In the

Supreme Court of the United States

Abbott Laboratories, et al.,

Petitioners,

V.

Portland Retail Druggists Association, Inc., etc.,

Respondent.

No. 74-1274

Washington, D. C.
December 16, 1975

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v.	:	No. 74-1274
PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., etc., Respondent.	:	

Washington, D. C.

Tuesday, December 16, 1975

The above-entitled matter came on for argument at 10:59 o'clock a.m.

BEFORE:

WARREN E. BURGER, Chief Justice of the United States
WILLIAM J. BRENNAN, JR., Associate Justice
POTTER STEWART, Associate Justice
BYRON R. WHITE, Associate Justice
THURGOOD MARSHALL, Associate Justice
HARRY A. BLACKMUN, Associate Justice
LEWIS F. POWELL, JR., Associate Justice
WILLIAM H. REHNQUIST, Associate Justice

APPEARANCES:

JAMES H. CLARKE, Esq., 800 Pacific Building, Portland, Oregon, 97204; for the Petitioners.

ROGER TILBURY, Esq., 1123 SW Yamhill Street, Portland, Oregon 97205; for the Respondent.

C O N T E N T S

P R O C E E D I N G S

MR. CHIEF JUSTICE BURGER: We will hear arguments next in Abbott Laboratories against Portland Retail Druggists.

Mr. Clarke, you may proceed whenever you are ready.

ORAL ARGUMENT OF JAMES H. CLARKE, ESQ.,

ON BEHALF OF THE PETITIONERS

MR. CLARKE: Mr. Chief Justice, may it please the Court:

This case is before you on a petition for certiorari to the Ninth Circuit, which reached a judgment in favor of the petitioners which had been entered on a motion for summary judgment by the District Court. The action is one for treble damages and injunctive relief for price discrimination brought by an association of retail druggists against drug manufacturers. One of the classes of allegedly unlawful discriminatory sales are to non-profit hospitals.

The petitioners pleaded as a defense the Nonprofit Institutions Act which exempts from the Robinson-Patman Act all purchases of supplies for their own use by non-profit hospitals and certain other non-profit institutions. It was the respondent's theory, which has never changed and has been stated in this Court, that the exemption is limited as a matter of law to purchases of drugs that are physically consumed on hospital premises and therefore cannot be competitively supplied by retailers.

The District Court disagreed. It held that all drug uses engaged in by the non-profit hospitals as shown by the record, were the own use of the hospital, and it granted summary judgment. On appeal the Court of Appeals affirmed as to the non-profit status of the 13 general service hospitals whose affairs are before you today but limited the exemption to in-patient and emergency room use. It agreed that all of the rejected drug uses by the non-profit hospitals serve the public and are proper hospital functions but have held that in those cases the hospital is not the consumer and these drugs were purchased for its purchaser's use instead of its own.

Q When a hospital sells to a customer who walks in off the street, are they performing a hospital function or a drugstore function?

MR. CLARKE: This would depend upon the circumstances of a particular sale, Your Honor. There is no contention by the petitioner, on the one hand, that a hospital can set up a retail drugstore and stock it with 13c merchandise. On the other hand, when a customer comes in who, as a matter of need, emergency, or for some other reason finds it inconvenient or a retail drugstore is unavailable, we say that the hospital is performing a hospital function even though in those cases there is no associated hospital service of a distinct kind.

Q What about just refilling prescriptions at the hospital by a former patient of the hospital who has been given a prescription while in the hospital and he constantly gets it refilled?

MR. CLARKE: A refilling of take-home prescriptions is one of the three so-called minor categories of business that are involved in this lawsuit. In that case, it still could be a matter of convenience or a matter of extending hospital services. The hospital has the pharmacy prescription and as a matter of convenience they will on occasion come back. Most of the hospitals, according to this record, will not refill take-home prescriptions. There are three or four that will do it.

Q Mr. Clarke, this case parses down, despite all the weight and breadth and length of the briefs, to the meaning of the phrase "for their own use," does it not?

MR. CLARKE: I believe so, sir.

Q And it can be read broadly to include, I suppose, certainly the situation that the Chief Justice referred to, the hospital pharmacy selling to somebody who comes in off the street in an emergency or otherwise because that is for the use of the hospital in that the profit is for the use of the hospital. And it can be read broadly certainly to the extent that you can read the phrase right out of the statute, can you not?

MR. CLARKE: You can. There is an additional analysis which we think supports our position in this area. We think that when a sick person gets a hospital drug and uses it, consumes it, which is all that happens to drugs, he is obviously using the drug. That is what the drug is for. It has been prescribed for him to make him well. He is using it.

It is our position that when the hospital dispenses the drug to him as part of its institutional function, it is also using the drug, because that is all hospitals use drugs for.

Q They sell them to make money, and they do make money. And, therefore, the sale of drugs is for their own use.

MR. CLARKE: They dispense drugs, they charge for them, they make net profits.

Q The profit is for their own use.

MR. CLARKE: That is right.

Q And therefore there is no limit on this. This phrase read that way would not impose any limitation at all, would it?

MR. CLARKE: That has never been the position of the petitioners. Our position has been that the dispensing has to be associated or should be associated in some way with hospital functions.

Q With hospital patients?

MR. CLARKE: No.

Q Because a hospital can define its function. It can say, "We are going into the retail pharmacy business as one of our functions."

MR. CLARKE: I would not disagree with that, and if this were an appropriate thing for hospitals to do at any given point in time, I would say that this would be a very possible conclusion.

As the Court is aware, the record shows that each hospital has a pharmacy. It is an integrated department of a hospital. It achieves net revenues, and those net revenues are devoted to institutional purposes, namely, the financing of non-revenue producing departments.

