an auditorium limited the number of trade shows in its facility per season and chose only one of a number of competing bidders. The court held that this conduct was not an unlawful denial and that it merely promoted competition for the use of the facility. 848 F.2d at 983. The court stated that "[t]he defendant has not refused to deal with anyone. It has merely refused to house more than one trade show per spring, and it has decided that that show will be given to the producer who makes the best bid. The plaintiffs simply failed to outbid their competitors." Id.

62. See, e.g., Aspen Skiing Co., 472 U.S. 585, 591-592 (1985) (defendant ski company offered plaintiff 12.5% share of joint revenues compared to past minimum of 13.2%); Consolidated Gas Co. of Fla. v. City Gas Co. of Fla., 665 F. Supp. 1493, 1534 (S.D. Fla. 1987) (offers for natural gas at seven cents per therm over cost held unreasonable when estimates of reasonable price were approximately one cent per therm), aff'd, 880 F.2d 297 (11th Cir. 1989), vacated, 889 F.2d 264 (11th Cir. 1990), on rehearing en banc, 912 F.2d 1262 (11th Cir. 1990), cert. granted and judgment vacated, 499 U.S. 915, (1991). In Aspen Skiing Co., for instance, it was necessary to consider the plaintiff's contribution to the joint marketing venture and its subsequent market share to determine the reasonableness of the defendant's offer. 472 U.S. 585, 587.

63. See supra notes 32-34 and the cases cited therein.
firm that lacks anticompetitive motivation but nonetheless denies its rivals use of its facilities may violate the essential facility doctrine and be subject to antitrust liability.

4. Business Justification Defense

Courts have recognized a business justification defense to the essential facility doctrine. The defense is consistent with the proposition that a firm possessing monopoly power is not automatically subject to antitrust liability because monopoly power may result from "superior skill, foresight and industry" or "superior product, business acumen, or historic accident."

A denial of access is justified where the defendant has a legitimate business reason for the denial. For instance, the feasibility of access element raises the question of whether access would overburden the facility, causing the defendant’s level of customer service to decline. A denial of access is permissible if access would prevent the owner from serving its own customers or would interfere with the owner’s expansion plans.

The defendant can also demonstrate that a denial is based on economic efficiency considerations. A firm defending against an essential facility claim can demonstrate that the net effects of denying access are pro-competitive (i.e., economic benefits outweigh any economic costs). A common example involves an essential facility action against a vertically integrated firm that controls some scarce or "essential" resource that its rivals demand. The excluded rivals’ claim is that the firm uses its monopoly power in the resource to extend or leverage such power into another level of production or distribution thereby foreclosing competition. This leveraging theory asserts that the vertically integrated firm creates a barrier to entry (i.e., the so-

64. See generally Areeda, supra note 6, at 847-52 (stating that "denial of access is never per se unlawful; legitimate business purpose always saves the defendant."); Werden, supra note 6, at 457-58 (noting that some, but not all, courts have recognized such a defense).

65. United States v. Aluminum Co. of Am., 148 F.2d 416, 430 (2d Cir. 1945).


67. See Areeda, supra note 6, at 849-52 (discussing "micro level" business justifications and "macro level" business justifications; the former focus on the circumstances of a particular case, while the latter focus on general economic policy considerations).

68. Id.

69. Id.


71. See, e.g., Fishman v. Estate of Wirtz, 807 F.2d 520, 540 (7th Cir. 1986).
called "bottleneck"). This bottleneck requires that rivals enter at more than one level of distribution or production simultaneously in order to compete against the vertically integrated firm.\footnote{72}

Courts have relied on this leveraging concept to hold that a vertically integrated monopolist’s refusal to provide access to its scarce resource at one level of production is unlawful because the monopolist can thereby extend its economic power into other stages of production or markets.\footnote{73} This leveraging theory, however, is subject to considerable dispute and is discredited by many antitrust scholars.\footnote{74}

In fact, there are a number of reasons why firms vertically integrate, many of which have little to do with the abusive use of monopoly power.\footnote{75} A firm may vertically integrate to internalize a transaction in which the firm previously engaged in with outside suppliers. By acquiring its own supply source, the firm avoids the costs of transacting in the market. These cost savings may alter the firm’s mix of inputs and result in greater production efficiencies. Vertical integration can also achieve cost savings when a firm that monopolizes an input vertically integrates “downstream” (i.e., forward in the production process) with a firm whose production technology enables a more commercial use of the input.\footnote{76}

Vertical integration also occurs due to the uncertainty of input prices.\footnote{77} This uncertainty creates an incentive for risk-averse firms to vertically integrate into the production of the input. By producing and warehousing its own supply of the input, the firm can insulate itself to some extent from market price fluctuations. This strategy, however, is limited by the storability of the input, costs of storage, and the opportunity costs of other investments. Consequently, firms can use vertical integration to enhance the economic stability of their production processes. Because of the economically justifiable results of vertical integration, courts should generally be unwilling to require firms to share

\footnote{72. \textit{Id.} at 540 ("The point of the essential facilities doctrine is that a potential market entrant should not be forced simultaneously to enter a second market, with its own large capital requirement.")}.

