IN THE MATTER OF

THE AMERICAN MEDICAL ASSOCIATION, ET AL.

FINAL ORDER, OPINION, ETC., IN REGARD TO ALLEGED VIOLATION OF THE FEDERAL TRADE COMMISSION ACT

Docket 9064. Complaint, Dec. 19, 1975 — Final Order, Oct. 12, 1979

This order, among other things, requires a Chicago, Ill. medical association to cease engaging in any action that would restrict its members' solicitation of patients by advertising, submission of bids, or otherwise; interfere with the amount or form of compensation exchanged for a member's professional services; characterize as unethical the use of close panel or other health care delivery plans that limit patient's choice of a physician; or characterize as unethical the participation by non-physicians in the ownership or management of health care organizations that provide physical services. The American Medical Association ("AMA") is further required to mail to each of its members a letter setting forth the terms of the order; amend its *Principles of Medical Ethics* and the Judicial Council's *Opinions and Reports* to conform with those terms; and publish the revised documents in specified medical journals. Additionally, AMA is required to terminate, for one year, all ties with any medical society that engages in prohibited conduct.

Appearances

For the Commission: *L. Barry Costilo, George J. Wright, Daniel R. Barney, Arthur N. Lerner* and *Ann Malester.*

For the respondents: *Newton N. Minow, Jack R. Bierig* and *Robert E. Youle, Sidley & Austin,* Chicago, Ill. for respondent The American Medical Association, *Bernard D. Hirsh* and *B.J. Anderson,* Chicago, Ill., Of Counsel, American Medical Association and *Grant N. Nickerson, William J. Doyle* and *Linda L. Randell, Wiggin & Dana,* New Haven, Conn. for respondents The Connecticut State Medical Society and The New Haven County Medical Association, Inc.

COMPLAINT

The Federal Trade Commission, having reason to believe that respondents The American Medical Association, The Connecticut State Medical Society, and The New Haven County Medical Association, ("AMA", "CSMS", and "NHCMA", respectively), have violated and are violating Section 5 of the Federal Trade Commission Act, and that this proceeding is in the public interest, issues this complaint.

PARAGRAPH 1. Respondent American Medical Association ("AMA") is a non-profit Illinois corporation with its principal place of business at 535 North Dearborn St., Chicago, Illinois. Its member-

ship consists of approximately 170,000 individual medical doctors, most of whom are members of state and local medical societies, including CSMS and NHCMA. AMA's affairs, including those complained of, are directed by delegates from state medical societies, including CSMS.

PAR. 2. Respondent Connecticut State Medical Society ("CSMS") is a non-profit Connecticut corporation with its principal place of business at 160 St. Ronan St., New Haven, Connecticut. CSMS is a constituent society of AMA. Delegates from CSMS participate in directing the activities of AMA, including those complained of. CSMS has approximately 4400 medical doctor members. [2]

PAR. 3. Respondent New Haven County Medical Association, Inc. ("NHCMA") is a non-profit Connecticut corporation with its principal place of business at 362 Whitney Ave., New Haven, Connecticut. NHCMA is a component society of CSMS. Delegates from NHCMA participate in directing the affairs of CSMS, including those complained of. NHCMA has approximately 1200 medical doctor members, which members direct the affairs of NHCMA, including those complained of.

PAR. 4. Most members of respondents are engaged in the business of providing medical care for a fee. In 1974, the fees earned by such physicians exceeded one billion dollars.

PAR. 5. Members of AMA are located in every state. In the conduct of their business, members of AMA and members of CSMS and NHCMA:

(A) Receive and treat patients from other states and countries;

(B) Receive substantial sums of money from the federal government and from private insurers for rendering medical services, which money flows across state lines;

(C) Prescribe medicines which are shipped in interstate commerce;

(D) Act in continuing association and cooperation with state and county medical associations, and with individual doctors, in every state, in furthering the agreements described below, in the course of which association and co-operation they use the mails and other media of interstate commerce;

As a result of which conduct, the acts and practices of respondents complained of are in or affect interstate commerce, within the meaning of the Federal Trade Commission Act.

PAR. 6. Respondents and others have agreed to prevent or hinder competition between medical doctors. This agreement has included agreements to prevent or hinder their members from:

(A) Soliciting business, by advertising or otherwise; [3]
(B) Engaging in price competition; and
(C) Otherwise engaging in competitive practices.

PAR. 7. Respondents and others have:

(A) Caused the agreements described above to be published and circulated in a publication called the *Principles of Medical Ethics;*
(B) Abided by the restrictions contained in the *Principles of Medical Ethics;* and
(C) Enforced, and have the power to enforce, adherence to the restrictions contained in the *Principles of Medical Ethics.*

PAR. 8. As a result of the acts and practices alleged above:

(A) Prices of physician services have been stabilized, fixed, or otherwise interfered with;
(B) Competition between medical doctors in the provision of such services has been hindered, restrained, foreclosed and frustrated; and
(C) Consumers have been deprived of information pertinent to the selection of a physician and of the benefits of competition.

PAR. 9. The acts, practices and methods of competition described above are unfair and constitute violations of Section 5(a) of the Federal Trade Commission Act.

MEMORANDUM OF CHAIRMAN PERTSCHUK IN RESPONSE TO MOTIONS FOR HIS RECUSAL IN THIS PROCEEDING

APRIL 18, 1979

Respondents American Medical Association, Connecticut State Medical Society, and New Haven County Medical Association have filed motions asking that I withdraw from this proceeding, or that the Commission disqualify me from further participation. For the reasons stated below, I believe my participation in this case is proper and decline to recuse myself.

The ground for disqualification asserted by respondents is that in three specified instances—testimony to Congress and speeches before the American Enterprise Institute and the Consumer Assembly—my remarks reflected prejudgment of "key issues in the case," or gave the appearance of such prejudgment. In [2] fact, I have not, in advance of an appropriate consideration of the record, reached any determination on the specific issues involved in this case, nor do

I believe that my public statements created an appearance of such prejudgment.

In each instance in which a court has disqualified an agency decisionmaker, that action has been based on comments showing what would appear to a disinterested observer as a viewpoint on specific controverted factual issues (*e.g., American Cyanamid Co.* v. *FTC,* 363 F.2d 757, 767 (6th Cir. 1966)), or the ultimate issue of liability (*e.g., Texaco, Inc.* v. *FTC,* 336 F.2d 754, 760 (D.C. Cir. 1964), *vacated on other grounds,* 381 U.S. 739 (1965); *Cinderella Career & Finishing Schools, Inc.* v. *FTC,* 425 F.2d 583, 590 (D.C. Cir. 1970)) in a pending adjudicative matter.[1] My comments, when considered in context (*see, e.g., Kennecott Copper Corp.* v. *FTC,* 467 F.2d 67, 80 (10th Cir. 1972), *cert. denied,* 416 U.S. 909 (1974)), demonstrate that no such appearance has been created here. [3]

The speeches and congressional statements cited by respondents can only be read as reflecting an underlying philosophy concerning broad policy issues such as the role of professionals and professional licensing in our society, competition in the health care sector of the economy, and the problem of rising health care costs. These are subjects currently of great interest to the public, and I believe that open expression of my views to Congress and the public is an entirely proper and essential part of my duties as Chairman. Cf. *FTC* v. *Cement Institute,* 333 U.S. 683, 701 (1948); 15 U.S.C. 46(f). The expression of views on such issues of policy which are, at most, only generally related to the specific factual and legal issues involved in a proceeding is not ground for disqualification. *See, e.g., Hortonville Joint School Dist. 1* v. *Hortonville Educ. Ass'n,* 426 U.S. 482, 493 (1976); *Laird* v. *Tatum,* 409 U.S. 824, 831 (1972) (memorandum of Rehnquist, J.); *United States* v. *Morgan,* 313 U.S. 409, 421 (1941); *Skelly Oil Co.* v. *FPC,* 375 F.2d 6, 18 (10th Cir. 1967), *modified on other grounds sub nom. Permian Basin Area Rate Cases,* 390 U.S. 747 (1968). [4]

The statements cited by respondents also contain brief references to previous actions taken by the Commission which were relevant to issues on which I had been asked to testify.[2] I consider the presentation to Congress and the public of information about the nature and status of Commission activities to be one of the principal responsibilities of the Chairman, and see nothing in my recitation of such information which would constitute an appearance of prejudg-

[1] *In Association of Nat'l Advertisers, Inc.* v. *FTC,* No. 78-1421 (D.D.C. 1978), *appeal docketed,* No. 79-1117 (D.C. Cir. Jan. 29, 1979), the district court reaffirmed the legal standards governing disqualification in adjudicative proceedings and adopted them in the context of a Commission rulemaking proceeding.

[2] *See, e.g.,* Statement Before Subcommittees of the Senate Committees on Human Resources and the Judiciary, October 10, 1977, at 5.

ment of this case. See *Cinderella Career & Finishing Schools, Inc.* v. *FTC, supra* at 590.

At no time have I commented on the merits of the specific issues raised in the pleadings in this adjudication. Rather, as part of a catalogue of Commission activities in the health care field, I advised the Congress that a complaint had issued challenging portions of the AMA and ADA codes of ethics which "*may* unduly restrain information about physician and dentist services."[3] I then stated: [5]

> Since these matters are currently in litigation, I hope you will understand why it would not be appropriate for me to comment further about them.[4]

Respondents cite no statements in which I have expressed a view on the merits of specific issues presented in this adjudication, such as whether the respondent medical societies unlawfully restrict advertising, solicitation, or other practices of their members.[5]

I reiterate that I have not arrived at any conclusion regarding the specific factual and legal questions involved in this case, nor have I expressed any opinion as to ultimate liability. Rather, I am reserving judgment until I have completed review of the record properly before me. Accordingly, I decline to recuse myself from further participation in the proceeding.

I will of course not participate in the Commission's consideration and ruling on the alternative motion addressed to the Commission.

INITIAL DECISION BY ERNEST G. BARNES, ADMINISTRATIVE LAW JUDGE

NOV. 13, 1978

PRELIMINARY STATEMENT

On December 19, 1975, the Federal Trade Commission issued its complaint in this matter charging the American Medical Association (AMA), the Connecticut State Medical Society (CSMS), and the New Haven County Medical Association, Inc. (NHCMA) with violations of Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45, by restricting the ability of their members to advertise for and solicit patients and to enter into various contractual arrangements in connection with the offering of their services to the public. Specifically, the complaint charges that respondents have agreed with others to prevent or hinder their members from:

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[3] *Id.* (emphasis added).

[4] *Id.*

[5] Nor has AMA identified any statement I have made that respondents are "subject to the jurisdiction of the Commission," despite its effort to attribute such a conclusion to me, at page 7 of the motion.

(1) Soliciting business, by advertising or otherwise;
(2) Engaging in price competition; and
(3) Otherwise engaging in competitive practices.

The complaint alleges that respondents and others have caused the agreements to be published and circulated in a publication entitled Principles of Medical Ethics, and they have enforced and abided by the restrictions set forth therein. It is further alleged that, as a result of these acts and practices:

(1) Prices of physician services have been stabilized, fixed, or otherwise interfered with;
(2) Competition between medical doctors in the provision of such services has been hindered, restrained, foreclosed and frustrated; and
(3) Consumers have been deprived of information pertinent to the selection of a physician and of the benefits of competition.

The aforesaid acts, practices and methods of competition are alleged to be unfair and to constitute violations of Section 5 of the Federal Trade Commission Act. [2]

On January 23, 1976, respondent AMA filed an answer admitting that it has published and circulated a publication entitled the Principles of Medical Ethics, but denying that it or its members are engaged in business, and further denying it has otherwise violated Section 5, as alleged. AMA also raised as an affirmative defense a claim that AMA is not subject to the jurisdiction of the Federal Trade Commission. On January 26, 1976, respondents CSMS and NHCMA filed answers making generally the same admissions and denials as did AMA, and also raising the affirmative defense of lack of jurisdiction.

Complaint counsel stated at the first prehearing conference in this proceeding that the complaint had issued without any formal precomplaint investigation. As a result, extensive discovery was conducted with respondents and with state and local medical societies located throughout the United States. On May 11, 1976, and June 22, 1976, complaint counsel filed memoranda identifying respondents' ethical restrictions on contract practice, advertising, and solicitation being challenged in the complaint. At a voluntary meeting with respondents' counsel on November 8, 1976, complaint counsel further detailed the restrictions being challenged. The transcript of that meeting was made a part of the record of the prehearing conference held on November 18, 1976. Complaint counsel has asserted that the complaint charges respondents with an

agreement or conspiracy with others to restrict or restrain competition. Respondents deny there was an agreement or conspiracy, and further deny that their acts and practices have prevented or hindered competition. Respondents have also contended throughout this proceeding that their ethical interpretations have changed in recent years to comport with changing legal considerations so that this proceeding is no longer in the public interest and should be dismissed.