The principal drug use is for dispensing to in-patients. The record shows that some 90 percent or more of all of these hospital drug purchases are used that way. And the dispute is over the remaining ten percent.

The bulk of this ten percent is used in three established distributional practices. The first is the take-home drugs that were referred to before. These are drugs that are prescribed by the doctor in amounts that are determined by the doctor. They are regarded as a continuation of the hospital's medication.

Probably the most hotly debated area before this

Court is in that of out-patient care. Out-patients fall into two classes, according to this record. There are the traditional out-patient clinics of which there are half a dozen in Portland associated with the hospitals as a hospital function, which cater primarily to the poor.

Q Are they all physically located within the hospitals?

MR. CLARKE: These are. I believe that Emanuel Hospital has sort of a campus type arrangement so it would not necessarily be in the same building.

Q But they are not wholly miles apart from the hospital?

MR. CLARKE: The clinics that I am now referring to are not. One of the issues in this case in the lower courts had to do with the Kaiser medical care, best Kaiser Hospital, which is a hospital for an HMO.

Q But that was reversed on another ground by the Ninth Circuit.

MR. CLARKE: That is correct, sir. But they have separated buildings.

The importance of out-patient care is not, however, limited to the clinics that conventionally served the poor. As I think is apparent from the American Hospital Association brief, which I will not repeat, this is a rapidly expanding area of hospital service. It is one which promotes the

public interest by reducing hospital costs and reducing the incidence of in-patient care by emphasizing the incidence of out-patient care.

Then the third primary category that was excluded is staff sales, the pharmacy privilege which is accorded by the hospitals to those who work for them and those who practice medicine in association with them. This is regarded by the institution as a benefit to the institution, something that promotes its operations; it is an important employee fringe benefit; it is negotiated for in some of the collective bargaining agreements that the institutions have; and it is a subject of the flyers and publicity that they give their employees when they come to work.

Q If hey are bound under a collective bargaining agreement or as a matter of their own self-imposed policy to sell drugs to their own employees and their employees' families at cost or a low price, they can continue to do so however this case is decided, can they not?

MR. CLARKE: The question is not, Your Honor, whether the hospitals should be selling these drugs in these ways. The question is whether they are performing appropriate hospital functions when they do. In the case of the pharmacy privilege, the record shows, we believe, that this is an integral part of the association of people and resources and materials which constitutes this hospital. It aids its

operations. And it is our theory that the exemption extends to all drug uses that aid or promote the operations of the hospital and that this is the scope of the statutory exemption.

Q And you make the same argument with respect to a surgeon who happens to practice in the hospital with respect to his office patients?

MR. CLARKE: I think so far as his patients who are hospitalized there is no problem as there is in any other case.

Q My question was not directed to them.

MR. CLARKE: But if the question is whether the surgeon should be allowed to supply his office patients with drugs purchased from the hospital pharmacy, if I am correctly construing--

Q I thought that was one of the categories at issue here.

MR. CLARKE: This is again one of the minor categories. The record shows that some, not all but some of the hospitals will sell drugs to a doctor for his office use, usually injectables or specialty items which are not available in the general retail market.

Q Let me take that one step further. If Dr. Smith who is on the staff, so to speak, of a particular hospital gives an office prescription to a patient, is that

patient free to go to the hospital and have it filled at the hospital pharmacy?

MR. CLARKE: Not if the hospital does not sell to walk-in patients.

Q And if it does?

MR. CLARKE: If it does, why then he would be like any other walk-in patient.

With respect to walk-in patients, the record is very clear that there are only two of these hospitals that make any walk-in sales on a non-discourage basis. There are two hospitals which are located in areas of particular need. One is next to a retirement home, and the other is in an area of elderly and poor people, and the administrators of those hospitals said that they will fill walk-in business for those two cases. Other than that, the record we think is quite clear, that the hospitals do not want walk-in business. They do not regard themselves as being in that business, and the incidence of walk-in sales is negligible, far less than one percent of total sales.

We think that the Court should consider in this case, in light of the statutory language, which is unlimited--it does not seek to define or limit the phrase "use"--that hospitals are institutions for the treatment of the sick and the injured. This is why they exist. And we say that it is the institutional use of their drugs when they are dispensed

for the use of the sick and the injured. It is a functional term.

The importance of drug therapy is also developed in the briefs. One of the keys to the expansion of out-patient services which reduces the exorbitant cost of in-patient services has been drug therapy which is received by hospital out-patients. All of these out-patients are registered hospital patients, and they are all receiving hospital services.

Q Mr. Clarke, so far the only function you seem to exclude for their own use is the actual operation of a retail pharmacy.

MR. CLARKE: I agree.

Q That is all?

MR. CLARKE: That is all.

Q Everything else is hospital use?

MR. CLARKE: My powers of imagination or inventiveness are perhaps limited, and there might be other categories that could be suggested.

Q Besides retail pharmacy?

MR. CLARKE: Besides a general retail store, but that is the obvious limitation. I do think that the Court can approach it from the other end and say that everything is hospital use which assists or aids or is associated with its institutional operations. That is a broad definition.

It is where we begin.

Q I do not see how that excludes a retail operation.

MR. CLARKE: The difference, as I see it, is that in the case of a straight commercial retail operation of the kind that Mr. Justice Stewart referred to, there is no association of hospital activities as such with the sale, and that is a possible ground of distinction. But I think I want to emphasize that there are categories of drug use in this case which are not associated with the actual performance of other hospital services. I am thinking particularly of supplying injectables to doctors' offices and supplying walk-ins that come in in the middle of the night and need drugs.