\footnote{73. \textit{See id.} at 539; MCI Communications v. American Tel. & Tel., 708 F.2d 1081, 1132 (7th Cir. 1982), \textit{cert. denied}, 464 U.S. 891 (1983).}


\footnote{76. This concept, termed variable input proportions production, is explained in ROGER D. BLAIR & DAVID L. KASERMAN, \textit{Antitrust Economics} 302-04 (1983).}

\footnote{77. BLAIR & KASERMAN, \textit{supra} note 75, at 83-109.}
such internal benefits with rivals unless no alternative means of promoting competition exist.  

I. ESSENTIAL FACILITY CASES: HEALTH CARE CONTEXT

Essential facility claims in the health care industry have an intuitive appeal because of the notion that health care services are "essential" to individual well-being. That health care services may be essential to good health, however, does not mean that particular health care facilities or resources are necessarily "essential" in an antitrust sense.

Despite the recent proliferation of antitrust actions claiming denials of access to "essential" health care facilities, courts generally reject the doctrine's application to the various facilities alleged to be "essential," although there are some exceptions. These claims have involved attempts to access hospitals and other medical buildings, medical staff privileges, and durable medical equipment (DME) referrals. Only claims involving DME have had success. As the next section discusses, most of the health care facilities at issue in these cases have not exhibited the characteristics of essential facilities.

A. Hospitals and Medical Office Buildings as Essential Facilities

1. Hospital Facilities and Equipment

A number of antitrust plaintiffs have claimed that a hospital and its departments, emergency units, or equipment are essential facilities. Courts, however, are generally skeptical of such claims and have almost uniformly rejected them, particularly where there is evidence that persons excluded continue to make substantial incomes despite being denied access. The courts question whether a facility can be

78. Areeda, supra note 6, at 852 ("There is no general duty to share. Compulsory access, if it exists at all, is and should be very exceptional.").

79. See, e.g., Advanced Health-Care Services, Inc. v. Radford Community Hospital, 910 F.2d 139 (4th Cir. 1990); Key Enterprises v. Venice Hospital, 919 F.2d 1550 (11th Cir. 1990), reh'g granted and opinion vacated, 979 F.2d 806 (11th Cir. 1992) (en banc), appeal dismissed and judgment vacated, 9 F.3d 893 (11th Cir. 1993) (en banc). See also M & M Medical Supplies & Serv. v. Pleasant Valley Hosp., Inc., 1992-2 Trade Cases. (CCH) ¶ 70,059 (4th Cir. 1992) (en banc) (essential facility claim involved but not explicitly discussed).

80. Id.


82. See infra text accompanying notes 123-26.
"essential" to competition if economic rivals continue to prosper without access.  

In general, access to a hospital’s facilities has become increasingly difficult. The growth in the number of physicians contrasts sharply with the decline in the number of hospitals and available hospital beds. Consequently, physicians and non-physician practitioners generally have fewer readily available facilities in which to practice. Also, the contemporary legal trend is to treat hospitals, rather than physicians, as primary providers of health care services. Hospitals, therefore, have the duty to use reasonable care in their selection and oversight of their staffs. In response to lawsuits alleging that the hospitals acted negligently in their review or retention of unqualified or inadequate physician staffs, hospitals have used more restrictive evaluation mechanisms to avoid such liability, further restricting access. In addition, the expansion of the antitrust laws to health care providers places additional constraints on hospital selection and retention procedures. The excluded physician or non-physician practitioner will often urge that a hospital’s decision to close or limit its staff is a concerted effort with competing physicians or non-physician practitioners to reduce competition rather than to increase the quality of service. Hospitals have a number of legitimate economic and administrative reasons for limiting access to their facilities. Limited access reduces the administrative burden of maintaining and monitoring the competence of the medical staff. The hospital’s increased control reduces the potential for mistakes and malpractice exposure. Administrative effi-

83. Id.
84. The three categories of hospital privileges are (1) medical staff membership (generally medical physicians); (2) limited practitioner with clinical privileges (practitioners who must have the permission of the medical staff before admitting, treating, or discharging patients); and (3) specified professional personnel (non-physicians who use hospital facilities but may not admit patients). Stephen E. Nagin, Litigation of Hospital Staff Privileges, Fla. B.J. 183, Mar. 1984, at 183-84.
85. In the period from 1960 to 1985, the number of physicians per 100,000 population increased from 141 to 204. During the period 1980 to 1985, however, over 270 hospitals closed resulting in a decline of almost 44,000 beds. See Alvin R. Tarlov, The Increasing Supply of Physicians, the Changing Structure of the Health Services System, and the Future Practice of Medicine, 308 New Eng. J. Med. 1235, 1238 (Shattuck lecture presented to the 202d Annual Meeting at the Massachusetts Medical Society, May 18, 1983).
88. Nagin, supra note 84, at 184.
ciency is also enhanced through the reduction of costs, as well as the variability of costs associated with staff scheduling and equipment maintenance. This rationale roughly parallels the business justification and denial of access elements of the essential facility doctrine. For instance, a hospital may "deny access" because the administrative costs of scheduling and monitoring additional physicians' use of its facility outweigh any resulting benefits.