On March 24, 1976, AMA filed a Motion for Summary Decision Dismissing the Complaint for Lack of Jurisdiction. CSMS and NHCMA filed a similar motion on April 26, 1976.[1] These motions were denied on April 26, 1976, and May 20, 1976, respectively, for the reason, *inter alia,* that the facts involved were complex, many were in dispute, and others were capable of any of several varying inferences, making summary decision inappropriate. Requests for interlocutory appeals were likewise denied.

On January 14, 1977, respondent AMA filed a Motion for Certification to the Commission of AMA's Motion to Reconsider Issuance of the Complaint because of changed circumstances. [3] Respondents CSMS and NHCMA filed a similar motion on January 24, 1977. On February 15, 1977, respondents' motions were certified to the Commission. The Commission, on April 26, 1977, denied said motions for reconsideration.

Pretrial conferences were held on February 25, September 15 and November 18, 1976, and August 2, and September 6, 1977. Adjudicative hearings began September 7, 1977, and were concluded May 4, 1978, with 57 days of actual trial. Presentation of the case-in-chief in Washington, D.C., took 20 trial days, running from September 7 through October 19, 1977. Complaint counsel called 25 witnesses. AMA's defense, which was heard in Chicago, Illinois, Los Angeles, California and Washington, D.C., began on November 28, 1977, and ended on January 20, 1978. During AMA's defense, 27 days of hearings were held, and 52[2] witnesses testified. CSMS and NHCMA called eight witnesses during the four days of their defense case, which took place in New Haven, Connecticut, from January 23 through 26, 1978. Complaint counsel called three witnesses in their rebuttal case, which ran from April 3 through 5, 1978. During the surrebuttal hearings, which took place in Chicago, Illinois, from May 2 through 4, 1978, respondent AMA called seven witnesses.

On October 8, 1976, a subpoena duces tecum was issued to

[1] Respondents contended they were exempt from Federal Trade Commission jurisdiction as nonprofit corporations, not organized for their own profit or that of their members.

[2] Dr. William Ruhe, Senior Vice President, American Medical Association, a defense witness, was recalled as a witness at surrebuttal hearings on May 2, 1978.

respondent AMA. AMA, on October 20, 1976, filed a timely motion to quash the subpoena. By order of November 12, 1976, AMA was directed to produce the subpoenaed documents, with certain modifications. By letter of December 7, 1976, AMA advised that it would not comply with the order, although AMA did comply with other subpoenas and discovery demands both prior and subsequent to this refusal. Complaint counsel thereafter requested that, pursuant to Section 3.38 of the Rules of Practice, certain inferences and sanctions be imposed on AMA because of its refusal to produce the documentary evidence being sought. By order of February 24, 1977, certain sanctions and adverse inferences were imposed on AMA to compensate for the withholding of the subpoenaed materials.

Court enforcement of subpoenas duces tecum was necessary in the case of some nonrespondent medical societies. In one instance, complaint counsel was permitted to put on case-in-chief evidence during rebuttal hearings because of the delay caused by the necessity of court enforcement of a subpoena (*see* transcript of hearings for April 4, 1978, pages 9146–9242, especially page 9167). [4]

During the course of this proceeding, approximately 3000 exhibits were received into the record, about 100 of which were accorded *in camera* treatment. Many of the exhibits were multi-paged. The transcript of record consists of almost 10,000 pages. The record for the reception of evidence was closed on June 1, 1978.

This proceeding is now before the Administrative Law Judge for decision based upon the complaint, the answers, pleadings, testimony and other documentary evidence of record, proposed findings of fact and conclusions of law and legal authority submitted by all the parties. These submissions have been given careful consideration and, to the extent not adopted herein in the form proposed or in substance, are rejected as not supported by the record or as immaterial. All motions not heretofore or herein specifically ruled upon, either directly or by the necessary effect of the conclusions in this Initial Decision, are hereby denied.

Having heard and observed the witnesses and after having carefully reviewed the entire record in this proceeding, together with the proposed findings of fact and conclusions of law submitted by the parties, the Administrative Law Judge makes the following findings of fact and conclusions and issues the Order set out at the end hereof.[3] [5]

[3] References to the record and other material are given in parentheses, and the following abbreviations are used:

F. – Findings of this Initial Decision followed by the finding and page number being referenced.
Tr. – The transcript of record in this proceeding followed by the page being referenced.
CX – Commission Exhibit followed by number of exhibit being referenced.

(Continued)

FINDINGS OF FACT

I. DESCRIPTION OF RESPONDENTS AND THEIR STRUCTURAL INTERRELATIONSHIPS

A. American Medical Association

1. Respondent AMA is a nonprofit corporation, organized under the Not For Profit Act, Ill. Rev. Stat. Ch. 32 §§ 163, *et seq.* AMA was founded in 1846, and was originally incorporated in 1897. Its principal place of business is located at 535 North Dearborn St., Chicago, Illinois (Comp. and AMA Ans. ¶ 1; Tr. 3922, 3932). AMA also maintains an office in Washington, D.C., which conducts AMA's affairs with Congress and governmental agencies (CX 1103E; Tr. 9886–87). AMA funds are derived principally from membership dues. Other sources of AMA funds are grants and contracts, primarily from the federal government, subscriptions to AMA scientific publications, and advertising revenue (RX 3). In 1976, AMA had projected annual revenues totaling $55,611,000 and total projected assets of $47,185,000 (RX 567, pp. 4, 7). The organization employs approximately 1,100 persons (AMA Interrogatory 49).

2. AMA's membership is comprised of physicians, osteopaths and medical students (Tr. 3944). Membership in AMA is not a precondition to obtaining a license to practice medicine (Tr. 3944–46). No physician needs to be a member of AMA in order to obtain board certification in a medical specialty or in order to join a specialty medical society (Tr. 3946). Similarly, no physician needs to be an AMA member in order to obtain hospital staff privileges (Tr. 3947). [6]

3. AMA is the largest medical and professional association in the world (CX 1522B). As of December 31, 1974, of the 379,748 licensed physicians in the United States, 52.6 percent were AMA members (RX 658, 660). Currently, approximately 60 percent of all physicians and over 75 percent of office-based medical practitioners in the United States are members of AMA (Tr. 3949–50). Over 80 percent of

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RX – Respondent AMA Exhibit followed by number of exhibit being referenced.
RCX – Respondent CSMS Exhibit followed by number of exhibit being referenced.
RNHX – Respondent NHCMA Exhibit followed by number of exhibit being referenced.
CPF – Complaint counsel's proposed findings, followed by the number of the proposed finding being referenced.
RAF – Respondent AMA's proposed findings, followed by the number of the proposed finding being referenced.
RCF – Respondent CSMS's proposed findings, followed by the number of the proposed finding being referenced.
RNF – Respondent NHCMA's proposed findings, followed by the number of the proposed finding being referenced.
Comp. – Complaint.

the board-certified physicians in the United States belong to AMA (CX 232–O, 1103E). Most AMA members are private practice, fee-for-service physicians who provide medical care for a fee (Comp. and AMA Ans. ¶ 4; CX 1042H–J, 197–O).

4. AMA is a federacy of its state associations, which are termed constituent societies. Constituent societies are recognized medical associations of states, commonwealths, territories or insular possessions of the United States which have federated to form the AMA (CX 990E). Component societies are county or district societies contained within the territory of and chartered by the state associations (CX 990E). There are 55 constituent societies of the AMA, and these constituent societies have chartered approximately 2,000 component societies. Some component (local) societies require their members to become members of the constituent (state) society (CX 2017C, 2020B). Membership in a local society is a prerequisite to membership in a state society (*e.g.*, CX 475F, U, 991D, M, 1886E, 1889C, 1891G, 1899D, 2543A–C); and, membership in a state society is a prerequisite to regular membership in the AMA (CX 990G). Most members of AMA are members of both state and local medical societies (Comp. and AMA Ans. ¶ 1). In Hawaii, Oklahoma, Illinois, Arizona and Wisconsin, membership in AMA is a condition of membership in the state society (Tr. 4045–46). Other state and local medical societies strongly encourage their members to join AMA (CX 1385B, 2020B). As of December 31, 1975, there were 359,683 nonfederal physicians, and 213,339, or 59.3 percent, were dues-paying members of state medical societies (RX 531A).

5. The articles of incorporation, constitutions and bylaws of AMA's constituent and component societies establish that an express purpose of these societies is to form, support and maintain, together with other medical societies, the American Medical Association (CX 14C, 47A, 472A, 756A, 983C, 991D, 1404A, 1736A, 1824C, E, 1827B, 1829D, 1833F, 1877B, 1886E, 1894A, 1899D, 1901D, 1904F, X, 1905D, 1915A, 1922A, F, 1961B, 1976I, 2017A, 2020A, 2021B, 2050J, 2226A, 2306C, 2307C, E, 2543A). AMA's constituent societies are required to and do collect AMA membership dues of each regular member and transmit these dues to AMA. A charge is made to AMA for this service (CX 990J; Tr. 4046). [7]

6. The AMA House of Delegates is the official legislative and national policy-making body of AMA (CX 990E). One delegate is elected for each one thousand, or fraction thereof, AMA members who are members of each state society (AMA Interrogatory 49; CX 958B, 990E, P; RX 220, pp. 27–28). Currently, there are 253 delegates (Tr. 3953). The House of Delegates is empowered to amend the AMA

Constitution, Bylaws and the Principles of Medical Ethics, to elect AMA's general officers and trustees, and to prescribe the amount of annual dues (CX 990E, F, J, Z-8; RX 220, p. 30). The House of Delegates acts as a legislative body by acting on reports of standing councils and committees of the AMA and on resolutions introduced by one or more members of the House of Delegates. Once the House of Delegates adopts a resolution or report, it becomes the policy of the AMA (Tr. 3954). The House of Delegates meets twice annually and the actions taken at its meetings are published (Tr. 3961-64; RX 53, 54, 101-02, 566). The members of the state societies' governing bodies are elected by their respective component societies (*e.g.*, F. 10; pp. 8-9; CX 477S, 1877B, 1889P, 1886F, 14F, 1899J, E, 475R, K).

7. The AMA's Board of Trustees is ultimately responsible for the day-to-day operations of the AMA. The Board is elected by the House of Delegates, and it supervises all activities of the AMA and is responsible for its annual budget and expenditure of resources (Tr. 9648; CX 990Z5-Z7; RX 220, p. 30). It is comprised of twelve trustee members and three general officers and has eight scheduled meetings per year, in addition to emergency meetings which are held as is necessary (Tr. 9649).

8. The AMA operates eight standing committees on specific subjects, which are known as Councils. The Councils study and evaluate matters in their respective subject areas and make recommendations to the House of Delegates (CX 990U-Y; RX 220, p. 30). The Council on Constitution and Bylaws periodically reviews and recommends revisions in those documents (Tr. 3974). The Council on Medical Education supervises the AMA's involvement in undergraduate and graduate medical education and accreditation functions (Tr. 3975). The Council on Medical Service is concerned with a variety of socio-economic problems in health care (Tr. 3976). The Council on Legislation analyzes legislation, gives testimony, prepares draft legislation, etc. (Tr. 3976-77). The Council on Long Range Planning and Development attempts to analyze the nation's future health care problems and areas the AMA should address itself to in the future (Tr. 3977-78). The Council on Continuing Physician Education prepares and conducts [8] courses in continuing medical education for physicians (Tr. 3978). The Council on Scientific Affairs concerns itself with the preparation of policy statements and public education programs concerning specific scientific issues affecting medical practice, such as the efficacy of laetrile in treating cancer (Tr. 3979-81). The Judicial Council has responsibility for interpreting the AMA Constitution and Bylaws and the Principles of Medical Ethics (Tr. 3982). Council members are nominated by the Board of

Trustees or by the AMA President, and are elected by the House of Delegates (CX 990U–V).

B. Connecticut State Medical Society

9. Respondent CSMS is a nonprofit corporation, organized under the laws of Connecticut, with its principal office located at 160 St. Ronan St., New Haven, Connecticut (Comp. and CSMS Ans. ¶ 2). CSMS was incorporated and chartered by the State of Connecticut General Assembly in 1792. CSMS is a constituent society of AMA (RCX 146 at I). CSMS is a federacy of eight component county medical societies, all located within the State of Connecticut. Respondent NHCMA is a CSMS component society (CX 991K). Members of the component (county) medical societies are not required to become members of CSMS; however, active membership in CSMS is limited to licensed physicians in Connecticut who are members of CSMS's component societies (CX 243A, 991D). Membership in CSMS terminates automatically when a physician loses his membership in a component society (CSMS Interrogatory 48(b); CX 991M). As of December 31, 1975, CSMS had 4,461 dues-paying members, which constituted approximately 81.6 percent of the 5,469 physicians registered in Connecticut as of July 1, 1975 (CSMS Interrogatory 27; CX 890D). CSMS members are not required to become members of AMA, but are eligible to do so (Tr. 8279, 8281; RCX 146 at II; CX 1480). A physician in Connecticut does not have to belong to CSMS in order to be licensed to practice in Connecticut (Tr. 8277). CSMS's annual revenues for 1975 totaled $409,911 (RCX 68, p. 18). Its total assets for that year amounted to $592,508 (RCX 68, p. 14).