Q You would exclude those?

MR. CLARKE: I do not exclude those. I say that under those circumstances the sale of the drug is itself a hospital use because it relates directly to the hospital's function as a community medical resource.

Q Suppose there is a hospital on one side of the street and it has established a retail drugstore on the other side of the street but it sells drugs to walk-in customers in both places. You would say the retail drugstore is out of bounds?

MR. CLARKE: I am not anxious to build fences around

this exemption.

Q I understand that, but you have excluded from the exemption retail drugstores.

MR. CLARKE: I have excluded that from the exemption because I think there is a distinction, which I have tried to explain.

Q Just a walk-in customer who has never been in the hospital before and is not about to be again comes in to buy some drugs. He does not want to cross the street to the retail drugstore, and you sell it to him out of the drug dispensary in the hospital, and he has never been a patient in the hospital. So far as you know, he is not a patient of anybody on the staff in the hospital, and you just sell it to him. What connection does that have to have to some institutional service of the hospital?

MR. CLARKE: That isolated kind of sale would have no connection.

Q That is one of the categories mentioned in the court's opinion below.

MR. CLARKE: That is correct, and the record shows that the policies of the hospitals are to discourage walk-in business. The record shows that the volume of this walk-in business is negligible.

Q You brought the case up here, and I want to know whether you think we should agree with the court below

on item eight in their opinion, namely, walk-in customers.

MR. CLARKE: No, sir. First, the record shows that the walk-in business which does occur is associated with the hospital function that is usually in cases of special need. Therefore, there is an association with the hospital's community responsibility and therefore there is a sufficient nexus with the hospital operation to justify it.

Q If the Eighth Circuit opinion were narrowed to provide that emergency situations were excepted from their ban, would that satisfy your purpose?

MR. CLARKE: I think--

Q They already allowed that, did they not?

MR. CLARKE: No, sir. I am afraid I do not follow your question.

Q I did not know they excluded from the exemption the dispensing of drugs in emergency situations.

MR. CLARKE: No, it is in the emergency room, which is a special service. This is not that kind of--the emergency rooms usually have their own little supply of drugs which they dispense to somebody who is brought in after an automobile accident.

Q They included that.

MR. CLARKE: That is correct, sir.

Q But you are talking about some other kind of emergency.

MR. CLARKE: I am talking about--well, let us take the example of Emanuel Hospital, which is located in the black district of Portland. Drugstores close early in the day. It is a rough neighborhood, and somebody has to get a prescription filled. So, they come to the hospital pharmacy and yes, Emanuel will sell that walk-in customer and they do not know whether she is a patient of the staff or not, that is correct.

Q You said that the hospitals try to discourage the one percent apparently--you used that figure--the one percent of those who come in off the street to buy. The Court of Appeals, of course, has rather firmly discouraged that kind of business. But if that were not so, if we were to reverse the Court of Appeals on that item, would that not put a premium on every hospital in effect to open a pharmacy right within their own establishment?

MR. CLARKE: Our position does not go that far.

Q I am asking you about a tendency. You cannot control all the hospitals. No one can. There are no limitations on a hospital's right to sell to walk-in customers, the same kind of customers who come into a drug-store, a traditional drugstore. Would that not encourage hospitals to expand their pharmacy operations and actually seek walk-in business? It is profitable business.

MR. CLARKE: Obviously it would do so if the court

put no fence at all around them. It is our position that the walk-in customer can properly be served in these cases of emergency or need.

It is also our position that there has to be a certain flexibility in this statute. The pharmacist, when the person comes in, has to be able to exercise some kind of judgment.

Q What if the defense were that the hospital pharmacy could not sell to walk-in patients before 9:00 in the morning or after 9:00 o'clock at night? I guess I have it reversed--that they could not sell to walk-in customers from 9:00 a.m. to 9:00 p.m.

MR. CLARKE: Whether that would cover the range of circumstances in which those sales would occur? I cannot speculate. It would be an artificial kind of limitation.

Q When is it artificial, when that is approximately the business hours of the ordinary pharmacy, the neighborhood pharmacy?

MR. CLARKE: This is the point. This statute represents a congressional decision that within the area of this statute this will happen. This statute does not say one word about limiting the use of supplies to non-competitive ways, which is the net effect of the Court of Appeals. It is the effect of APHA's brief.

Q What about the language Justice Stewart read

to you, for their own use, unless you give this expansive reading to the term "their use"?

MR. CLARKE: It is our position that there must be a nexus between the dispensing of a drug and the operation of a hospital. And if there is that nexus, it does not matter what the circumstances or what kind of dispensing is involved. This is the fence you build around it. It must be related in some ways to the hospital's operations. It must assist the hospital's functions in treating the sick and the injured. But within that admittedly broad category there are going to be many kinds of drug dispensing, and the statute contemplates--because it is an exemption statute--that from time to time there will be an impingement on somebody else's business.

Q That would mean that they could always sell aspirin and bufferin to anyone who had a pain. Would you say that that is the function of the hospital embraced in the language "for their own use"?

MR. CLARKE: I would say that if they were at the hospital for diagnosis and they were under the care of a hospital, yes.

Q I am talking about walk-in patients. That is the subject, the frame. Are you saying that under this language it is a hospital function to sell aspirin or similar materials to any person who has a pain who walks in off the

street?

MR. CLARKE: I do not think that at this stage of hospital development that it necessarily is, no. I do think--

Q Then you should have no objection to a court construing that language as not including the casual walk-in customer.