An initial question in hospital "essential facility" cases is whether a plaintiff can demonstrate that a hospital has sufficient economic power in its challenged facility to enable it to successfully engage in anticompetitive conduct. Determining whether a hospital has monopoly power in a relevant product and geographic market (or submarket) is a difficult economic question. Courts have taken a relatively pragmatic approach by determining a relevant product market generally under a so-called "cluster approach." This approach determines whether a cluster of services that hospitals offer constitutes a relevant product market. The rationale is that hospitals provide a bundle of complementary services that provide patients and physicians with full service health care. Hospitals provide such services, in part, due to the economies of scale and scope that result. Under the cluster approach, the relevant product market is an array of health care services that provides additional benefits to patients and health care suppliers beyond those benefits that each service individually provides.

A criticism of the cluster approach is that it excludes hospital competitors who provide one or more, but not all, of the cluster services. For example, freestanding surgical and emergency care units do not

89. Milton L. Cruz, Product and Geographical Market Measurements in the Merger of Hospitals, 91 Dick. L. Rev. 497, 508 (1986). Other methods of defining the relevant product market are possible, such as reliance on the existence or organization of diagnostic related groups (DRGs). See, e.g., Loiterman v. Antani, No. 90-C-0983, 1991 WL 117209 (N.D. Ill. June 25, 1991) (summary judgment inappropriate because parties disagreed on factual issue whether product market consisted of five or twelve DRGs).

90. See, e.g., In re American Medical Int'l., 104 F.T.C. 177, 194 (1984) (defining relevant product market as the cluster of general acute care hospital services).

91. In American Medical, the Federal Trade Commission stated:

Although each individual service that comprises the cluster of general acute care hospital services may well have outpatient substitutes, the benefit that accrues to patient and physician is derived from their complementarity. There is no readily available substitute supplier of the benefit that this complementarity confers on patient and physician.

Id. at 194. In addition to considering the uniqueness of the cluster of services provided by the general acute care hospital, the Commission considered also the following factors in determining the relevant product market: (1) the uniqueness of the individual services and equipment provided; (2) the low cross-elasticity of supply; and (3) recognition that general acute care hospitals comprised a separate market. Id. at 193.
provide the cluster of services hospitals provide.92 Yet these units compete directly with hospitals for surgical and emergency care patients. The product market under the cluster approach therefore may be too narrow and may provide an inaccurate measure of the actual competitive environment.93

The determination of the relevant geographic market entails analyzing from which geographic areas hospitals draw their patients.94 This approach generally relies upon patient inflow and outmigration statistics.95 The patient inflow statistic measures the percentage of patients from outside a particular area who come to the hospital within the area.96 The patient outmigration statistic measures the percentage of patients from a particular area that use hospital services outside the area.97 If both the inflow and outmigration statistics are low, the particular geographic area is probably the relevant market.98 If both statistics are high, the geographical market should be enlarged.99

The court's market analysis in Robinson v. Magovern100 is instructive. A thoracic surgeon sued the hospital and staff members for denial of staff privileges. The court accepted the surgeon's contention that the relevant product market was "adult open heart surgery" because "no substitute for the product exists and because high entry barriers prevent most surgeons from becoming suppliers of open heart procedures."1101

The surgeon urged the court to adopt a narrow two-county geographic market and the defendant-hospital urged a broader national

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92. Cruz, supra note 89, at 513.
93. Some states, however, mandate that hospitals provide a cluster of health care services. Id. In these states, the cluster approach provides a more accurate product market description because most non-hospital service providers will not offer all the services the state mandates. Id.
94. In United States v. Philadelphia National Bank, 374 U.S. 321, 359 (1963) the Supreme Court stated that the relevant geographical market is that area "in which the seller operates, and to which the purchaser can practicably turn for supplies." (emphasis and citations omitted). The inquiry, therefore, requires a methodology for determining the predominant geographic area in which hospitals compete for patients.
96. Blair & Fesmire, supra note 95 at 45-50.
97. Id.
98. Id.
99. Id.
101. Id. at 878. The court noted the small elasticity of substitution between open heart surgery and patients' other alternatives by stating "[a] candidate for open heart surgery has no real choice." Id. In addition, the court determined that pediatric open heart surgery was a distinct product market because of the specialized procedures and equipment it requires. Id.
market. The court, however, rejected both parties' definitions and found that the relevant geographic market consisted of an intermediate sixteen-county area.\footnote{102} The court determined that a high percentage of open-heart surgery patients chose to have surgery in a hospital within the sixteen-county market.\footnote{103} The court further noted that almost all of the sixteen counties were represented at the six open heart hospitals in the market.\footnote{104} Although a high percentage of residents within the two-county area underwent open heart surgery at hospitals within that area, the court noted that hospitals within the two-county area had a fifty percent market share of residents from the remaining fourteen counties.\footnote{105} This evidence demonstrated that a two-county market was too narrow.