10. The CSMS House of Delegates is the legislative and policy-making body of CSMS. It has two scheduled meetings each year, which are an annual meeting and a semi-annual meeting; special meetings may also be called (Tr. 8276–77; RCX 146 at I, III). The House of Delegates is composed of delegates elected by component societies, voting members of the CSMS Council, and may include ex-officio non-voting members (past presidents of CSMS and others, as approved by the House of Delegates). The number of delegates is proportionate to [9] the number of CSMS members in the county societies: one delegate for each 35 (or fraction thereof) county society members who are also CSMS members. Based on year-end 1975 membership data, the 1976 House of Delegates would include 131 delegates, which would include 34 from respondent NHCMA (RCX [illegible], pp. 12–13, RCX 146 at I, IV). The House of Delegates is empowered to amend the society's Bylaws and to elect its general

officers and its delegates to AMA's House of Delegates (CX 991E, F, N).

11. The CSMS Council is the executive and administrative body of CSMS when the House of Delegates is not in session. The Council is composed of the general officers of CSMS, any member of CSMS who is serving as an officer of AMA, and representatives from the county societies (CSMS Interrogatory 48(b); CX 243A, 991G, H). CSMS's Council appoints an Executive Director who manages and supervises the ordinary affairs and operations of CSMS, and whose duties include maintaining active liaison with AMA and collecting AMA dues from all CSMS members who are also members of AMA (CSMS Interrogatory 48(a); Tr. 8205, 8243–44; CX 991H; RCX 146 at VI). As of December 31, 1975, 2,445 of the 4,461 members of CSMS were also members of AMA (CSMS Interrogatory 48(a)). CSMS actively encourages its members to join AMA (CX 1385B).

C. New Haven County Medical Association, Inc.

12. Respondent NHCMA is a nonprofit corporation, organized under the laws of Connecticut, with its principal office located at 270 Amity Road, Woodbridge, Connecticut (Comp. and NHCMA Ans. ¶ 3). NHCMA is a component society of CSMS and its bylaws are required to be not in conflict with those of CSMS (Comp. and NHCMA Ans. ¶ 3; NHCMA Interrogatory 44(a); CX 140K). One of the purposes of NHCMA is to unite with other societies to form and maintain CSMS and AMA (NHCMA Interrogatory 44(a); CX 1404A, 1405A). Members of NHCMA are not required to become members of CSMS or AMA (Tr. 8283, 8439; RCX 146 at II; RNHX 139). As of December 31, 1975, NHCMA had 1,179 members, which constituted approximately 71 percent of the 1,660 physicians registered in New Haven County as of July 1, 1975 (CSMS Interrogatory 28, 29; CX 890D). NHCMA's requirements for eligibility for membership cannot conflict with the Charter or Bylaws of CSMS or with the Constitution or Bylaws of AMA (CSMS Interrogatory 48(b); CX 991L). NHCMA membership dues are collected by CSMS and then forwarded to NHCMA (NHCMA Interrogatory 44(a)). [10]

13. Active and life members direct the affairs of NHCMA. They conduct two regular meetings each year and elect the NHCMA officers, delegates and alternate delegates to the CSMS House of Delegates, and the Councilors to the CSMS Council (Comp. and NHCMA Ans. ¶ 3; CX 1404B, E; RNHX 139, p. 16). Between meeting of NHCMA, the NHCMA Board of Govenors is the policymaking body of NHCMA and is authorized to conduct all activities of the society. The Board of Governors is composed of the NHCM

Executive Committee, the NHCMA delegates to CSMS and the chairmen of the NHCMA standing committees (Tr. 8436; RNHX 139, pp. 7–8; CX 243A, 1404D, E). The NHCMA Executive Committee, composed of the NHCMA President, Vice President, Clerk, Councilor and Associate Councilors to CSMS, and the immediate past president of NHCMA, is empowered to execute the policy of the Board of Governors between meetings of that body (Tr. 8436; RNHX 139, pp. 6–7). NHCMA has three staff employees: a part-time Executive Director, one full-time secretary and one part-time secretary. Prior to August 1977, the NHCMA Executive Secretary was employed on a full-time basis (Tr. 8436–38). All NHCMA policy matters must be approved by the Board of Governors or the NHCMA membership as a whole (RNHX 139, pp. 7–8).

D. Commerce

14. The challenged acts and practices of respondent AMA are in or affect interstate commerce (Tr. 2120, 2124).

In the conduct of their business, members of CSMS and NHCMA receive substantial sums of money amounting to several million dollars from the federal government and from private insurers for rendering medical services, which money flows across state lines (Comp. and CSMS Ans. ¶ 5(b); NHCMA Ans. ¶ 5(b)). Substantial sums of money are paid by the federal government under Medicare and Medicaid, by Blue Cross, Blue Shield under the federal employees insurance program, and by other private health insurance firms and organizations for services rendered by CSMS and NHCMA members. Some of CSMS's and NHCMA's members receive and treat patients from other States of the United States and from foreign countries (Tr. 1741–42, 1781; Comp. and CSMS Ans. ¶ 5(a); NHCMA Ans. ¶ 5(a)).

The United States mail has been used by CSMS and NHCMA in corresponding with AMA and others, including specific applications of AMA's restrictions on advertising and solicitation (CX 78B, 673, 781, 783, 785; CSMS and NHCMA Adm. 20(b), (d), filed June 20, 1977), and in obtaining from AMA and distributing to their members opies of, or excerpts from, AMA's Principles of Medical Ethics and [1] interpretations thereof (CX 202–19, 221, 1748, 1787; CSMS and HCMA Adm. 19(c), (d), filed June 20, 1977). Also, delegates, ecutives, members and employees of CSMS and NHCMA attend MA conventions and conferences outside Connecticut, including nventions of AMA's House of Delegates at which AMA's Principles Medical Ethics, and interpretations thereof, are adopted, amend-

ed, discussed and interpreted (CSMS and NHCMA Adm. 17(b), (c), filed June 20, 1977; CSMS Interrogatory 10(a)).

II. ACTIVITIES OF AMERICAN MEDICAL ASSOCIATION

A. Background

15. An important threshold question is whether the respondents are subject to the jurisdiction of the Federal Trade Commission. This question arises out of Section 5(a)(2) of the Federal Trade Commission Act, 15 U.S.C. 45 (a)(2), in which Congress limited the jurisdiction of the Commission to "persons, partnerships or corporations." The jurisdictional question hinges on whether respondents are "corporations" within the meaning of the Act. The word "corporation," for purposes of Section 5(a)(2), is defined in Section 4, 15 U.S.C. 44, to include:

> . . . any company, trust. . .or association. . .which is organized to carry on business for its own profit or that of its members, and has shares of capital or capital stock or certificates of interest, and any company, trust. . .or association, incorporated or unincorporated, without shares of capital stock or certificates of interest, except partnerships, which is organized to carry on business for its own profit or that of its members.

Each respondent has argued vigorously that it does not come within this definition because it is not "organized to carry on business for its own profit or that of its members." Determining whether the respondents are within the Commission's jurisdiction requires an analysis of their activities. The following findings, contained in Sections II, III, V, VI, VIII, *infra,* detail the activities of respondents which have been considered in making this determination. [12]

B. Educational Activities

16. (a) *Undergraduate and Graduate Medical Education.* From its inception, the AMA has been involved in medical education (Tr. 4068–70). Very early in its history, the AMA established a Committee on Medical Education to develop standards for admission to medical school and to establish a system of postgraduate medical education (Tr. 4070–73). The AMA group presently responsible for medical education is its Group on Medical Education. Approximately 10% of all AMA employees are directly assigned to this Group (Tr. 4067). The Group is divided into two divisions: the Division of Medical Education Evaluation and the Division of Education Policy Developments (Tr. 4076–77).

The Division of Medical Education Evaluation, which is concern

with the establishment of standards of education and accreditation at all levels of medical education and in certain allied health fields, is divided into four groups:

(1) The Department of Undergraduate Medical Education, which deals with medical school accreditation and related activities;
(2) The Department of Graduate Medical Education, which deals with residency programs;
(3) The Department of Continuing Medical Education, which deals with accrediting institutions and organizations offering courses to practicing physicians; and,
(4) The Department of Allied Health Evaluation, which shares responsibility with various allied health professions in establishing and accrediting educational programs in health fields (Tr. 4077–78).

Since 1942, the AMA has shared medical school accreditation functions with the Association of American Medical Colleges through a joint enterprise called the Liaison Committee on Medical Education, a body whose accrediting power is recognized by the U.S. Commissioner of Education (Tr. 4074–75). [13]

The AMA is also involved in accreditation of medical education at the graduate level, which encompasses residencies and other activities after graduation from medical school (Tr. 4091). In January 1972, the AMA joined with several other organizations to create the Liaison Committee on Graduate Medical Education, which became the accrediting body for graduate programs on January 1, 1975 (Tr. 4094). The Liaison Committee, in addition to its accreditation functions, also prepares "Essentials of Approved Residencies" (RX 543A–2(10)), a document which is distributed to anyone seeking information on residency programs (Tr. 4092, 4095). "Essentials of Approved Residencies" is also included in the "Directory of Accredted Residencies" (RX 9), a document compiled and published nnually by the AMA (Tr. 4097). The Directory also contains tatistical data on and analyses of trends in graduate medical lucation, lists of residencies broken down by geographic location id specialty, information on the availability of graduate medical ucation in the U.S. and information on the standards against ich residency programs are measured. It is distributed to all third ir medical students, all deans of medical schools, all hospitals with redited residency programs, state licensing boards and various er private and governmental entities (Tr. 4097–99). The AMA lishes about 40,000 copies of the Directory each year and ibutes them without regard to membership in the AMA or the

Student American Medical Association, and at little or no cost (Tr. 4098–4100).

(b) *Continuing Medical Education.* In the area of continuing medical education, the AMA's involvement dates from the early 1900's (Tr. 4111). Today, AMA shares accreditation responsibilities with six other groups by means of the Liaison Committee on Continuing Medical Education (Tr. 4111). In 1977, the Liaison Committee reaccredited more than 900 organizations, agencies and institutions, which offer approximately 7,300 courses in continuing medical education (Tr. 4115). The general standards and requirements for accredited continuing medical education courses have been developed by the AMA and are published in a document entitled "Essentials for the Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" (RX 556; Tr. 4120). This document has been adopted by the Liaison Committee and is distributed to state medical boards and all institutions, organizations and agencies seeking to be accredited (Tr. 4121).

AMA's Department of Physician's Qualifications and Credentials is active in assisting individual physicians to maintain their professional knowledge and skills (Tr. 4151). [14] The AMA gives the Physician's Recognition Award to physicians who meet its established criteria for continuing medical education. Membership in the AMA or a state or local medical society is not required to receive the Award (Tr. 4153–54). This department further assists physicians in maintaining their medical skills by making films and other audio-visual materials available to hospitals and medical societies for group viewing (Tr. 4163). These films are distributed without regard to organizational affiliation (Tr. 4164). The Department is also active in the area of medical licensure, gathering information from state medical boards and making it available to the Federation of State Medical Boards, hospitals and health services agencies (Tr. 4164).

(c) *Allied Health Education.* The AMA's Committee on Allied Health Education Accreditation is recognized by the U.S. Commissioner of Education as the duly authorized accrediting body in more than 28 allied health fields (Tr. 4124). The AMA publishes the "Allied Medical Education Directory" (RX 560), which analyzes trends in allied health education and lists institutions which offer accredited allied health programs (Tr. 4130–31). The Directory is often used by high school students and their parents, high school guidance counselors and college guidance counselors as a reference work in evaluating health service careers (Tr. 4131–32). The selling price of the Directory is less than the AMA's cost of publishing and compiling it (Tr. 4134).

(d) *Summary.* It is AMA's position that AMA's accreditation of educational programs assures students that a school is properly prepared to train them and assures the public that a physician or other health professional has completed a satisfactory course of study (Tr. 4076). AMA asserts that it has undertaken accreditation activities because of its responsibility for the improvement and furtherance of education and knowledge in medicine and related health fields (Tr. 4075, 4090, 4104, 4128). In participating in the field of medical education, it is AMA's position that it has sought to promote the science of medicine and the betterment of public health (Tr. 5174). In doing so, AMA seeks to continually improve the qualifications and skill of American physicians (Tr. 5174–75), thereby improving the quality of care delivered to the patient (Tr. 5176). No fees are charged to medical schools for the accreditation process, and the income from other accreditation activities does not cover AMA's costs (Tr. 4101–03). AMA incurs a net operating deficit for [15] accreditation activities of approximately $2 million per year (Tr. 4102). The AMA contends that no pecuniary advantage accrues to members as a result of its involvement in the accreditation of undergraduate, graduate, continuing and allied medical education (Tr. 4091, 4119, 4129–30).