MR. CLARKE: I think that it has to include--not exclude--the exemption has to include the casual walk-in customer who is there, for whom the hospital is providing a resource that the customer needs.

Q Then by your definition the hospital presumably determines its own function. And if it decides that that function should be performed out in a series of retail outlets separated from the hospital, you would still say that by selling bufferin and aspirin in those outlets it is performing a function which the customer needs.

MR. CLARKE: Mr. Justice Rehnquist, we do not say that the hospitals have an unlimited discretion to define their own functions. These functions are changing. They are changing.

Q But I have yet to hear from you any place where you would limit it.

MR. CLARKE: The hospital's discretion?

Q Yes.

MR. CLARKE: I think that there is an area within

which you can say that certain kinds of activities are appropriate and certain kinds are not. At this point I would not say that opening a retail drugstore is a proper function of a non-profit hospital. But 20 years from now it might be.

Q And under this same statute then those activities would be exempt.

MR. CLARKE: If these were appropriate and proper hospital functions, yes, sir, they would be.

Q And "appropriate" and "proper" is defined by hospital practice generally.

MR. CLARKE: That is correct, sir.

Q Mr. Clarke, you have devoted a good deal of your argument to a problem that involves, as I understand what you say, less than one percent.

MR. CLARKE: About one-third of one percent.

Q One-third of one percent. May we come back to what seems to me to be more substantial. I have in mind at the moment out-patient operations. You said there were two categories of those, the traditional out-patient department that serves for the most part indigents and, secondly, a newer type of out-patient department that serves the public generally, primarily to relieve the burden of in-patient service for which facilities are inadequate. Are both of these functions performed from the same out-patient

facilities, or do you have different types of facilities for the two?

MR. CLARKE: The general pattern, Mr. Justice Powell, is that the out-patient services are performed at the central institution. However, around the country the system of satellite clinics is developing, and in Portland this has developed with the Kaiser organization which of course is not before us.

Q Do you have satellites in two of the 12 hospitals?

MR. CLARKE: That could be. There either are or they are being projected.

Q But basically the same facilities serve both types of patients?

MR. CLARKE: That is my understanding.

Q Right. And you said, as I understood it, that out-patients are registered.

MR. CLARKE: That is correct.

Q What does that mean?

MR. CLARKE: That means that they are registered on the books of a hospital as hospital patients just as an in-patient is registered when he comes in.

Q And when a prescription is issued to a registered out-patient, does the prescription show on its face that the patient is a registered patient so that the

pharmacy can distinguish between the registered out-patient and the walk-in non-patient?

Q I believe not. The way this is done at Emanuel, which is the outstanding example in Portland because it is so much larger and more compresensive than the other, is that at least at the traditional out-patient clinics they give the patient a card, and he shows that card to the pharmacy when he comes in.

Q Which identifies him as a registered out-patient?

MR. CLARKE: That is correct.

And the employee will have a card that identifies him.

Q Right. And there is no reason why the out-patients who are registered cannot be identified.

MR. CLARKE: In that particular case. I do not know how this is handled in the other institutions.

Q It is physical possible to devise means to identify registered patients.

MR. CLARKE: That is correct.

Q Right. Another question I wanted to ask relates to renewals of prescriptions for in-patients. You said that this ordinarily occurred at the time of a discharge, the prescription being provided for the patient to take home with him or her. Does the record show the

percentage of renewals that occur or have occurred according to this record subsequent to discharge at the hospital--in other words, repetitive renewals?

MR. CLARKE: It does not show a percentage. There are only three or four of the hospitals which will refill take-home prescriptions. And I believe in one or two of them they did estimate the volume of it, and the volume was quite low, as I recall, 25 or 30 a week or 20 a week or something of that kind in one of the larger ones. But there is no hard information about the actual volume of refill business. As a matter of fact, if a patient lives any distance from the hospital, it will be more convenient to go to a retail drugstore anyway. This would tend to happen only in these cases where the hospital pharmacy is convenient.

I will reserve the rest of my time.

Q Before you sit down, may I ask you this question. On the front of your brief and on the inside cover of your brief are listed several petitioners in this case. I think those lists are not identical. May I ask, are there any other petitioners?

MR. CLARKE: No, sir. So far as I am aware, the lists are identical. If they are not, it is the printer's error.

Q Specifically may I ask, is Merck & Company a petitioner?

MR. CLARKE: No, sir.

Q Thank you.

MR. CHIEF JUSTICE BURGER: Mr. Tilbury, you may proceed when you are ready.

ORAL ARGUMENT OF ROGER TILBURY, ESQ.,

ON BEHALF OF THE RESPONDENT

MR. TILBURY: Mr. Chief Justice, may it please the Court:

First I would like to answer Judge Powell's question that he just presented as to the ratio of refills. There is in the record that in so far as Kaiser is concerned, the ratio is approximately 40 percent. The other hospitals do not assign a new number to a refill, and for this reason it is difficult to know, and their records are incomplete. They sometimes will assign a letter after a number, but we think it is substantially larger than the defendants so far have conceded.

Q Kaiser has a different kind of operation though than the other hospitals, did it not? And its summary judgment was reversed on a much broader ground by the Ninth Circuit.

MR. TILBURY: In a way, Your Honor, that is true. However, the other hospitals are patterning themselves to a degree after Kaiser, and we can see that if this Court should sustain the position that Mr. Clarke wishes, that they are

soon going to embark upon the same type of program. It is true, as you point out, that the Ninth Circuit did send that back for a reexamination in so far as Kaiser. But the matter of developing these clinics which are considerably removed, incidentally--in the case of Kaiser some of them are up to 10 and 12 miles away from the hospital--will be the way in which they are definitely trending to go.