Some courts take a less rigorous approach in determining the relevant geographic market. For instance, in Mandava v. Howard County General Hospital, Inc.,\footnote{106} an anesthesiologist claimed antitrust violations against a hospital and staff for termination of his staff privileges. The defendants moved to dismiss the antitrust claims based on the hospital's lack of monopoly or market power in a relevant market and the hospital not being essential for the provision of anesthesiological services.\footnote{107} The anesthesiologist argued that because the hospital was the only acute care hospital in the county at issue, the county itself was the relevant geographic market.\footnote{108}

The court agreed with the Court of Special Appeals of Maryland which, in deciding an identical case brought by the same plaintiff, stated that "the relevant market must correspond to commercial realities and commercial realities are defined by proximity."\footnote{109} The court therefore rejected the one-county market definition because "at least seven other hospitals are within twenty miles or thirty driving [sic] minutes driving time of the [h]ospital."\footnote{110} The court also noted that there was no evidence that the defendants did anything to prevent the anesthesiologist from practicing at these other hospitals.\footnote{111} Because the one-county market definition was too narrow and failed to ac-
count for the "realities of [c]ompetition," the court dismissed the anesthesiologist's monopolization and essential facility claims.\textsuperscript{112}

The methodology the court in \textit{Mandava} used in reaching its conclusions regarding the relevant geographic market is less precise than the use of in patient inflow and outmigration statistics.\textsuperscript{113} For instance, if it were determined that the inflow and outmigration statistics for patients at the hospital at issue in \textit{Mandava} were low (based on a one-county geographic market), the court's conclusions regarding the relevant geographic market would be erroneous. Although the court was correct in recognizing that the geographic proximity of other hospitals is a relevant factor, the inflow and outmigration statistics are a better means of assessing relevant markets in antitrust cases.

With these market analyses in mind, a few illustrations show how some courts have analyzed hospital essential facility cases. In \textit{McKenzie v. Mercy Hospital},\textsuperscript{114} a short-term general care hospital, Mercy Hospital, was the only hospital in Independence, Kansas, and one of only three hospitals in the surrounding county.\textsuperscript{115} McKenzie, a physician, was granted staff privileges at Mercy Hospital from 1978 until late 1982 when the hospital's board voted not to renew his privileges based on their finding that he had violated hospital and medical staff bylaws and had engaged in unprofessional, disruptive conduct.\textsuperscript{116} The physician alleged that the refusal to renew his staff privileges constituted, in part, a violation of the essential facility doctrine.\textsuperscript{117}

The trial court held that the physician failed to establish the elements of the essential facility claim because he could not demonstrate that he and the hospital were competitors and even if he and Mercy "did compete in the physician services market, the facilities of Mercy Hospital were not essential to [the physician's] practice of providing non-emergency care."\textsuperscript{118} Notably, the physician's definition of the purported "essential facility" changed during the course of litigation from the entire hospital to the hospital's obstetrical care and emergency care units, and later to the hospital's emergency room.\textsuperscript{119}
The appellate court accepted the assertion that the essential facilities at issue consisted of both the emergency room and the obstetrical care unit.\textsuperscript{120} The court also accepted the physician’s assertion that the physician and the hospital were competitors because they offered similar services.\textsuperscript{121}

In addressing the essential facility issue, the appellate court explained that the doctrine prohibits certain refusals to deal that are part of “a vertical integration scheme calculated to drive a competitor out of business.”\textsuperscript{122} In reaching its conclusion that the facilities at issue were not “essential,” the court relied to a great extent on evidence the physician presented. One of the physician’s legal memoranda stated:

\textit{Doctor McKenzie has a substantial obstetrical care practice and in fact delivers infants in his office in Independence. To the extent that Dr. McKenzie does not admit these obstetrical patients to Mercy Hospital, Mercy Hospital is denied a market for the provision of hospital facilities to those patients. This is direct and immediate competition. In addition, it is indisputable that Dr. McKenzie at one time had a substantial emergency room practice. Since most emergency room visits are not in fact true emergencies, Dr. McKenzie is still competing with the emergency room to the extent that many of those patients could be treated by Dr. McKenzie in his clinic. If they were to choose to go to Dr. McKenzie, instead of Mercy Hospital’s emergency room, Dr. McKenzie would have the benefit of supplying them with ancillary services and supplies.}\textsuperscript{123}

The court relied upon this evidence to support its conclusion that the emergency room and the obstetrical care unit were not essential to the physician’s practice.\textsuperscript{124} Instead, the evidence demonstrated that the physician had a substantial and growing obstetrical care practice and continued to compete with the hospital’s emergency room even after losing his staff privileges.\textsuperscript{125} The court, therefore, concluded that the physician’s essential facility claim failed.\textsuperscript{126}