(e) *Education Counseling and Health Manpower.* The second division of the Group for Medical Education is the Division of Educational Policy and Development, which is, in turn, comprised of two departments: the Department of Health Manpower and the Department of Physician's Credentials and Qualifications (Tr. 4135). The Department of Health Manpower provides information and advice to people seeking information about health careers, including students, guidance counselors and health career program directors (Tr. 4137). The AMA responds to about 60,000 such inquiries each year (Tr. 4137). The Department also publishes a number of books on different health careers, which are available to the public upon request (Tr. 4147). The AMA does not charge for any of these services other than bulk requests for pamphlets, which are then sold at cost (Tr. 4138). The Department of Health Manpower is responsible for evaluating federal and state legislation which affects medical education and training programs, and for staffing the committee which recommends whether or not a new health occupation should be recognized for the purpose of establishing essentials for the educational program (Tr. 4138–39). The Department is also involved in the accumulation and distribution of data (RX 10, 28, 562), the AMA being the primary repository for physician manpower information needed by private agencies and local and regional planning

bodies (Tr. 4139, 4144–45). Other data, developed by the AMA in conjunction with the Census Bureau and the National Center for Health Statistics, is used by the U.S. Department of HEW, state licensing bodies and other groups for such things as targeting continuing education courses (Tr. 4141, 4148–49). Data collected by the Department of Health Manpower is also used in the preparation of directories published by other AMA departments (Tr. 4139). AMA contends no pecuniary benefit flows to its members from these activities (Tr. 4150).

(f) *Vietnamese Medical Education.* In 1966, the Agency for International Development ("AID") requested the AMA to join in its efforts to improve the quality of Vietnamese medical education (Tr. 4756; RX 512). In response to this request, the AMA conducted a feasibility study and thereafter entered into a contract with AID whereby AMA agreed to assist in the development of medical education in South Vietnam. AMA's first attempts were to recruit American medical school faculty members to instruct Vietnamese students at the medical [16] school in Saigon (Tr. 4758). Over the course of several years this approach was modified, and the AMA concentrated on helping the Vietnamese faculty members improve their own methods of teaching (Tr. 4758). The program continued in force until the fall of South Vietnam in April 1975 (Tr. 4762). Prior to 1975, AMA was also involved in a program entitled American Volunteer Physicians Program for Viet Nam. The program was intended to bolster the medical resources in provincial hospitals of South Vietnam, and involved the recruiting of American physician volunteers to spend a 60-day period of service in Vietnam (Tr. 4771; RX 511).

When the Republic of South Vietnam was overrun in 1975, some 600 South Vietnamese physicians who escaped the country found their way to the United States. Most of them were unable to bring along their credentials to authenticate their medical training and licensure (Tr. 4773–74). The AMA, in conjunction with the Department of HEW, worked to provide authority and documentation for the Vietnamese physicians to practice in the United States (Tr. 4775–76; RX 510). AMA has also undertaken to place the foreign physicians in professional positions around the country (Tr. 4776).

C. Scientific Activities

17. (a) *The AMA's Group on Scientific Affairs* is involved in a variety of scientific activities. The Group has 86 employees and is divided into two divisions, the Division of Scientific Affairs and the Division of Continuing Medical Studies (Tr. 4405). The basic fun-

tions of the Division of Scientific Affairs are to disseminate scientific information to the medical profession and general public and to assist the AMA in developing policy positions on scientific matters (Tr. 4406). The Division is broken down into six departments dealing with the following substantive areas:

(1) Drugs;
(2) Food and Nutrition;
(3) Mental Health;
(4) Environmental, Public and Occupational Health;
(5) Medical Terminology and Nomenclature; and,
(6) Health Education (Tr. 4406). [17]

(b) *The Department of Drugs,* staffed by both physicians and nonphysician pharmacologists, evaluates new and existing drugs (Tr. 4406–07). These evaluations are published in the triennial "AMA Drug Evaluations" (RX 270), a book used by physicians, nurses, hospitals, pharmacists and medical students (Tr. 4407–09). The royalties paid to the AMA by the book's publisher do not cover the cost of performing the evaluations and compiling the book (Tr. 4412). In addition, the Department prepares articles on new drugs for the *Journal of the American Medical Association ("JAMA");* these monographs discuss the uses, risks and benefits associated with new drugs (Tr. 4414). The Department is also responsible for answering the 500 to 1,000 drug-related inquiries received by the AMA each year; no charge is made for responding to these requests (Tr. 4416–17).

(c) *The Department of Environmental, Public and Occupational Health* provides the medical profession and the general public with information on environmental and occupational health problems (Tr. 4417). The AMA works with the Public Health Service and the National Center for Disease Control and has sponsored publicity efforts and television advertising to inform the general public of immunization campaigns (Tr. 4418). In the area of environmental ıealth, the AMA publishes a number of brochures dealing with such opics as air pollution (RX 81), water pollution (RX 82) and noise ollution (RX 83), and has sponsored a series of conferences on ırious environmental matters, some of which have been published book form (Tr. 4419; RX 84, 85, 86). The conferences are open to yone who wishes to attend; AMA members receive no price count in purchasing the various brochures and publications (Tr. 0). In the field of occupational health, the AMA authors a nber of publications, dealing with topics ranging from airport

emergency services to the use of pesticides by farmers (Tr. 4423; RX 78, 599). (*See also* RX 79, 107, 597).

The Department of Environmental, Public and Occupational Health is also active in such diverse areas as industrial and household toxicology, venereal disease and sports medicine (Tr. 4421, 4428; RX 106). The AMA responds to questions from the medical profession and the general public at no charge, sponsors conferences and has published numerous brochures, such as "Comments in Sports Medicine" (RX 30), "Sports and Physical Fitness" (RX 92) and "Standard Nomenclature of Athletic Injuries" (RX 32; Tr. 4421–22. *See also* RX 31, 33, 34, 35, 105). Most of the publications offered by the Department are available to physicians and the general public at no charge (Tr. 4446; RX 619). [18]

(d) *The Department of Medical Terminology and Drug Nomenclature* has two major functions (Tr. 4453). In the area of medical terminology, the AMA provides all of the staff and editorial work for a compendium entitled "Physicians Current Procedural Terminology" (RX 8; Tr. 4454). The book seeks to systematize the nomenclature of procedures used in medicine and facilitate the compilation and analysis of statistical information used by physicians, medical economists and the government (Tr. 4455). The staff of the Department is also active in the field of standardization of generic names for pharmaceuticals (Tr. 4457). The AMA has a representative on the United States Adopted Names Council and provides the Council's secretarial staff (Tr. 4459). Finally, the Department performs functions which have carried over from the now defunct AMA Committee on Transfusion and Transplantation, including the distribution of documents, such as "Guide for Hospital Committees on Transfusions" (RX 180), a brochure which is distributed free of charge to anyone who requests it (Tr. 4461).

(e) *The AMA's Department of Mental Health* concerns itself with such topics as mental retardation, alcoholism, drug abuse and the problem of the impaired physician (Tr. 4462). The Department has eight employees and it provides information primarily to physicians and other health professionals to help them better understand th problems associated with mental illness and alcoholism (Tr. 4646 This information is distributed to all physicians without regard AMA membership (Tr. 4647). Included among the activities of t Department of Mental Health are the publication of booklets a pamphlets, sponsorship of conferences, and abstracting of scientific literature (Tr. 4648. *See, e.g.,* RX 35, 65, 142, 188). Repr of articles from AMA scientific journals are distributed fre charge; charges for other publications are equal for AMA and

AMA members (Tr. 4649). The journal abstraction service is available without charge to anyone who wishes to use it (Tr. 4653).

The Department of Mental Health sponsors two types of workshops and conferences. One is a public program of presentations and discussion meetings; the other involves bringing together experts for a nonpublic meeting from which written material is eventually produced (Tr. 4654). Participation in conferences and workshops is not contingent upon being a member of the AMA (Tr. 4654). [19]

The Department is also involved in several ongoing projects in such areas as child mental health, television and health, and the problem of impaired physicians (Tr. 4655–58). The AMA has attempted to identify and influence the broadcasters and sponsors of violent television programs and supports research in that subject area (RX 514A–B; Tr. 4658, 4669). In its television and health program, the Department has made a number of grants to encourage further research. Grants have gone to the National Citizens Committee on Broadcasting ($36,000), the National Parent-Teacher Association ($32,000) and Professor George Gerbner of the University of Pennsylvania ($100,000). Several publications have resulted (RX 520, 521; Tr. 4659, 4662–63). The AMA also sponsors training sessions for physicians who are interested in learning more about the issues of television violence (Tr. 4665). The AMA receives no revenue as a result of this program (Tr. 4666). The AMA has also presented testimony before the Senate Health Committee's Subcommittee on Communications on the issue of television violence (RX 513A–J). The AMA's total out-of-pocket expenditure in connection with the television project is approximately $300,000 (Tr. 4670). The objective of the program is to reduce the deleterious impact of violent programming on viewers, particularly children (Tr. 4671).

The Department's program on impaired physicians involves etermining how best to identify such physicians and remove them om practice until they are rehabilitated (Tr. 4672–76). The AMA s published an article in *JAMA*, entitled "The Sick Physician" X 523), has made recommendations on dealing with the impaired ysician to state and local medical societies (Tr. 4675–78) and has fted model legislation authorizing state licensing boards to mine and deal with impaired physicians and provide legal unities for the person making an allegation of impairment (Tr. -79). Other activities of the AMA in this area include involves in workshops and symposia (RX 524–25; Tr. 4679). The out-of-t expenditure incurred to date by the AMA in connection with npaired physician program is approximately $200,000 (Tr.

4681). These efforts are directed at AMA and non-AMA members alike (Tr. 4682–83).

(f) *The Department of Food and Nutrition* is another part of the AMA Group on Scientific Affairs. The AMA's formal involvement in the areas of food and nutrition dates back to 1929 (Tr. 4514). From 1955 to the present, the AMA has sponsored more than 40 symposia, published 15 books and caused about 125 articles to be published in *JAMA,* all [20] dealing with food and nutrition (Tr. 4517). The primary interest of the Department of Food and Nutrition is in the area of clinical nutrition. To this end, the Department has held symposia on topics such as the metabolic aspects of critically ill patients (RX 112, 618) and parenteral nutrition (Tr. 4520–22; RX 64, 108, 109, 110, 111. *See also* RX 602). These programs are open to all who wish to attend (Tr. 4528).

The AMA has developed a number of programs to further education in the area of nutrition. The Goldburg Medical Student Fellowship program enables medical students at schools that do not offer significant clinical experience in nutrition to attend a clerkship or preceptorship at a school which has a strong nutrition program (Tr. 4532). The award of a Goldburg Fellowship is not limited to members of the AMA or the American Student Medical Association (Tr. 4533). The Department also sponsors a roster of about 20 experts in nutrition who visit medical schools for two or three days each year and act as visiting professors, conducting seminars, lectures and the like (Tr. 4533–34).

A third interest of the Department is the area of public health nutrition (Tr. 4534). The AMA prepares pamphlets and articles in this field, acts as an information source for writers and broadcasters, responds to proposed governmental rules and regulations and helps develop testimony for Congressional hearings before bodies such as the Senate Select Committee on Nutrition (Tr. 4534–35). The Department also runs a program, aimed at physicians and the food industry, which deals with problems in the area of food composition, safety and toxicity (*Id.*).

The AMA is also responsible for originating the Western Hemisphere Nutrition Congress (RX 104), a symposium involving 800 to 1,000 participants, which is held every three years (Tr. 4535). The AMA manages the symposium, publishes a synopsis of its proceedings and is the major financial contributor to the Congress (Tr. 4536 The AMA has also worked in conjunction with the White Hou Conference on Food and Nutrition and various other groups (T 4539–40). Several books have resulted from these conferenc including works in topics such as food processing technology (RX

and processed foods (RX 600, 601; Tr. 4540). These books are available to anyone wishing to purchase them (Tr. 4543). Other activities include the screening of articles on the subject of nutrition for publication in *JAMA* (Tr. 4530–31), the preparation of three continuing education films on subjects such as digestion and absorption (RX 52; Tr. 4544) and the compilation of book reviews of books on the subject of nutrition (RX 62). [21]

(g) *The Department of Health Education's* primary responsibility is to provide information regarding health and disease. The Department is currently involved in projects dealing with subject areas such as physical fitness, health in school and college communities and automobile safety (Tr. 4577). Another project is to establish a national patient education clearinghouse which would serve as a central source of information about patient education materials for anyone who is interested (Tr. 4578). The AMA's patient education activities also include responding, without charge, to the approximately 50,000 mail and telephone inquiries received from the general public each year (Tr. 4579–80).