Q But the lawsuit has got to be decided on the basis of the facts as they exist, I presume.

MR. TILBURY: I would certainly agree, yes. As a matter of fact, Your Honor, since you mention that point, I would like to say that much of what Mr. Clarke has said seems to us to be irrelevant for the very reason that the issues he assigned in his two briefs, his petition and all the way through his primary brief, do not deal with the category of walk-ins, they do not deal with refills, and they do not deal with the category of office use by doctors. The only three things that he has assigned, as you recall, deal specifically with the employee and staff position sales and with the take-home sales to a patient on his way out and to the matter of out-patients. These are the only things that--

Q The out-patients include the out-patient clincs.

MR. TILBURY: Well, that is an interesting question.

Q Does it not?

MR. TILBURY: I am not so sure. I cannot tell for certain exactly what he has said. He has mentioned the factor of out-patients, but I am not entirely sure as to what position he is taking.

Q In the out-patient clinic or the clinic where the hospital operates a clinic for the public, I take it the doctors are hospital agents or employees.

MR. TILBURY: Sometimes.

Q Anyway, the bill the patient gets is from the hospital.

MR. TILBURY: Yes, sir.

Q So, if one of those patients, out-patients in an out-patient clinic, is suddenly hospitalized and he is there a week and then he is discharged but he is still an out-patient, he will just get periodic bills from the hospital.

MR. TILBURY: He would be billed by the hospital.

Some of the doctors, however--I think almost all the doctors at the Kaiser clinic in Portland practice only at the clinic, and it is only in a rare situation that they would refer anyone to the primary hospital. They operate truly in the case of Kaiser, and this is tending to be true in other cases as well, as drugstores in the true sense of the word. As a matter of fact, they are within a few blocks of many of them. They have doctors that are there who are

technically and in a real sense of the word employees of the Kaiser Foundation, although they have their own separate corporation called Permanente Services, I might add, and in the sense that their connection with the hospital is a rather tenuous one, except they are all technically under the Kaiser blanket.

Q Do you quarrel with the hospital filling a prescription or refilling it or selling a non-prescription item after normal business hours to meet an emergency?

MR. TILBURY: Not at all, Your Honor.

Q It is not our business or even the Court of Appeals to undertake to prescribe forms and mechanisms. But from your close association as both of you gentlemen have had with this case, would it be difficult, in your view, to set up a procedure and a mechanism to take care of some kind of certification as to particular after-hour sales for an emergency which would define what the emergency was?

MR. TILBURY: Not at all, Your Honor. We have never objected to any sales by the hospitals of any kind. As a matter of fact, we would not object--I do not think we can since we also believe in free enterprise--if they wanted to conduct a retail store.

Q That would be on different terms, though.

MR. TILBURY: Yes, sir.

Q I am talking about within the framework we have

here. You, I take it then, would not object to walk-in service, walk-in customers, for emergencies after normal business hours.

MR. TILBURY: Not at all, Your Honor. We certainly do not want to deprive anyone who needs medication getting the medication.

Q When you say you would not object, do you concede that those drugs would have been purchased by the hospitals for their own use?

MR. TILBURY: No, sir. There is a distinction, and I hope I am making it.

Q I was asking the question in the framework of our entire dialogue here. In fact, I prefaced the question, Do you think that is a proper hospital function? I will repeat it: Is it a proper hospital function in this framework--the only reason that we are all here--if sales are made to walk-in customers after regular business hours and for some declared emergency situations?

MR. TILBURY: I am sorry if I am not making it clear, Your Honor, and I will try to make it clear. We do not object to any type of sale that the hospital wishes to make. But we do say that Congress, when it passed 13c, limited exemption to their supplies for their own use.

Q Let me narrow the question. Is it for their own use to sell after regular business hours to meet an

emergency for a patient? Is it "for their own use"?

MR. TILBURY: No, sir, unless that patient happens to be a hospitalized patient and unless he uses it in the emergency room on the premises, in other words. And this has always been the case. As a matter of fact--

Q But if you will help me, Mr. Tilbury, if you will not mind stating exactly what do you say is for their own use within these eight categories that Judge Merrill specified?

MR. TILBURY: We think the Court of Appeals decision is correct, that it should be limited to a use on the hospital premises by a patient or somebody--

Q One, they would dispense to the hospital's in-patients during the course of treatment. That is for their own use, is it?

MR. TILBURY: Yes, sir, we concede.

Q The second one is they would dispense in the course of treatment to patients of emergency clinics operated by the hospital; is that for their own use?

MR. TILBURY: Yes, sir, we think it is.

Q They were provided to departing in-patients as take-home prescriptions; is that for their own use?

MR. TILBURY: No, sir. Just the first two, Your Honor.

Q Only the first two?

MR. TILBURY: Yes, sir.

Q The other six are all within Robinson-Patman?

MR. TILBURY: That is correct, for the reason, Your Honor--

Q I just wanted to know what your position was.

MR. TILBURY: For the reason that it is not used on the premises, is not used under hospital supervision. The individual has no connection with the hospital once he leaves the hospital. And the reports indicate, despite what Mr. Clarke has said, that this was not intended to encompass the world, that Congress did intend to restrict it to a situation where it was intended to be used on the premises and for that particular function.

Q But does not that overlook the modern trend--and when I say modern, it is beginning 30 or 40 years ago--to (a) keep people out of hospitals if they can and (b) to get them out of hospitals as quickly as possible after surgery or other treatments?

MR. TILBURY: We will all agree that that is a desire, yes.

Q There just are not enough hospitals, are there?