\begin{itemize}
\item \textsuperscript{120} \textit{Id.}
\item \textsuperscript{121} \textit{Id.} at 370-71.
\item \textsuperscript{122} \textit{Id.} at 368.
\item \textsuperscript{123} \textit{Id.} at 370.
\item \textsuperscript{124} \textit{Id.} at 371.
\item \textsuperscript{125} \textit{Id.} at 371 n.11.
\item \textsuperscript{126} \textit{Id.} at 371. The court decided not to reach the question whether the essential facility doctrine should apply to hospital staff privilege decisions. The court stated that “[w]hether the doctrine’s per se rule ought to condemn termination of a physician’s privileges is a question that must be answered only when all four criteria of the \textit{Hecht}/\textit{MCI} formula are satisfied. Because we conclude that Dr. McKenzie has failed to show that he was denied access to an essential facility, we do not address that question in this opinion.” \textit{Id.} at 371 n.12 (emphasis omitted). \textit{Id.} at 371 n.12 (emphasis omitted).
The court's conclusion is consistent with economic analysis. The physician did not demonstrate that the hospital's emergency room and the obstetrical care unit were "essential," constituted a natural monopoly, or created significant barriers to competition. Nor did the physician demonstrate significant accessible economies of scale. Instead, the evidence demonstrated that the physician continued to profitably provide services without the use of the hospital's facilities. While the physician's practice might have been more comprehensive and lucrative with access to the emergency room, the purpose of the essential facility doctrine is not to maximize the physician's income or protect the physician from competition. The court's refusal to grant access, therefore, was justifiable.

Essential facility claims are sometimes cast as "tying claims" where physicians are denied privileges because of existing exclusive agreements with other physicians. The excluded physicians may claim that such an agreement unlawfully "ties" the exclusive services to the essential facility, the hospital and its equipment. For example, in Konik v. Champlain Valley Physicians Hospital Medical Center, anesthesiologist brought an antitrust action against a hospital and a professional anesthesiology corporation. The physician, a hospital staff member for twenty-two years, withdrew from an anesthesia group practice that had entered a formal exclusive contract with the hospital. The hospital removed the physician from her anesthesia rotation schedule shortly thereafter.

The physician alleged that the hospital constituted an essential facility because it was the only major medical facility that operated continuously and provided anesthesia services in a three-county area. The hospital was also the area's only referral hospital and teaching institution and was unequaled in both reputation and staff expertise. The trial court, however, denied the physician's motion for summary judgment on the essential facility claim. The court applied the essential facility doctrine to the hospital's exclusive agreement with other anesthesiologists. The physician could have avoided this problem by alleging a tying violation under section 2 of the Sherman Act, which applies to unilateral conduct.

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127. In Mercy Hospital, the physician alleged an illegal tying arrangement under section 1 of the Sherman Act (which requires collective action). Id. at 366 nn.3-4. The court rejected his claim, however, because he did not demonstrate the hospital conspired with other persons or entities to engage in the tie. The physician could have avoided this problem by alleging a tying violation under section 2 of the Sherman Act, which applies to unilateral conduct.


129. Id. at 707.

130. Id.

131. The hospital contended that other hospitals in the three county area had similar facilities. Id. at 719.

132. Id.

133. Id.
facility test and stated that, even assuming the hospital was an essential facility, the physician had not established she was "unfairly denied" use or that denial of access resulted in any severe economic hardship. The court noted that the physician "has worked, and can continue to work, in other facilities." Finally, there may have been other hospitals in the relevant geographic area that had successfully duplicated the defendant-hospital's services thereby creating doubt regarding the physician's essential facility claim.

Again, the court's analysis is consistent with economic analysis. The physician continued to prosper without access and evidence indicated that others had replicated the purported "essential" facility.

One other case demonstrates judicial reluctance to embrace the doctrine as applied to hospitals. In *Smith v. Northern Michigan Hospital, Inc.*, the court rejected the application of the doctrine because of the lack of a horizontal relationship between the defendants. A group of physicians brought claims under sections one and two of the Sherman Act against a hospital and a clinic. The physicians, who had limited privileges at the hospital, alleged that the hospital's decision to award the clinic an exclusive contract for the provision of emergency room services was an unreasonable restraint of trade.

The physicians relied, in part, on the essential facility doctrine and urged that the defendants were horizontal competitors whose joint control over an essential facility resulted in an unreasonable restraint of trade. The court concluded, however, that the hospital was in a vertical relationship with the clinic and had to staff its one emergency room in the most "effective, efficient and medically prudent manner." For this reason, the essential facility doctrine was inapplicable. The court also found that the hospital had acted properly and had not adopted the exclusive contract to force the physicians from the market.

The court's conclusion is disputable because the court overlooked the fact that the essential facility doctrine can apply to vertically-inte-
grated firms or relationships that create "bottleneck" situations.\textsuperscript{144} The court nonetheless recognized that the contractual vertical integration between the hospital and clinic resulted in economic efficiencies that might be eliminated if the excluded physicians were given mandatory access.\textsuperscript{145} The court, however, did not consider whether these economic efficiencies outweighed the benefits of providing access to the alleged bottleneck. For this reason, further economic analysis was warranted. The case nevertheless indicates the general unwillingness of courts to impose the doctrine on hospitals.

2. Medical Office Buildings

Essential facility claims are not limited to medical facilities such as hospitals. Some claims have alleged that office space in a medical office building is an essential facility for the provision of medical services. For example, in \textit{Registered Physical Therapists, Inc. v. Intermountain Health Care, Inc.},\textsuperscript{146} a group of physical therapists, RPT, which provided out-patient physical therapy services at four locations, brought an antitrust action alleging they were denied access to a new medical office building.\textsuperscript{147} The primary defendant, IHC, owned and operated hospitals in the relevant product and geographic markets to which the parties had stipulated.