The Department of Health Education has for the past eight years maintained a committee on exercise and physical fitness (Tr. 4580). In addition to developing exercise programs, the committee has issued various guidelines covering such topics as stress testing for cardiac rehabilitation and has published a variety of pamphlets and articles in connection with the President's Council on Physical Fitness (Tr. 4581–82).

The Department's work in the area of health education for schools includes involvement of the AMA's Medicine and Education Committee on School and College Health, a group composed of representatives from sixteen national organizations interested in school health (Tr. 4583). The Department also sponsors a biannual conference on the subject of physicians in schools, publishes numerous statements and pamphlets and has produced three books dealing with health instructions, health services and health environment Tr. 4584–85). The AMA is also involved in such diverse projects as eeking to identify a relationship between school environment and arning, and screening school children for visual defects and aring impairment (Tr. 4585–86).

In the automobile safety area, the AMA has helped develop a ies of training films for driver's license examiners, has helped elop the Abbreviated Crash Injury Scale and has collaborated n the National Safety Council on subjects such as the efficacy of belts and motorcycle helmets (Tr. 4587–88). In addition, the A publishes several pamphlets in this area: "Drinking and

)riving" (RX 126), "You May Be Involved in an Automobile Collision Today" (RX 156) and "Are You Fit to Drive" (RX 177).

The Department also publishes pamphlets and brochures covering a wide variety of subjects (Tr. 4589). One group of brochures deals with a number of common diseases and is [22] used by consumers for general education purposes (Tr. 4591); it includes such publications as "Athlete's Foot" (RX 120), "Your Blood Pressure" (RX 130), "Venereal Disease" (RX 127) and "Smoking Facts You Should Know" (RX 134. *See also* RX 118, 119, 122, 125, 128, 129, 134, 146, 159, 162, 163, 168, 171, 179, 183, and 186). These pamphlets are revised and updated by a full-time staff of writers working in conjunction with expert consultants (Tr. 4592). Single copies of the pamphlets are given away free of charge, at a cost to the AMA of about $20,000 per year (Tr. 4591–92).

Another group of approximately 15 brochures deals with the area of dermatology, which includes "Something Can Be Done About Acne" (RX 173), "The Sun and Your Skin" (RX 155) and "Soap, Its Use and Abuse" (RX 132. *See also* RX 152, 175, 149, 144, 143, 117, 124, 138, 160, 161, 164, 136, 140, 588, 589, 590). A group of brochures deals with topics related to reproduction. Included in this group are "What To Do After Your Baby Comes" (RX 129), "Infertility" (RX 189) and "What You Should Know About the Pill" (RX 169. *See also* RX 139, 170, 93). Other sets of brochures deal with aging and retirement (RX 167, 172, 180, 178, 114), sex education (RX 99, 98, 91, 90, 62, 181, 137), food and nutrition (RX 131, 153, 154, 184), athletics (RX 187, 150, 113, 95, 185) and miscellaneous topics such as "Sensitivity Training" (RX 131), "Psychotic Drugs" (RX 176), "The ABC's of Perfect Posture" (RX 157) and emergency medical services (RX 87, 145. *See also* RX 141, 147, 148, 174, 166, 158, 182, 595, 123, 187). The AMA also distributes posters dealing with various medical problems, including athletic injuries (RX 203), venereal disease (RX 201), heroin (RX 199) and emergency medical identification tags (RX 197. *See also* RX 198, 200, 202). These pamphlets and posters are distributed primarily to the general public, and are available at no charge and without regard to medical society membership (Tr. 4596–97, 4599–4600, 4604, 4613).

In addition to brochures and posters, the AMA publishes the proceedings of conferences on a number of health issues. Several of these conferences have grown out of the Department's auto safety project, *e.g.*, "Proceedings, National Conference on the Aging Driver" (RX 569) and "Conference Proceedings on Current Problems in Driver Licensure" (RX 570. *See also* RX 571, 572, 573). The conferences bring together professionals with expertise in the area

auto safety, without regard to AMA membership (Tr. 4629). Other auto safety activities include reprinting *JAMA* articles on the subject; "Visual Factors in Driving" (RX 575) and "Physician Reporting of Driver Impairment" (RX 577) are just two examples of such reprints (*see also* RX 576, 578, 581, 582, 583, 584, 585, 586). Other publications include scales for standardizing automobile injury data (RX 574, 594, 579, 580). [23]

In addition to the above activities, the AMA publishes numerous scientific works, such as treatises on the neurobiology of cerebellar evolution or on spectroscopy as it relates to biomedical problems (RX 38, 63), "Current Concepts in Cancer" (RX 29) and "General Principles of Blood Transfusion" (RX 598). The AMA also publishes less technical books which, while intended for physicians, can also be used by laymen (Tr. 4475); "Human Sexuality" (RX 43), a work dealing with sexuality and other family problems, is an example of such a book (*see also* RX 46, 88).

Finally, the AMA puts out several publications designed for use in health education at the elementary and secondary levels (Tr. 4477–78); "The Wonderful Human Machine" (RX 58, 59) and "The Miracle of Life" (RX 60) are examples of such brochures. The AMA is also active in advising educators on methods of improving health services in schools. To this end, the AMA has issued three publications: "Healthful School Environment" (RX 39), "Suggested School Health Policies" (RX 40) and "School Health Services" (RX 41). The AMA has also participated with the National Education Association in preparing and publishing a book which instructs students in hygiene and personal health habits (Tr. 4482; RX 42).

The AMA prepares over 100 other brochures for distribution to the general public (Tr. 4484). These publications cover a broad range of areas, including such topics as prenatal care (RX 115) and diabetes (RX 116). While these brochures carry a nominal charge of 25 to 30 cents, they are generally distributed to individuals free of charge (Tr. 4483–85). Several AMA publications address the various problems related to child care. The AMA distributes height and weight interpretation folders (RX 214) to schools, physicians and others who ıeed to chart the growth progress of a child, and has helped prepare Growing Pains" (RX 74), a publication directed to parents (Tr. 487). Other AMA publications are concerned with issues relating to ·inking and smoking; "Breath Alcohol Tests" (RX 97) is an position of the various tests that can be used for measuring blood ·ohol levels (Tr. 4488). The AMA also distributes plaques contain- the words "For the Sake of Your Health and the Comfort of ıers, No Smoking, Please" (RX 216, 217). The objective of the

AMA in placing a nominal price on some of the above-mentioned items is to recover a portion of the costs of printing and distribution and to make the documents more valuable to the purchaser (Tr. 4491).

(h) *Scientific Publications.* AMA publishes 10 scientific journals. The most well known of these is *JAMA,* which is published weekly (Tr. 5086). AMA also publishes nine specialty journals: *Diseases of Children, Archives of General Psychiatry, Archives of Internal Medicine, Archives of Neurology, Archives of Ophthalmology, Archives of Otolaryngology, Archives of Pathology, Archives of Surgery* and *Archives of Dermatology* (Tr. 5086, 5100). [24]

JAMA serves three separate functions. It is the official bulletin of the AMA and periodically contains information such as the names of AMA's elected officers, the AMA annual budget, etc. (Tr. 5087). It is also a scientific journal of medicine, as it includes a large number of articles on the diagnosis and treatment of disease (Tr. 5087). *JAMA* also publishes notices of relevant current events in American medicine, such as the date of scientific meetings, coverage of medical breakthroughs, etc. (Tr. 5087–88; RX 213, 608). Scientific articles take up the majority of space in *JAMA.* The AMA receives approximately 4,000 major scientific manuscripts per year from physicians and scientists around the world, and the editorial staff selects and edits about 800 of the articles for publication each year (Tr. 5088–89). *JAMA* is the world's most widely circulated medical journal, with a print run of about 250,000 issues per week (Tr. 5090–91, 5095). *JAMA* is distributed to about 210,000 subscribers (Tr. 5098). About 150,000 of these are AMA members who receive *JAMA* as part of their annual dues package (Tr. 5098–99). The remainder of the issues are distributed to nonmember subscribers such as physicians, scientists and libraries. Nonmembers receive *JAMA* at a cost of $30.00 per year in the United States and $50.00 per year in foreign countries (Tr. 5098).

The nine AMA specialty journals are published on a monthly basis and consist almost exclusively of scientific articles relating specifically to the particular medical specialty (Tr. 5100; RX 609–17). The articles are selected and edited by autonomous editorial personnel, most of whom hold positions of responsibility in medical education and are not members of AMA (Tr. 5104–05). The specialty journals occasionally sponsor symposia or conferences on a specific disease or treatment. The journals publish the papers which are presented at these meetings and distribute them to subscribers at no additional charge (Tr. 5106–07; RX 66–73).

The nine specialty journals have the following approximate circulation characteristics:

	TOTAL CIRCULATION	CIRCULATION TO AMA MEMBERS
Archives of General Psychiatry	23,000	14,000
Archives of Internal Medicine	60,000	15,000
Archives of Neurology	14,000	6,000
Archives of Opthalmology	17,000	7,000
Archives of Otolaryngology	13,000	5,000
Archives of Pathology	10,000	5,000
Archives of Surgery	45,000	38,000
Archives of Dermatology	16,000	7,000
Diseases of Children	26,000	16,000

(Tr. 5102–03)

[25] AMA members receive one specialty journal as a part of their regular dues package (Tr. 5101). Nonmembers are charged at an annual rate of $18 per journal, the same price which is charged to AMA members for additional specialty journals (Tr. 5102).

The AMA receives various advertising and subscription revenues in connection with its publication of the journals. Revenues from AMA medical journals go into the general funds of the Association and journal expenditures are made from the same general fund (Tr. 9571). Since 1975, the revenue received by AMA from advertising and subscriptions has roughly equaled the direct expenditures associated with the journals (Tr. 6438, 9590; CX 2586T, H; RX 567, pp. 7, 15, 17). In 1975, advertising, subscriptions and book and pamphlet sales revenues were approximately $12.253 million, and expenditures were approximately $10.703 million (RX 567, p. 7). In 1977, advertising revenues were estimated at $10.187 million, subscription revenues were estimated at $2.114 million and sales of books and pamphlets were estimated to earn $.545 million, for a total of $12.846 million; expenditures were estimated at $12.666 million (RX 567, pp. 15, 17). AMA's senior Vice President in charge of medical education, scientific activities and scientific publications testified that: "I think in any of our activities which we carry on, and its the same with non-publications, if there is a potential to offset the

cost of that operation through legitimate income, we attempt to do it" (Tr. 9590).

Through its efforts in the areas of scientific affairs and publications, AMA contends that it has also sought to achieve its goal of improved patient care by encouraging continued medical research and by communicating the resulting knowledge to physicians (Tr. 517–679). These programs constitute one of the primary reasons for the Association's existence (Tr. 5182–83). AMA further contends that the few programs it offers which may directly benefit its membership, such as retirement and insurance plans, are not a primary function of the organization. The basic purpose of AMA, it is asserted, continues to be to advance the public health through its programs in medical education, scientific affairs and scientific publications (Tr. 5184–85).

D. Public Health Activities

18.(a) The *Division of Medical Practice* concerns itself with federal and state medical regulations, practice management programs, professional peer review, a project to improve the [26] quality of medical care in jails, physician placement, the application of computer technology to the practice of medicine, rural and community health programs and a program involving consumer affairs (Tr. 4950).

In 1972, the American Bar Association and the Chief Justice of the United States Supreme Court coauthored a report concerning the quality of health care in American jails. The report urged organized medicine to join in an effort to improve the quality of such medical care (Tr. 5039–40). The AMA undertook a detailed study entitled "Medical Care in U.S. Jails" (RX 497), which it funded entirely at a cost of $48,000 (Tr. 5040). AMA organized a national advisory committee composed of representatives from the AMA, the American Bar Association, the American Correctional Association and the National Sheriffs' Association (Tr. 5041). Since 1972, AMA's effort has focused upon the development of a national accreditation program to determine whether jails have complied with certain minimum standards of medical care (Tr. 5044). The AMA has now completed a draft of minimum standards for medical and health care services in jails (RX 496). AMA representatives, along with those of the national advisory committee, have also attempted to monitor jails' compliance with the standards (Tr. 5048). The AMA has published and distributed a number of informational monographs for use by jail medical personnel (Tr. 5054–59; RX 498–507, 658). The AMA spent about $50,000 on the program during each of the years

1976 and 1977, and about $70,000 was budgeted for expenditure in 1978 (Tr. 5060–61).

In the area of federal and state regulations affecting medical practice, the Division of Medical Practice advises governmental agencies of the potential effect of such regulations upon the ability of physicians to deliver high quality care to patients. The AMA also attempts to keep the nation's physicians aware of the existence of governmental regulations which govern medical practice (Tr. 4951–52).