MR. TILBURY: Certainly that is true. I do not think there are enough drugstores either, Your Honor, at the present time.

Q As a result, after the delivery of the baby,

they are having mother and child go home sometimes in 24 hours; after surgery that formerly was two or three weeks, they now send them home in two or three days or even less. Are you going to have a trend that is going to lengthen the hospital stay here?

MR. TILBURY: In a way. As I again repeat, Your Honor, we do not object to anything they can do to alleviate the plight of the patient, whatever that may be. And if they wish to sell in any way, at emergency times, whatever, but we think that Congress meant what it said when exemption was not an unlimited one. If they had meant strictly that it applies to all non-profit institutions, they could have said it that way, but they did not. They specifically said purchases of their supplies for their own use.

As you well know, the words are construed with regard to their normal usage. Congress has not presumed to use superfluous words. Those words have a meaning, and the word use has always meant consumption by the individual using it. It does not mean a resale.

As a matter of fact, rather strangely, Mr. Clarke seems to be at cross purposes with his own client, Lilly, because Mr. DuBose, for example, told Congress during the extensive hearing--which agreed with our interpretation by Congress in 1967 and 1968--extending over a thousand pages that that was what it meant. It meant a use within the

institution itself. And Mr. DuBose, who used to be in charge, manager of the Portland office for Lilly, told Congress that "In general, I think we can say that the furnishing of drugs to out-patients or to patients off the street probably results in a competitive inequity to the retailer." And for years Lilly has required all the hospitals that buy from it, before they can acquire their goods at a preferential price, to sign an agreement that the particular institution will "use the products only for its own use within the institution and not for resale."

Q How about a clinic in a hospital, as far as Lilly is concerned, where the hospital itself in the hospital is operating the clinic?

MR. TILBURY: I would again say, since--

Q I am just asking about Lilly. What is their view about that?

MR. TILBURY: I would interpret Lilly's agreement to mean that it has to be used at the hospital.

Q It is used at the hospital in their clinic.

MR. TILBURY: All right, then I would say it is a proper hospital use.

Q As far as Lilly is concerned?

MR. TILBURY: I can hardly speak for them, but I would think so.

Q But you disagree with that?

MR. TILBURY: No, sir. No, I do not disagree with it.

Q That comes under two?

MR. TILBURY: Yes.

Q Why does that come under two? It is not an emergency clinic.

MR. TILBURY: Whether they call it a clinic, whatever they call it, if it is used at the hospital under hospital doctors on the premises for consumption there, then this is the sort of thing that Congress intended.

Q Do you agree that that is within the exemption?

MR. TILBURY: Yes, sir, if it is used at the hospital.

Q That seems to me much broader than one and two. Maybe I just do not understand.

MR. TILBURY: My own position--

Q Let me follow through a little bit on this because you have just said for consumption there.

MR. TILBURY: Yes, sir.

Q Suppose a prescription is given to an in-patient for a hundred tablets, whatever it is, and when he is discharged tomorrow, he has 90 of them left and takes them home. Still all right under the Robinson-Patman Act?

MR. TILBURY: No, sir, I do not think so because the point of consumption is no longer at the hospital. It is

for use at home.

Q So, the hospital then on your theory would have to parse that between the ten that were consumed while an in-patient and the 90 that he took home?

MR. TILBURY: Yes, Mr. Justice Blackmun, and, incidentally, that is not a difficult thing because once it leaves the hospital, the hospital rules and the Oregon statute and the statute in every state that I am aware of require that it be given a prescription number; they actually will repackage it in those situations, or they are supposed to under the state law--and they do, I think--and assign a number at the point it leaves the hospital because it is no longer under the hospital control or supervision. And when they came to Congress and asked for this, they talked in terms of the need and extending the care to the needy patient. This was the thing that was stressed. The hospital is not providing care when the individual is no longer at the hospital. By definition he cannot be extended the care of the hospital if he is not at the hospital. And this is our position, and I think this is what Congress--

Q To go back to the clinic case, an out-patient of a hospital clinic that is operated on the hospital premises comes in regularly for shots. You say apparently that is within the exemption.

MR. TILBURY: I think it is. I think it is.

Q That is certainly broader than number two, just in emergency.

MR. TILBURY: Your Honor, my difficulty is this--

Q It is though, is it not?

MR. TILBURY: I do not visualize it as such. Perhaps Your Honor may disagree with me, but the fact is that what is an in-patient and an out-patient is a matter of definition, and there is considerable disagreement among hospital administrators as to what that term means. But I think when Congress spoke in terms of care and supervision and "for their own use," they were speaking in terms of the hospital because they not only said the word "their" once, they used the word twice, and of course they used the term "supplies for their own use," and "use" has always--as far as I know, since Wycliffe in 1388--said that that means consumption; it does not mean that you resell it to somebody else for their use. We are talking about two entirely distinct things at that point. And at the point that the hospital has no more control over it, in the case that Justice Blackmun mentioned where the drugs are taken home for consumption, at the point it leaves the hospital there is no more supervision at that point.

Q Let me put this in a practical but hypothetical question. Thirty years ago or more, an appendectomy or herniotomy meant two weeks at least in the hospital. Go on

that assumption. It is the fact. Today it is two days or three days. But with the patient may and usually does go some sedation and pain killer and that sort of thing. Do you say that that is not part of the hospital care, for the hospital to furnish that material when the patient leaves the hospital to go home and do at home just what formerly was done for the patient in the hospital?

MR. TILBURY: At the point it leaves the hospital, the hospital is no longer using it. The former patient is using it. And I think there is a distinction there.

Q Are they not using it if they give it to him before he leaves?