IHC had completed a new office building on a hospital campus and entered a ground lease agreement with a limited partnership, MMB, whereby it owned the land but MMB owned the building.\textsuperscript{148} Soon after completion, RPT sought to lease space in the building but IHC denied its request and leased the space to a competing back institute.\textsuperscript{149} IHC's lease with MMB contained a covenant preventing MMB from leasing space to any other physical therapists.\textsuperscript{150} Soon thereafter, the hospital contracted out its in-house physical therapy work to a joint venture that operated the back institute and was partially owned by a physical therapist who competed with RPT.\textsuperscript{151}

RPT claimed that its denial of space in the new medical office was the product of concerted action to keep it from competing with the

\textsuperscript{144} \textit{Id.} at 953; \textit{see supra} notes 72-78 and accompanying text.
\textsuperscript{145} \textit{703 F.2d} at 953 ("NMH not only may, but also is obliged, to staff its limited facilities in the manner which best serves the public interest. The evidence is overwhelming that it has done just that.").
\textsuperscript{146} 1988-2 Trade Cases. (CCH) \textsection 68,233 (D. Utah 1988).
\textsuperscript{147} \textit{Id.} at 59,483.
\textsuperscript{148} \textit{Id.} at 59,482.
\textsuperscript{149} \textit{Id.} at 59,482-83.
\textsuperscript{150} \textit{Id.} at 59,483.
\textsuperscript{151} \textit{Id.}
back institute. For purposes of analysis, the trial court assumed that the alleged conspiracy existed and that its purpose was to exclude competition from the new medical building.

RPT claimed that the new building was an essential facility because it could not be reasonably duplicated by competitors and access was necessary for RPT's competitive survival. The court, however, held that the facility failed to qualify on both counts. First, other suitable office space was available within a half-mile of the building, and space in the building could therefore be reasonably duplicated. Second, access to the building was not necessary for RPT to compete because RPT and its physical therapists were already competing "quite successfully" in the relevant market. The court concluded that the location of the building "was not essential to compete in the relevant market, even if the relevant geographic market were limited to the [building] and its immediate environs."

The court also analyzed RPT's claim under the rule of reason and concluded that no injury to competition had been demonstrated. RPT claimed that competition was hurt because the defendants allowed only a single back facility in the building, precluded doctors from using providers of their choice, and denied consumers a choice of therapists. The court concluded, however, that any such limitations are not the result of the plaintiffs' exclusion from the [building] but of their decision not to open a back clinic at another location. The plaintiffs were free to open up a back clinic at any of their existing locations along the Wasatch Front or to establish a back clinic at a new location, including one in the vicinity of [the hospital]. If consumers have been denied the benefits of new technology it is because the plaintiffs elected not to introduce it, not because they were denied access to the [building].

152. Id.
153. Id.
154. Id. at 59,486-87.
155. Id.
156. Id.
157. Id. at 59,487. "In fact, they had four offices in the geographic market, none of which was on a hospital campus or in an office tower adjoining or adjacent to a hospital. The only evidence in the record suggests that whether a physical therapist had an office in the tower or whether he had an office within half a mile of the tower made little difference in the referral practices of a physician whose office was in the tower." Id.
158. Id.
159. Id.
160. Id.
161. Id.
The court further concluded that even if the relevant market was limited to the new building and its immediate surroundings, no evidence of injury to competition existed. In fact, the defendants' decision to open a back clinic in the new building "actually increased competition by adding a new competitor to the market." In summary, these cases demonstrate that courts have been very skeptical in their analysis of claims that a hospital or other medical buildings are essential facilities. The courts have generally ruled that such facilities are not essential in an antitrust sense. None of these cases presented facts where an allegedly "essential" facility exhibited the characteristics of a natural monopoly. The courts' analyses generally did not require significant analysis of vertical integration issues, although one case based its conclusion on the benefits of contractual vertical integration (without weighing such benefits against the benefits of access). The courts have generally focused on factors that indicate whether denials of access actually resulted in any competitive harm. Because excluded physicians and others continued to compete effectively against the hospitals and facilities from which they were excluded, the courts concluded that no harm to the competitive process resulted.

B. Staff Privileges As Essential Facilities

Physicians and non-physician professionals sometimes claim that staff privileges or exclusive service contracts are essential facilities. They assert that they are unable to compete without privileges or contracts that permit access to such facilities. A number of courts, however, have rejected this position and have held that the staff privilege relationship between physician and hospital is unique and not subject to significant antitrust scrutiny.