The AMA holds practice management seminars to instruct young physicians how to deliver high quality medical care to their patients in an organized and efficient manner (Tr. 4953–55). These seminars are available to the public, and are attended by nonphysicians and physicians who are not AMA members (Tr. 4954). The Division of Practice Management also conducts seminars to advise medical personnel of the increasing role of computer technology in the health care field, and publishes a newsletter on this subject. The computer seminars and newsletters are made available to the general public (Tr. 4958). [27]

The Division of Medical Practice helps to design and administer the operation of peer review organizations which evaluate the appropriateness and quality of medical services performed by physicians (Tr. 4957–62). Thus, the Division has established a number of task forces to look into development of health quality assurance programs nationwide (Tr. 4852). The AMA has also received a $1 million grant from the U.S. Department of HEW to help finance its project to develop sample criteria for care in short-stay hospitals. These criteria are designed for use by Professional Standards Review Organizations (PSRO's) around the country (Tr. 4853–54). The HEW grant facilitated publication of a resource manual containing sample criteria of care which is now in use throughout the nation (Tr. 4853–54).

The AMA's physician placement service is a program designed to locate physicians to serve areas in need of medical service. The placement service is available to any physician or community, and is run by the Division of Medical Practice free of charge (Tr. 4963). The AMA has also assisted the National Health Service Corps to locate physicians in medically underserved areas designated by the Secretary of HEW, and has performed a similar function on behalf of The Indian Health Service. The AMA made no charge for these services (Tr. 4964). In the areas of community and rural health, the Division of Practice Management has held numerous conferences and seminars to improve the delivery of health care in the urban and rural

environment (Tr. 4966–67). The AMA is also involved in a pilot urban medical care program in cooperation with the Robert Wood Johnson Foundation and the National Conference of Mayors (Tr. 4968). The Division of Medical Practice is engaged in a program designed to improve the nation's emergency medical services (Tr. 4971). The Division is also in the process of establishing a consumer affairs program to provide patient input into the practice of medicine (Tr. 4971–72).

(b) The AMA's *Division of Public Affairs* includes programs in the area of federal communications, speech writing, public speaking, membership development, government interface and officer services (Tr. 4973). AMA's membership development programs are designed to maintain the level of AMA membership and to solicit nonmember physicians to join the Association. This is done through direct mail, publications, pamphlets and speeches (Tr. 4973–74). The Division is engaged in a continuing effort to provide information of interest to other medical organizations, such as state or county medical societies (Tr. 4975–76). The Division also staffs a speaker's bureau. At the request of public or civil organizations, AMA members are sent to speak on questions concerning medical practice and health care (Tr. 4976–78). AMA trains its [28] spokesmen in the art of public speaking, and makes the service available to the public, usually at no charge (Tr. 4977–79). The Division also employs a number of speech writers to prepare remarks for AMA officers who are called upon to speak at public meetings (Tr. 4980–84).

The AMA Division of Public Affairs conducts a program of government interface. There are two major aspects of the program: one involving legislative work with the Congress or state legislatures and one with federal administrative agencies such as the Department of HEW and the Veteran's Administration (Tr. 9827). In 1977, for example, AMA representatives testified or submitted statements concerning some 110 proposed bills or regulations affecting the public health (Tr. 9828). In the majority of instances, AMA testifies at the specific request of the committee or agency (Tr. 9829). AMA testifies on a wide range of issues from the use and regulation of drugs, funding of medical procedures under medicare, mental health programs, etc. (Tr. 9829; RX 696–97). The AMA also is engaged in the preparation of draft legislation and regulations, as well as lobbying for bills which it favors (Tr. 9831).

According to AMA, its purpose in engaging in a program of governmental interface is to encourage state and federal governments to initiate and maintain programs which will best serve the public health and to encourage government to promote economic

efficiency in its health programs (Tr. 9835). AMA contends that there is no substantial economic motivation underlying AMA's program of governmental interface (Tr. 9836). When AMA formulates a position on a specific item of legislation or regulation, its probable economic effect upon physicians is rarely discussed and is not a major consideration (Tr. 9836–38). While AMA's position on some legislative matters, such as the Keogh Act, has been influenced by economic motivations, this occurs in only a small percentage of situations (Tr. 9836–38). AMA further states that the vast majority of AMA's efforts to influence government policymakers have involved questions which do not directly affect the economic welfare of physicians (RX 696–97). Over recent years the AMA's program of government interface has gradually increased as the number of health-related bills introduced in Congress has grown (Tr. 9838).

The AMA further contends that it does not engage in political activities, such as partisan activities on behalf of a specific candidate or political party, and does not collect or dispense money on behalf of political candidates (Tr. 9842). [29]

(c) The AMA's *Division of Professional Relations* is engaged in working with other professions and groups in areas of common interest. This activity most often involves participation in public health programs, such as AMA's involvement with the Joint Commission on the Accreditation of Hospitals (Tr. 4991–92. *See also* F. 41, p. 53). The Division is engaged in a liaison activity with the student's business and house staff sections of AMA. This program encourages greater participation of medical students and young physicians in AMA programs (Tr. 4992, 5000). The Division conducts various negotiation seminars to help physicians develop an ability to communicate well with patients, their colleagues and the public (Tr. 4993). The Division is also involved in a program to assist foreign medical graduates in their efforts to establish themselves in the United States and to help them enter the mainstream of the medical profession (Tr. 5002).

E. Data Collection and Analysis

19. Chris N. Theodore, a Group Vice President of AMA, is responsible for the following four divisions of the AMA: the Division of Corporate Facilities and Services, which is charged with management of AMA's physical plant and office facilities; the Division of Personnel Management, the group responsible for supervision of AMA's employees; the Division of Computer and Information Systems, which supervises the acquisition and use of computer

systems in connection with Association activities; and the Center for Health Services Research and Development (Tr. 9721).

The *Center for Health Services Research and Development* ("Center") is engaged in a comprehensive program of research in the area of medical care. The Center collects data concerning the American physician population and analyzes the data in order to set out and evaluate alternative courses of action with respect to problems in the health field (Tr. 9725–26). The Center's physician data base was established in 1962, and was designed on the basis of recommendations made by an *ad hoc* committee of the United States Committee for Vital Statistics (Tr. 9735–37). One member of this committee was Professor Paul J. Feldstein of the University of Michigan. The Center is funded through general AMA revenues, which are allocated by the Board of Trustees. The Center's instructions from the Board of Trustees are to gather the most reliable data possible, to provide objective analysis of the data and to encourage other groups and institutions to participate in the field of health research and analysis (Tr. 9734–35). The Center will disseminate [30] information from its master physician file on request, although the identity of the individual physician-respondents are withheld to preserve the confidentiality of the data base (Tr. 9753–55). All of the Center's reports are made public after their completion (*Id.*).

The Center routinely performs a survey of AMA members to determine physicians' attitudes toward various contemporary health issues as well as certain activities of the AMA (Tr. 9758). This project is similar to one performed by the Department of HEW, and is designed to provide policymakers in government and at the AMA with accurate, reliable information on how physicians are likely to react to a proposed health program (Tr. 9760). The Center has also prepared a report, entitled "Analysis of Malpractice and Professional Liability." The report analyzed the effect of rising malpractice insurance premiums upon the location and practice of physicians. The report was designed to provide policymakers with information as to what effect the so-called "malpractice crisis" has had upon the availability of medical services (Tr. 9761–62).

The Center has been active in a program entitled "Commission on the Cost of Medical Care" (*See* F.20, p.33, *infra*). The AMA Center provided research and data collection services to the Commission at no charge, and prepared a three-volume report of the Commission's findings and recommendations (Tr. 9677).

The Center prepared a report entitled "Distributional Characteristics of Health Manpower." This report, prepared in response to a recommendation by the National Committee on Vital Statistics, sets

out information on the distributional characteristics of physicians by specialty, geography and activity (Tr. 9767). The purpose of the project is to make such information available for the use of government officials, the academic community and other interested parties (Tr. 9678).

The Center has prepared an "Analysis of Physician Mobility" in order to provide legislators and federal agencies with information regarding the factors which may lead physicians to relocate in underserved areas of the country (Tr. 9678). The analysis was also prepared to make information about physician mobility available to medical schools, state governments and other researchers (Tr. 9768–70).

The Center periodically prepares a report entitled "Physician Distribution and Medical Licensure" which contains biographical information about physicians' licenses in the various [31] states (Tr. 9770–71). The report is prepared for use by medical licensing boards and government policymakers (Tr. 9771–72).

The AMA Center also publishes an "FMG Book" which contains biographic and demographic data concerning American physicians who have graduated from foreign medical schools (Tr. 9772). The Center prepared its FMG Book at the request of the Department of HEW in order to aid policymakers in evaluating the optimal utilization of foreign medical school graduates (Tr. 9772–73).

The Center has prepared a report entitled "Health Service Area and State Distribution of Physicians" in order to generate comprehensive and reliable information concerning the physicians located within "health service areas" (Tr. 9774). This report has been utilized by the Department of HEW (Tr. 9776).

The Center sometimes prepares "Policy Issue Papers" to set forth alternatives and recommendations concerning contemporary problems in health care. These papers are published in various medical and/or economic journals and are presented to AMA management (Tr. 9777). The Center has also prepared a report entitled "Analysis of Institutions Affecting Medical Care Delivery" which studies the economic effect of government regulations upon the delivery of medical care. This project is prepared for use by government policymakers and other research institutions (Tr. 9779).

The AMA's *Division of Library and Archival Services* serves as an information source for the Association, its members and the general public. It receives all major domestic medical journals and most major foreign language medical journals (Tr. 4693). The Division also reviews and indexes about 700 medical journals each month for use in a computer data collection service called "Medline" (Tr. 4694).

AMA makes Medline services available to physicians, whether or not members of AMA, and to the general public (*Id.*).

The Division operates a public service information project in conjunction with the National Health Service Corps. Under this program, physicians employed by the National Health Service Corps may call a toll-free telephone number to obtain medical literature and information free of charge from AMA (Tr. 4694). This program is available largely to physicians practicing in economically depressed areas (*Id.*). The Division prepares free medical bibliographies for physicians, whether or [32] not AMA members, upon request (Tr. 4695). The Division also donates volumes of its literature to other medical libraries throughout the country (Tr. 4699; RX 653).

The Division receives and responds to a large number of requests for information from the general public. This involves answering questions about specific diseases, treatments, etc. (Tr. 4702–03). The Division also processes complaints about individual providers of medical care (Tr. 4704).

Another activity of AMA involves the maintenance of biographical files on individual physicians. This information is stored with a computer data base, and can be retrieved via a cathode ray tube screen or reproduced in printed form (Tr. 4704–05). The AMA Survey Data Center is the nation's only centralized source of information about each of the country's licensed physicians, all of which is obtained via responses to a periodic AMA questionnaire form. Such information includes the physician's name, office address, medical school, year of graduation, place of internship and/or residency, specialty, subspecialty, licensure information, etc. (Tr. 4705). Many individuals and groups make use of this physician data base, including hospitals, state medical licensing boards, students and the general public. About 2,500 requests for information from the data base are processed each week (Tr. 4706). The only potentially derogatory information contained in the computer data base concerns the revocation of a physician's license to practice (Tr. 4710).

The Division also maintains certain other information in a group of inactive files from the AMA's Department of Investigation, which was disbanded in 1975. These files contain information concerning physician's medical licensure actions, medical society expulsion and unproven methods of medical practice. The Department of Investigation's files are not accessible to anyone at the AMA except the Director of the Division's Department of Automation and Technical Services (Tr. 4713). Information from the Department of Investigation's files is never released to an inquiring party (Tr. 4713). If an inquiry is made about a physician who has had his license revoked,

for example, the inquiring party is informed that the appropriate state licensing board may have further information about the physician (Tr. 4713-14). Since May 31, 1975, only about 10 inquiries have been referred to other agencies or medical societies for further information (Tr. 4716). None of these incidents concerned a physician's involvement in allegedly unethical advertising or contract practice (Tr. 4717-18). [33]

F. Miscellaneous

20. AMA lists the following activities under a category of "miscellaneous." In 1976, the AMA Board of Trustees created a 27-member Commission on the Cost of Medical Care. The Commission is comprised of representatives from organized medicine, federal and state government, private industry, the insurance industry and organized labor. The Commission later divided into task forces examining cost increases arising from miscellaneous market factors, technological advancements, the increased demand for services and the supply of health services. After completion of its analyses, the Commission plans to report on the causes of rising health care costs and to recommend options for policies to contain such costs (RX 3, p. 6; CX 1545E-F). In 1975, the AMA established a committee to study disciplinary mechanisms of medical associations, determine the effectiveness of medical discipline and recommend modifications in self-regulation and in state statutes and regulations (CX 1545F).