MR. TILBURY: Yes, if they give it to him before he leaves for consumption at the hospital, yes.

Q No, no, before he leaves for consumption at home, for consumption whenever he needs it, under instructions.

MR. TILBURY: It is not the use by the hospital, and I think we have to use the language that Congress itself used, and the congressional committee said that at the point it leaves the hospital that it is no longer the hospital that is using it. It is a private individual because there is no control over that at the point it leaves the hospital.

Q But you are reading "use by the hospital" as if it meant use in the hospital. I mean, there is no use by the hospital in the sense that the hospital as an institution does

not itself take any drugs. It is patients that take drugs.

MR. TILBURY: Of course that is true in the sense that the hospital, a corporation, does not imbibe and use the drugs, no. But at the point that the hospital ceases to have any control over what happens to those drugs--and we have had many cases where we found that they not only had given them medication for a couple days but they had given them medication for six months and longer. Incidentally, we have also in the record where they have actually forced sales on people who did not want the drugs at the time they left the hospital but found it on their bills. And when they protested, they were not able to have it removed in certain cases.

And, incidentally, the quantum of these is not the one percent or the one-third of one percent. We have evidence in the records showing that in the case of Kaiser it is well over 400,000 prescriptions--

Q But Kaiser is not here in any capacity.

MR. TILBURY: All right, in the case of St. Vincent's, another one, 231,000 over the space of about five and a half years. In the case of Good Samaritan it is roughly 54 a day. These are not minimal things. He is trying apparently to argue de minimis again, although at various times he disavows that de minimis is a defense here.

Q Does the record show what the economic impact of hospital sales is on the drugstores, or do the

hospital pharmacies undersell the drugstores?

MR. TILBURY: Yes, they do, quite often. And another problem is that they charge a differential price to their in-patient as against people that come in off the street. They do not pass along the savings in cost, we have found many times, to the in-patient. He is charged sometimes considerably more even than an individual that went to the corner drugstore to buy it. But then having that leverage, plus not being taxed, which they are not, then they are able to slas the market considerably at the other end by selling to drop-in type people, people having no connection with the hospital. Was this the intent of Congress, to literally destroy the corner drugstore? Because make no mistake about it, I do not exaggerate; that is precisely what has occurred in Portland and will occur nationwide and is occurring. This sort of thing is a real source of danger. I do not think there was the intent by Congress to upset the original patterns of distribution which had evolved over so many years. We say this; sure, the hospitals perform a function and a very good function. Fine, let us preserve them. But at the same time do not destroy the alternative which all of us have had up until now.

Q You do not want them to perform your client's function. That is the essence of it, is it not?

MR. TILBURY: No, Your Honor, I do not say that. I

say they can.

Q Is that not what the case is about?

MR. TILBURY: I say this, that if they decide to act like corner drugstores, they should pay the same price. Only that.

Q That is what my question, if it was a question, had in mind.

MR. TILBURY: Well, 13c gives them an exemption, as you know, for certain purposes. At the point it is no longer for their use, then we say the Robinson-Patman Act applies and they should treat with equality the drugstores and the hospitals, if a hospital conducts its operation in precisely the same way as the corner drugstore, and they are. They are indistinguishable in many cases, and it is not limted strictly to Kaiser. Anyone can come in. And incidentally the amount of these we have found--we have several affidavits in the files saying and showing that it is very easy to purchase at some of these hospitals even though their administrators later have disavowed this. But we have investigators that have been able to buy them with simply impunity and not have it questioned at all. And this sort of thing is going to happen and will occur with greater frequency unless in some way the Court says that that law means what it says.

Q Mr. Tilbury, you draw the line at whether or

not the drugs were consumed on the premises of the hospital. Suppose there were no Section 13c at all. Would there be any competition with respect to drugs consumed on the premises of the hospital?

MR. TILBURY: I do not feel that that is a competitive impact if it is consumed on the hospital premises by an in-patient. Fine.

Q So that with respect to the drugs that you think--

MR. TILBURY: Excuse me, may I qualify that. I do not say that there would be a competitive effect in so far as our clients are concerned. There would be an impact in so far as say a profit hospital that might be two blocks away. So, in this regard the law was changed.

Q This case involves only your clients.

MR. TILBURY: Yes, sir, that is true. But I did want to point out that that change did take place because of 13c because now, even though competition is affected, they may discriminate in price in favor of a non-profit hospital even though it may have rather devastating effects to a profit hospital.

Q In terms of the interest you represent, your clients, what purpose does Section 13c serve in light of your view of the act?

MR. TILBURY: It clarified the law. It permitted them

to make sales within the hospital because Congress felt in 1938 that that was illegal. Both the Senate and House committees and also the letter which is quoted in both of those reports from the man who then headed the Hospital Bureau of Supplies and who was more or less the instigator of this particular bit of legislation felt that--

Q If there is no adverse effect on competition resulting from drugs consumed within the hospital, you never get to 13c, do you?

MR. TILBURY: In light of the present case law, that is true. In light of the case law as it was in 1938 Congress felt that that was an illegal operation. I am willing to concede--

Q That is talking about the secondary line, but there would still be a question of competition to a primary line--

MR. TILBURY: There could be a primary line, yes.

Q --between manufacturers.

MR. TILBURY: That is true.

Q And 13c would serve in that respect in any event.

MR. TILBURY: Yes, Your Honor, that is certainly correct that that effect also took place, yes.

But Congress certainly felt it was serving a function in passing 13c. And Congress felt it was illegal at

that point. And the Senate committee said so and so did the--as a matter of fact, it said it had now made it illegal. So, this change was brought about by 13c. And it clarified the situation of the in-hospital use as well. So, I concede it, and in light of the case law now, I would concede that probably even then it was unnecessary if the case law had developed to the point that it now has. But that was something that Congress was not in a position to forecast accurately.