In the oft-cited case, Pontius v. Children's Hospital, the plaintiff alleged that a hospital and other physicians conspired in violation of

162. Id.
163. Id. at 59,487-88. The court noted that the defendants' decision to keep RPT out of the building "allowed [the] fledgling back clinic to grow to the point where it could compete effectively." Id. at 59,488.
165. See Tarabishi v. McAlester Regional Hosp., 951 F.2d 1558, 1568 n.14 (10th Cir. 1991) (citing cases that have declared the essential facility doctrine inapplicable to staff privilege cases for public policy reasons), cert. denied, __ U.S. ___, 112 S. Ct. 2996 (1992); Robles v. Humana Hosp. Cartersville, 785 F. Supp. 989, 995-96 (N.D. Ga. 1992) (access to hospital is necessary for practice of obstetrics but "inappropriate" to apply doctrine that would prevent hospital from keeping unqualified doctors off its staff).
the antitrust laws not to retain him as a cardiovascular physician on the hospital's staff. The plaintiff asserted a per se essential facility claim. The court, however, held that the essential facility doctrine is inapplicable to hospital staff privileges decisions and entered judgment for the defendants. The court stated:

Even if we accept, without any evidence having been put forward, the proposition that [the hospital's] thoracic and cardiovascular surgical facilities may not practically be duplicated, we believe it would be singularly inappropriate to apply a doctrine which would prevent a hospital from keeping doctors it had adjudged unqualified off of its staff. Neither public policy nor the Sherman Act can countenance such a result. Consequently we now hold that the essential facilities doctrine is inapplicable to hospital staff privileges decisions.

The court's decision appears to be based entirely on its concern that mandatory access under a per se essential facility test could prevent a hospital from denying medical staff privileges to unqualified applicants.

The court's lack of significant economic analysis in rendering this public policy judgment is unfortunate. As discussed earlier in this Article, the per se standard is inappropriate for essential facility analysis. In some circumstances, staff privileges can exhibit the characteristics of a natural monopoly such that exclusion would significantly reduce competition. The court could have applied the doctrine, but ruled that either the facility could be replicated or that the admission of an unqualified applicant would inhibit the hospital's ability to service its customers adequately under the fourth part of the essential facility test.

Some courts have recognized that denial of hospital staff privileges can form the basis for an essential facility claim. Nonetheless, a greater number of courts have followed Pontius generally without significant analysis of the claims presented or the economics of the alleged denial of access. For example, in Castelli v. Meadville Medical Center, the court cited Pontius in support of its conclusion that the

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167. Id. at 1367.
168. Id. at 1370.
169. Id. (emphasis added).
170. See supra notes 35-38 and accompanying text.
171. 552 F. Supp. at 1352.
essential facility doctrine does not apply to "exclusive service contracts by hospitals." The court's conclusion was not as sweeping as it might appear. The court further stated in dicta that "if there were a case in which a hospital would be an essential facility, [the defendant] would not be that hospital. Within a forty mile radius of [the defendant-hospital], there are eight other hospitals at which Castelli potentially could practice." The court, therefore, undertook some economic analysis and concluded that the presence of a significant number of competing facilities negated the essential facility claim presented.

C. Exclusive Durable Medical Equipment Supply Contracts As Essential Facilities

The one type of essential facility claim that has had some success relates to exclusive contracts and referral relationships that hospitals enter into with suppliers of durable medical equipment and supplies (DME). Typical situations include a hospital entering into an exclusive contract with a single supplier of DME or forming a joint venture for this purpose. Excluded suppliers, who may have previously sold their products or services to the hospital's patients, claim that the exclusive contract denies them access to an essential facility (i.e., the market for DME to the hospital's patients). Hospitals counter that exclusive contracts are justifiable business arrangements that increase administrative convenience, reduce consumer confusion, and have little or no anti-competitive consequences.

The court in Advanced Health-Care Services, Inc. v. Radford Community Hospital was one of the first to recognize a DME essential facility claim. AHCS, a provider of DME, claimed that three acute care hospitals entered exclusive marketing arrangements with a com-

174. Id. at 1209.
175. Id.
176. The primary cases are Advanced Health-Care Services, Inc. v. Radford Community Hospital, 910 F.2d 139 (4th Cir. 1990), and Key Enterprises v. Venice Hospital, 919 F.2d 1550 (11th Cir. 1990), reh'g granted and opinion vacated, 979 F.2d 806 (11th Cir. 1992) (en banc), appeal dismissed and judgment vacated, 9 F.3d 893 (11th Cir. 1993) (en banc); see also M & M Medical Supplies & Serv. v. Pleasant Valley Hosp., Inc., 1992-2 Trade Cases. (CCH) ¶ 70,059 (4th Cir. 1992) (en banc) (not directly addressing essential facility claim).
178. See Advanced Health-Care Services, Inc. v. Radford Community Hospital, 910 F.2d 139 (4th Cir. 1990); Key Enterprises v. Venice Hospital, 919 F.2d 1550 (11th Cir. 1990), reh'g granted and opinion vacated, 979 F.2d 806 (11th Cir. 1992) (en banc), appeal dismissed and judgment vacated, 9 F.3d 893 (11th Cir. 1993) (en banc).
179. 910 F.2d 139 (4th Cir. 1990).
peting DME supplier in return for a financial stake in DME sales. AHCS claimed that two of the exclusive contracts violated the essential facility doctrine. The trial court, however, dismissed AHCS’ claim.