In 1975, the AMA supported legislation to modify the Self-Employed Tax Retirement Act ("Keogh Act"). The modification increased the annual limit of contributions which a self-employed individual can make to a qualified personal retirement fund to the lesser of 15 percent of earned income or $7,500 (CX 1533A. *See also* F. 29, p. 45, *infra.*).

In 1967, the Legal Research Department of the AMA prepared a model partnership agreement to aid attorneys in drafting partnership agreements for physicians (CX 340).

In 1973, in response to a request, the AMA sent a physician a copy of a monograph, entitled "The Sale or Disposition of a Medical Practice." There is no indication that this material was prepared by the AMA (CX 347-48).

The AMA participated in the preparation of a model health insurance claim form. There is no indication that use of this material has been limited to AMA members or of the benefit which its use may have conferred upon insurance companies, government agencies or the general public (CX 351A-G).

A publication entitled *The Business Side of Medical Practice* was

published by the AMA to assist physicians in efficiently organizing a practice and managing an office. There is no indication that the use of this material was limited to AMA members (CX 376). The AMA prepared a paper, [34] entitled "The Doctor Rents an Office," to assist physicians in dealing with the problems of renting an office. There is no indication that this material was made available only to AMA members (CX 378). The AMA, the American Association of Medical Clinics and Medical Group Management Association issued a pamphlet entitled "Group Practice Guidelines to Joining or Forming a Medical Group." This publication was first published in 1962 and revised in 1972. There is no indication that it was distributed to or used only by members of the AMA (CX 380).

The AMA frequently assists boards of medical examiners in the evaluation of credentials of physicians who are applying for licenses to practice (Tr. 6726).

Other AMA activities include publishing a weekly news publication entitled *American Medical News,* which is distributed to its members and certain selected outside readers. *American Medical News* reports news on legislative, economic, legal and other nonclinical areas and includes a monthly opinion section which provides a forum for interpretation and analysis from authors on the socioeconomic aspects of medicine (CX 1046Z–17, 896).

The AMA offers its members and their families various insurance plans at reduced rates. In soliciting new members or renewals, the AMA has indicated the availability of its plans (CX 1521, 1523, 1537–38, 1542, 1548, 1561). The AMA also offers a retirement plan for its member physicians who are self-employed practitioners. The plan is open to nonmember partnerships provided at least one physician partner is a member of the AMA (CX 331–35).

In a number of its activities, AMA is assisted by volunteers who are not compensated for their efforts. The majority of volunteer time used by the AMA is devoted to its programs in the areas of medical education, scientific affairs and scientific publications (Tr. 9557–58). For example, each of the standing advisory committees of AMA's Council on Medical Education is staffed entirely by volunteers, as is the Council itself (Tr. 9557). AMA's survey team in the accreditation of medical educational programs is comprised largely of volunteers (Tr. 9557–58). The AMA Council on Scientific Affairs staffs consultant panels comprised exclusively of volunteers (Tr. 9558). The editorial staffs of AMA's 10 medical journals are comprised largely of volunteers (Tr. 9559). Volunteer time is also spent on legislative work. The volunteer time spent on behalf of AMA in the area of

legislative work is far less than that devoted to scientific and educational pursuits (Tr. 9560-63). [35]

G. AMA Education and Research Foundation

21. The AMA Education and Research Foundation was established in 1954 as a means of providing financial support for medical education (Tr. 5167). Since 1954, the Foundation has solicited donations from physicians which are used to finance scholarships and loans to medical students who demonstrate financial need (Tr. 5167-71). Loans are granted to applicants without regard to their affiliation with the Foundation or the American Student Medical Association (Tr. 5169-70). The Foundation has also granted about $1 million per year to American medical schools in unrestricted grants (Tr. 5171; RX 564). Another AMA program finances interest-free loans for underprivileged medical students (Tr. 5171-73).

H. American Medical Political Action Committee

22. The American Medical Political Action Committee ("AMPAC") was established by the AMA in 1961 as a nonprofit, voluntary individual membership organization (Tr. 4785; CX 1258A, 1493A, 1723G, 1487A, 1021B). AMPAC is a separate, segregated fund of the AMA and operates in conformity with the provisions of the Federal Election Campaign Act of 1971, 2 U.S.C. 431-455. This law permits membership organizations to establish separate, segregated funds with which to make campaign contributions to Federal candidates under certain limitations (CX 1021A-B). AMPAC has its own constitution and bylaws, and its own board of directors (Tr. 4797).

The AMA Board of Trustees appoints the ten-member Board of Directors of AMPAC, which consists of nine physicians and one physician's spouse (CX 1021B). Many of AMA's current officials, including its two highest officers, Executive Vice President Dr. James Sammons and Deputy Executive Vice President Joe D. Miller, served previously as high AMPAC officials. Dr. Sammons served as chairman of AMPAC's Board of Directors and Mr. Miller served as AMPAC's Executive Director (Tr. 4025, 4030-31, 4801-11; CX 460). Similarly, a substantial number of AMPAC's board members have also served on the AMA Board of Trustees and the AMA Council on Legislation (Tr. 4003-35, 4803-11). AMPAC's bylaws were approved by AMA (CX 1484A). AMPAC Board members serve a one-year term and may be appointed for a maximum of 10 consecutive years (Tr. 4799). No individual has ever served as a director of the AMPAC

Board while simultaneously serving as an officer, director or trustee of the AMA (Tr. 4826). [36]

AMPAC conducts a two-phase program; one phase is a political educational program and the other is a political action program (Tr. 4783, 4796). AMPAC's political education activities are intended to increase the participation and effectiveness of physicians and their families in the political process (Tr. 4874–85). These activities consist of the distribution of the AMPAC newsletter and other written materials, as well as sponsorship of films and seminars for physicians on activities such as conducting absentee ballot drives, voter education and registration drives, establishing a telephone bank, managing a campaign, scheduling and advance work (Tr. 4784, 4786–87). AMPAC political education activities are available to physicians regardless of their party affiliation or political views.

The second phase of AMPAC activities consists of its political action program, in which AMPAC makes financial contributions to candidates for the United States Senate and House of Representatives (Tr. 4787). A committee of the AMPAC Board decides which candidates will receive contributions (Tr. 4787).

AMA provides 100 percent of AMPAC's administrative and operating expense budget (Tr. 4800). During five past fiscal years, AMA made the following transfer of funds to AMPAC:

1972	$744,500
1973	689,435
1974	804,825
1975	642,420
1976	650,422

AMA budgeted $900,382 for AMPAC support in 1977 (RX 743, App. IID). AMPAC rents office space in the AMA headquarters building and rents computer services from the AMA. AMPAC owns its personal property and office furniture, and maintains its own administrative and support services separate from those of the AMA (Tr. 4796–97).

In the past, AMPAC board members appeared before the AMA Board of Trustees to outline and justify the amount of funds AMPAC requested for its political education activities. This presentation is now given in writing (Tr. 4800–01). AMA and AMPAC do not now cosponsor joint meetings or seminars (Tr. 4812–13). Prior to 1975, they cosponsored an annual meeting to educate physicians on political processes such as campaign management techniques or the formation of [37] political action committees (Tr. 4812–13). In 1975 and 1974, the AMA and AMPAC boards had dinner together (Tr.

4812). On two occasions, new members of the AMA Board of Trustees attended AMPAC board meetings as observers in order to acquaint themselves with AMPAC activities (Tr. 4828–29). The Chairman of AMPAC has made a three-to-five minute speech to the AMA House of Delegates to urge the delegates to participate in and to join AMPAC (Tr. 4794–95).

Prior to 1969 or 1970, AMPAC maintained field offices in various cities throughout the country. In 1972 and 1974, in the months immediately prior to national elections, a number of AMA field representatives were placed upon the AMPAC payroll to work directly on AMPAC political campaigns that were providing support services for candidates (Tr. 4795, 4815–16). The AMA field service staff also worked with AMPAC officials in planning AMA–AMPAC Public Affairs Workshops, where numerous physicians participated in discussions of campaign techniques and health legislation (CX 1050Z8, 1051Z9). AMA's field offices were closed in 1974 (Tr. 4795). In 1975, responsibility for various AMPAC membership activities was transferred to the AMA Department of Federation Affairs (CX 1376A–B).

AMPAC conducts political education activities in cooperation with state medical political action committees. It provides information to these organizations upon request. AMPAC sends a bulletin to sustaining members of AMPAC, who are people that have contributed a large sum of money to AMPAC, and to members of boards of directors of other medical political action committees (Tr. 4825–26). AMPAC and state medical political action committees occasionally solicit funds jointly (Tr. 4821). AMPAC from time to time gives an award to a state political action committee which joins in an AMPAC program that results in breaking an AMPAC membership record (Tr. 4821–22). AMPAC has made one grant of funds to a state medical political action committee (Tr. 4824). AMA constituent medical societies raise money for AMPAC's candidate funding activities by soliciting contributions to AMPAC (CX 1436L, M). The AMA House of Delegates has commended these state medical societies, urged other societies to raise money for AMPAC and urged AMA members to support AMPAC (CX 1436L, M, 1484B). In 1976, AMPAC reported campaign fund transfers of more than $1 million (CX 1760), making it the second largest political action committee in the United States (CX 1722B. *See also* F. 39, p. 50). [38]

III. ACTIVITIES OF THE AMERICAN MEDICAL ASSOCIATION WHICH HAVE PECUNIARY BENEFIT FOR ITS MEMBERS

A. Organizational Attributes and Acknowledged Benefits to Members

23. AMA was founded and exists as an organization of and for the medical profession (CX 1042J). The original constitution of AMA proclaimed as one of its purposes, "promoting the usefulness, honor and interests of the medical profession" (Memorandum in Support of Respondent American Medical Association's Motion for Summary Decision Dismissing the Complaint for Lack of Jurisdiction filed March 24, 1976, p. 13). The articles of incorporation adopted by AMA near the turn of the century declared one of its purposes to be "safeguarding the material interests of the medical profession" (CX 1355H). In 1975, the AMA House of Delegates recognized that one of the "major missions" of the AMA is to "act as a spokesman for physicians to the public, the government, industry, and others" (CX 1042S).

Membership in the AMA is limited to those who hold the degree of Doctor of Medicine or Bachelor of Medicine, hold an unrestricted license to practice medicine or surgery, are interns and residents in training or are medical students, all duly authorized by their state societies as members of the state societies (CX 990G). Over 75 percent of office-based medical practitioners and over 80 percent of the board-certified physicians in the United States are members of the AMA. Most AMA members are private practice fee-for-service physicians (Comp. and AMA Ans. ¶ 4; Tr. 3949–50; CX 197 0, 232 0, 1042H–J, 1103E). AMA is the largest medical and professional association in the world (CX 245B, 1522). It professes to be the national spokesman for the medical profession (CX 263Q), and it is the only national organization of physicians large enough to act as an umbrella organization to represent the entire physician community in the United States (CX 246, 1042N).

AMA's budgeted expenses in 1977 were $46,205,000 (RX 567, p. 15). Its income totalled $57,770,000, of which $36,869,000, or 63.8 percent, came from members' dues (RX 567, p. 15). The bulk of the remainder came from advertising and subscription revenue from AMA's publications (RX 567, p. 15). Only a very small portion of AMA's income comes from disinterested third parties (RX 567, p. 15).

Most of AMA's members are in private practice and receive fees for the services they render to patients (CX 1042J; Comp. and AMA Ans. ¶ 4). AMA has repeatedly told its members that it operates to protect and foster their interests (CX 232D, 263–O, 1224, 1528B,

1532B) and that one of its primary purposes is to serve its membership (CX 259C). It has frequently cited [39] the remarkable range of tangible benefits it provides for its members (CX 259C, 263Z4) and the intangible benefits they receive from AMA's collective action to influence legislators (CX 259A). In its activities, AMA supports the "usual, customary and reasonable fee" concept for the compensation of physicians for their services (CX 954F, 1697B, C). AMA has acknowledged that, as the single, strong national voice speaking for American doctors (CX 1545D), it does at times represent the self-interests of the profession (CX 1109L). In 1973, AMA's House of Delegates voted that AMA officers and the Board of Trustees should take steps to increase AMA's capacity to "speak with authority in representing the interest of the medical profession and the public in the socioeconomic areas" (CX 2589B).

Some representations which AMA has made to its members about AMA activities for the benefit of its members are as follows:

> AMA won landmark victories in the Federal courts; made significant progress towards solving the medical liability crisis; won an important legislative battle to prevent Federal control of residencies; fought for and won exemption for current medical students from paying back Federal grants to medical schools; supported a pay increase for V.A. physicians; and many more. None of these accomplishments could have happened without the active participation and continued support of all members. (1976 Direct AMA Members Renewal Letter - CX 1522).

One page from an AMA brochure, entitled "What's the AMA done for you lately?," is reproduced hereafter: [40]

ex245 D

What's the AMA done for you lately?