Again, I return to the words of the statute which I think basically is what we are talking about. The word "supplies" also means something other than resale. A supply wagon in the days of the Old West meant supplies that went to a particular fort or a particular city or something of that kind. It did not mean things that were going to be sold in a vendor's cart from door to door. These are not supplies. And "use" means--and certainly under all of the use taxes of every state I can think of--that at the point something is re-sold--and of course this is the Astor case which this Court decided in 1882--when you talk about a resale, that is no longer a use. It is simply supplying something to be used by somebody else. And when Congress stressed the word "their" twice, their supplies--and I notice this seems to be dropped occasionally from the petitioners' brief--their supplies for their own use, that word "their," used twice, certainly meant the hospital. It did not mean the private consumption of

somebody off the premises having no connection with the hospital and particularly when they went to Congress and said we need it to take care of the needy sick within the institution.

Q To be more precise, it has to mean for the use of the hospital's own patients.

MR. TILBURY: Well, I suppose. That is an interesting thought.

Q If you are talking about the use of the hospital, the hospital does not use the drug.

MR. TILBURY: They could do it for experimental purposes, Your Honor. I could conceive of that, but that is about the only exception.

Q That is not what you are arguing about.

MR. TILBURY: No.

Q But you do not insist on that limitation. I mean, if read literally, as my Brother Rehnquist says, then the only supplies actually used by a hospital would be things like furniture and so on, but in the area of drugs it would just be for their own corporate use--

MR. TILBURY: I do not interpret it that way.

Q --own corporate consumption.

MR. TILBURY: No, I would not so limit it. I think in the case of use by the patients in the hospital, that certainly is a permissible thing. No question about it.

I might say also that at the very least--of course I do not need to argue extensively the point that this was decided on a summary judgment. It was decided at the earliest stage I have ever seen a case resolved in the sense that we had no meaningful discovery; we were not permitted to ask any interrogatories; no motion to produce was permitted to us; we were not permitted to ask the depositions or take the depositions of a single one of any of the petitioners' employees. The only thing we were permitted to ask was to pose a few of the hospital people, and we were greatly limited there.

Q Did you not win?

MR. TILBURY: Pardon me?

Q Did you not win?

MR. TILBURY: Did I win?

Q Yes.

MR. TILBURY: Well--

Q You won in the Court of Appeals.

MR. TILBURY: That is true, but in the lower court--yes, sure. In the lower court we had to go with a very handicapped situation, and we still think that the quantum of this discrimination--he is now insisting it is like one-third of one percent. We think it is more like 40 percent if the truth emerges, and we certainly hope that it does. But I can never recall a case in my own experience where it has

been resolved with so little discovery.

Q Do I correctly translate your observation to mean that this Court should not reverse the Court of Appeals on this record? We might affirm them on this record but not reverse them; is that what you are saying?

MR. TILBURY: Yes, sir. I would be pleased about that, yes, sir.

Q Well, you have to cross-petition to bring before us any problem as to the adequacy of the summary judgment here in the District Court, I would think.

MR. TILBURY: That is true, and I did not. That is very true.

I might say this. Our target is not the entire drug industry. As a matter of fact, you will notice we have only sued 12 defendants, which is probably enough to keep me talking--only 11 of these actually because one is a holding company. There are many drug companies in this field, including, I thought, Lilly--because Lilly has this agreement--which do not make this dichotomy at all, that do recognize the law and do have a unitary price in so far as you have a competitive situation.

This Court has said in the Sun Oil case and many others, in the Robinson-Patman case, that competitors, where you get a competitive impact should start from the same plane. That is all we ask. We ask that if they want to act like

drugstores, then give us the same break. Please let us acquire the same drugs and then let the consumer make the choice. If he prefers a hospital to us, fine. That is his privilege. But I do not think that if you are going to have a race--and that is what competition I guess fundamentally is--that one competitor should start off at ten yards behind the rest of the competitors. And that is where we are. The degree of competition here is astounding. I believe it was far in excess of anything that I would have ever imagined. Sometimes we are being charged five times what the hospital is. If the drugstore--and I say this quite literally--is to survive, then they must be given a chance to compete on fair and equal terms. They are not being given that chance now, and they have challenged me on the numbers. The fact is there are not 211, as he stated in his reply brief. In Portland at the present time there are 152. And if you want to go strictly to the city of Portland itself, there are only 64 within the city limits for a city of 450,000. There used to be 123 more within the tri-county area, as our map in the back of our exhibits shows. These are real dangers.

We think the drugstore is a part of the American scene too, but it will no longer be that.

Q How many Portland drugstores that you are talking about are in a chain?

MR. TILBURY: At the present time within the city of

Portland, if you exclude the chains, Your Honor, there are 64.

Q And if you add the chains?

MR. TILBURY: The chains would add within the city limits itself I think a number 17 or so, something like that.

Q That is individual retail outlets?

MR. TILBURY: Yes, sir. That is counting each individual retail outlet, even though it may be part of a chain. But this is a problem.

And, incidentally, they mentioned just in passing that 23 new ones have opened. Those 23 are not all community pharmacies, and this is since 1971. Only seven of those are what we normally describe as drugstores. The others are clinics, they are nursing homes, they are things of this kind.

My time is up. Thank you.

MR. CHIEF JUSTICE BURGER: Thank you, gentlemen. The case is submitted.

[Whereupon, at 12:00 o'clock noon the case was submitted.]

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