AHCS asserted that the essential facility was continued access to the hospitals’ patients for the purpose of selling DME. AHCS alleged that such access could not be duplicated and that the hospitals could feasibly return to their prior practice of providing AHCS and others access to their patients. AHCS further claimed that the hospitals could leverage their monopoly power in the provision of acute care hospital services into the retail provision of DME to discharged patients. AHCS contended that all DME dealers had equal ability to provide their services to patients, physicians, and discharged personnel before the hospital entered into exclusive contracts.

The appellate court held that AHCS met all the elements of an essential facility claim. The court’s decision hinged on its conclusion that the hospitals’ financial stakes in the sale of DME raised a factual issue whether the hospitals were competitors with AHCS. The court therefore remanded to allow AHCS to proceed with its essential facility claims. The importance of the court’s decision is that it recognized the doctrine’s application to exclusive DME contracts and provided excluded DME providers with a recognized cause of action.

Essential facility claims arise where hospitals vertically integrate into the provision of DME or enter joint ventures for the same purpose. For example, in Key Enterprises v. Venice Hospital, an excluded supplier of DME successfully asserted antitrust claims against a hospital that had formed a joint venture with a competing DME company. The trial court, however, granted judgment notwithstanding the verdict. A panel of the Eleventh Circuit reversed, but its

180. Id. at 142.
181. Id. at 142-43.
182. Id. at 143.
183. Id. at 142-43.
184. Id. at 150-51.
185. Id. at 149.
186. Id. at 150.
187. Id. at 151.
188. Id.
189. See also M & M Medical Supplies & Serv. v. Pleasant Valley Hosp., 1992-2 Trade Cases ¶ 70,059 (4th Cir. 1992); see generally Kopit & McCann, supra note 177 (arguing against application of the essential facility doctrine to DME diversification).
190. 919 F.2d 1550 (11th Cir. 1990), reh’g granted and opinion vacated, 979 F.2d 806 (11th Cir. 1992) (en banc), appeal dismissed and judgment vacated, 9 F.3d 893 (11th Cir. 1993) (en banc).
191. 919 F.2d 1550 (11th Cir. 1990).
opinion was vacated when the case was voted to be reheard en banc.\textsuperscript{192} Subsequent settlements on appeal mooted the action.\textsuperscript{193}

Although the panel opinion was vacated and has no precedential effect, its analysis remains instructive. In reinstating a verdict for the plaintiff, the panel held that sufficient evidence supported the jury's conclusion that the actions of the hospital and its DME joint venturer were an illegal conspiracy to monopolize the DME market in Venice, Florida, and impermissible monopoly leveraging.\textsuperscript{194} The panel stated that the plaintiff had presented sufficient evidence that the hospital had monopoly power in the acute care market in the relevant geographic market.\textsuperscript{195} The plaintiff's expert had also concluded that the hospital was an essential facility in terms of DME referrals (such "captive referrals" amounted to about 85\% of all referrals from the hospital and more than 46\% of the entire DME market).\textsuperscript{196}

The panel addressed the essential facility issue and discussed certain aspects of the economics of vertical integration. The panel pointed out that when hospitals vertically integrate into DME sales they can create barriers to entry by independent DME suppliers.\textsuperscript{197} The barrier can arise because excluded DME suppliers may not be able to enter the market without the referral source the hospital controls. On the other hand, the panel recognized that hospitals are entitled to vertically integrate simply to "reap the benefits of . . . integration."\textsuperscript{198}

In its opinion, the panel noted that it was for the jury, and not the trial court, to decide whether the hospital had entered the DME joint venture simply to benefit from contractual vertical integration, or to create or maintain a monopoly on its DME referral source.\textsuperscript{199} For this reason, it was improper for the trial court to supplant the jury's judgment on this issue.\textsuperscript{200} The panel therefore reinstated the jury's verdict.\textsuperscript{201} As mentioned, however, the Eleventh Circuit voted to review the case en banc but it was dismissed as moot due to intervening settlements on appeal.\textsuperscript{202}

The application of the essential facility doctrine to joint ventures and vertical integration by hospitals into DME markets involves com-
peting economic considerations. Hospitals have legitimate reasons to vertically integrate into DME to accrue the benefits of such integration. These benefits, however, must be weighed against the possibility that hospitals are maintaining their dominance over their own captive referral markets and thereby reducing competition and consumer welfare. Whether DME referrals constitute an "essential" facility or a "bottleneck" depends in large measure on whether alternatives exist and whether DME suppliers can survive without access.

**Conclusion**

Federal courts throughout the country have adopted the antitrust essential facility doctrine despite the lack of a consensus regarding the validity of the doctrine's legal and economic underpinnings. In the health care industry, the essential facility doctrine has become a potential weapon for health care professionals, service providers, and medical equipment distributors to access allegedly essential facilities such as hospitals, medical buildings, and medical equipment supply relationships. Courts have generally ruled unfavorably for such plaintiffs, in part because of the failure of the plaintiffs to demonstrate that denial of access has injured competition. Consequently, the outcomes of the cases discussed have been consistent with the premise that few truly "essential" facilities currently exist in the health care industry.