Here are some of the things that haven't happened to you and the profession because the AMA went to bat for you:

- Precertification of hospital admissions
- Kennedy-Griffiths NHI Plan and others you couldn't live with
- Discriminatory controls on physician fees -- "No Phase V"
- Sweeping Federal HMO grants
- Public utility control of your practice
- National re-licensure
- Unrealistic restrictions on physician discretion in prescribing drugs
- Mandatory government service for all medical school graduates
- Premature HEW establishment of consumer-run program review teams for Medicare and Medicaid

Here are some of the key benefits services AMA membership provides:

- Insurance programs that provide broader coverage at a cost lower than you can find anywhere. (Excess Major Medical Program, Group Term Life Insurance, Supplemental "In Hospital" Insurance, Accidental Death & Dismemberment Plan, Disability Income Insurance.)
- AMA Members Retirement Fund
- The nation's largest physician placement service
- Leading scientific publications
- Authoritative legal information and guidelines on every aspect of the practice of medicine
- Professional management information and guides to increase the productivity and profitability of your practice
- The research resources of one of the nation's greatest medical libraries
- The most comprehensive scientific programming available anywhere at the AMA Annual and Clinical Conventions
- AMA MEMBERSHIP BENEFITS AND SERVICES ARE THE MOST EXTENSIVE OF ANY PROFESSIONAL ORGANIZATION, AND NEW ONES ARE CONTINUALLY BEING ADDED.

Here are some of the things that HAVE happened because the AMA represented your interests:

- Modification of the Keogh law to allow increased annual contributions to retirement plans of 15% of earned income or $7,500, whichever is less
- Universal health insurance claim form
- Broader ambulatory insurance coverage
- Model state legislation to safeguard medical information
- AHA acceptance of the concept that medical staffs should be represented on hospital boards
- Due process guarantees for physician hospital privileges
- Reduction of third party interference in physician-patient relationship
- *Physician-Hospital Relations* -- AMA report which establishes policy and procedure for protecting important medical staff and physician rights

Here is some of the legislation the AMA has either sponsored or supported to improve health care in America:

Drafted and Sponsored

- National Health Insurance (Medicredit)
- Nationwide System of Emergency Medical Services
- Amending Antitrust Laws Regarding Blood Banks
- Improved Rural Health Care
- Better Drug Labeling

Supported

- Health Manpower Training -- maximum funding
- Nurse Training--maximum funding
- Public Health Training
- Indian Health Care Improvement Act
- National Health Service Corps
- Extension of the Maternal and Child Care Health Program
- Community Mental Health Centers
- Drug Abuse Education Act
- Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation
- Communicable Disease Control Act
- Allied Health Training

Here are some of the innovative and on-going programs the AMA has developed and activities it pursues to improve health care in America:

- Model school health screening programs
- Model emergency medical services programs for the nation's airports
- Pilot nutritional education programs for the poor
- Model drug abuse programs for local communities
- Innovative rural health care delivery systems
- New approaches to health care delivery for the poor
- Exploration of environmental, occupational health problems and development of solutions.
- Distribution of over 10 million pieces health education literature to the public schools, and public health agencies
- Investigation and exposure of quacks and quack products
- Guidelines for comprehensive emergency medical care systems, training of ambulance personnel, and categorization of hospital emergency care capabilities

Here are some of the ways the AMA works on behalf of the profession to assure quality medical education and care:

- As a member of CCME, the AMA participates in accreditation of medical schools and review and certification of internship and residency programs
- As a member of JCAH, the AMA shares responsibility for accreditation of hospitals and other health care facilities and services
- Accredits schools and training programs for allied health personnel
- Assists in the development of continuing education study programs in every branch of medicine. Instituted the Physician Recognition Award
- Participated in development of utilization review committees of medical staffs
- Guardian of medical ethics
- Sponsors or co-sponsors more than 1,000 meetings and medical and health education sessions each year

[41] B. Efforts to Influence Governmental Action

24. AMA furthers the economic interests of its members through legislative and lobbying activities. AMA stresses to its members that it represents their interests before Congress and federal administrative agencies (CX 232D, 1223, 1224, 1225, 1532, 1545D), "serving the vital functions of intermediary between government and the profession" (CX 1545D). AMA declares that although it offers the most extensive range of "tangible benefits and services" of any professional association (CX 259C), the "most important" AMA membership benefit is having AMA as an "effective and influential national spokesman to represent your views, yes *your* views, interests and rights" (CX 259Z13)(Emphasis in original).

AMA's legislative activities focus on legislation of economic significance to its members. The three major areas of activity of AMA's Department of Governmental Relations for the year July 1972 to June 1973 were price controls on physicians' fees under the federal Economic Stabilization Program, health maintenance organization legislation and professional standards review organizations (CX 1050Z-12). In the following year, its major activities involved price controls on physicians' fees, professional standards review organizations and national health insurance (CX 1051Z-14). AMA's Department of Congressional Relations identified five legislative proposals of particular concern to AMA from July 1973 to June 1974—national health insurance, price controls on physicians' fees, health maintenance organizations, professional standards review organizations and liberalization of the Keogh Act (CX 1051Z13, Z14). In 1975, the year this proceeding began, the AMA declared that AMA's "number one priority" was resolving the malpractice insurance crisis (CX 1102B) which threatened many of its members with "loss of livelihood" (CX 1003A). The economic significance of these legislative issues and AMA's positions on them are detailed hereinafter (*See* F. 25, p. 43; 27-30, pp. 44-46; 35, pp. 47-48; 43-44, pp. 54-55).

AMA stated recently that lobbying to protect its members' interests is equally as important as lobbying for passage of health legislation for the public's benefit (CX 1224). AMA has also explained to its members that its representatives have testified before the Congress on more than two dozen occasions during the 92nd Congress to state and explain the profession's views, "To protect its interests," in addition to being advocates for passage of legislation for better health care (CX 1225). AMA has also declared that it concerns itself with any congressional bill that affects the

public's health *or* the profession's interests—"The AMA does represent our profession - and effectively" (CX 1223). [42]

Communicating with AMA members in 1975, the head of the AMA New England field office distinguished between those legislative actions AMA undertakes for the benefit of the public and those it undertakes for the benefit of its physician members:

> *In behalf of the consumer,* your patients, AMA has sponsored bills to develop rural health delivery systems, community emergency medical programs, to provide education against drug abuse, to ensure safety and quality in medical devices, and to make available better funding for maternal child care. These are but a sampling.
>
> *For the physician,* AMA has lobbied for and secured markedly increased tax-deferred contribution allowances under the Keough [*sic*] Law, obtained acceptance by the AHA and the JCAH that physicians on medical staffs should be represented on hospital boards, has successfully resisted pre-certification of hospital admissions, Phase V controls on physicians' fees, national re-licensure, mandatory service for all medical school graduates, cradle-to-grave federally financed national health insurance, and sweeping federal aid for HMOs. These too comprise only a partial list. (CX 246) (Emphasis in original).

AMA has intensified its lobbying and legislative program in recent years (CX 209M, 1042T; *cf.* Tr. 9838), and these activities have become one of AMA's most important functions (CX 1360C). AMA has 10 lobbyists registered with the federal government, five of whom lobby regularly before Congress (Tr. 9886). In addition, three AMA Washington office staff members are directly responsible for handling relations with federal administrative agencies (Tr. 9886–87). AMA lobbyists are in contact with members of Congress and congressional staff every day (Tr. 9887). The lobbyists spend 75 percent of their time on Capitol Hill when Congress is in session (Tr. 9887). Also, AMA board members and other AMA officials spend considerable amounts of time preparing and delivering testimony before Congress (CX 1055E, 1225, 1228, 2586I). [43]

C. Price Controls on Physicians' Fees

25. AMA took an active role in its opposition to federal price controls on physicians' fees (CX 246, 258C, 434, 998E, 1697D, 461Z18–Z23, 1051Z8). AMA challenged controls on physicians' fees administratively through the Cost of Living Council in 1973; its representatives met with President Nixon and testified many times on Capitol Hill in 1974 in opposition to such controls (CX 461Z18–Z23). In 1974, AMA also mounted an antiprice controls letter writing campaign by physicians, who sent over 15,000 letters to Congress (CX 461Z21; Tr. 9921). In 1974, when the Economic Stabilization Control Program was about to expire, AMA successfully opposed congressional efforts

to continue the price controls on physicians' fees (CX 245D, 998E). While controls on self-employed physicians' fees were still in effect, AMA objected to the *removal* of price controls from nonphysician psychologists and optometrists, and from salaried physicians working in health maintenance organizations and hospitals (CX 434B, 461Z20).

D. Medicare

26. AMA opposed the initial passage of the Medicare program in 1965 (CX 1543P). Since passage of Medicare legislation, AMA has actively sought to ensure that the program does not adversely affect its member physicians (CX 1543P, Q). It has done so by championing private practice and fee-for-service health care delivery (CX 1545C), and insisting that physicians providing services under the Medicare program be paid their usual, customary and reasonable fees (CX 1697B, C; Tr. 8852, 8887–89, 9860, 9906–07).

In 1974, AMA's Council on Legislation opposed a congressional proposal to allow governors to establish statewide Medicare fee schedules (CX 1697B; Tr. 9906–07). Under the proposal, lists of physicians agreeing to accept payment according to the fee schedules were to be published; those physicians not agreeing to do so were to be reimbursed under the existing usual, customary and reasonable fee system (CX 1697B). The AMA Council feared that unless state medical society approval for each fee schedule were required, the resulting "ceiling on physician charges" would not accord with physicians' usual and customary charges (CX 1697B). The Council emphasized to the AMA Board of Trustees that the legislation would "have a far-reaching and deleterious effect on the reimbursement which physicians receive" (CX 1697B). AMA officials subsequently testified against the statewide Medicare fee schedule legislation which, in AMA's judgment, violated the usual, customary and reasonable fee concept (Tr. 9906–07; RX 652J). [44]

The chairman of the AMA Board of Trustees also testified before Congress against a Nixon administration proposal to place a four percent cap on physicians' annual fee increases under the Medicare program, and a delegation of AMA officials subsequently met with President Ford to protest against this proposal (CX 1545C). In 1976, AMA informed its members that, to many physicians, this one action was worth many times the $250 annual AMA dues (CX 1545C).

E. National Health Insurance

27. In recent years, AMA has opposed national health insurance

proposals harmful to the economic interests of physicians, including those that involve more government scrutiny of physicians' incomes and fees (Tr. 8886–87; CX 1109G, H, 263L, M, 2586G). Thus, AMA has opposed national health insurance legislation that would provide for reimbursement of physicians on the basis of a nationwide fee schedule or out of a predetermined budgetary allotment for each region of the country (CX 1109G, H; Tr. 8887, 9848). AMA has favored a national health insurance program retaining private practice, fee-for-service medicine as the dominant mode of medical care delivery (CX 258C, 263L, M, 1224, 1533B, 1545C), a system under which physicians have the highest incomes of any profession (Tr. 9837).

In the last five years, national health insurance has been one of AMA's major concerns (CX 1228A, 1051Z13–Z14), involving work by the AMA Field Service until its phase-out in 1975 and by the AMA Washington Office staff (CX 1050Z7, 1051Z13–Z14). AMA "dues money," "many, many man-hours of a superb Washington staff," testimony and speeches by virtually every one of AMA's officers and trustees and many of its council and committee members have helped to dissipate support for the national health proposals AMA opposes (CX 1228A–B).

AMA's current national health insurance proposal is a departure from its long-standing opposition to national health insurance (Tr. 8999–9000; CX 2586K, 2601, 1435Z60–Z61). It is more favorable to physicians however than other national health insurance proposals (Tr. 8999–9000, 9049–50; CX 1109G–H). Previously, AMA spent over $2.5 million in 1950 alone—over half its annual budget—on a National Education Campaign against President Truman's national health insurance proposal (CX 1435Z61–Z62, 2598B, 2601). The public relations firm of Whitaker and Baxter directed the campaign, coordinating the efforts of AMA and its state and local affiliates and arranging for dissemination of approximately 100 million pamphlets and brochures in a single year (CX 2601C, D, E). [45]

F. Health Maintenance Organizations

28. Health maintenance organizations ("HMOs") are prepaid comprehensive health care delivery systems that offer alternatives to the fee-for-service delivery system (Tr. 484, 550, 4886. *See also* F. 102, p. 134). The AMA House of Delegates has recognized that potential domination of community hospital medical staffs by closed panel prepaid group practice physicians "poses some threat to private practitioners" (CX 959Z43–Z44). In 1971, AMA opposed the initial proposals for federal funding of HMOs (CX 1710A, B). In 1972

and 1973, the AMA Field Service mounted a campaign against HMO legislation, describing HMOs as "contract practice" (CX 1950Z7). In its lobbying "[f]or the physician," AMA succeeded in limiting the HMO Act that was passed in late 1973 to restricted experimentation (CX 246, 258C, 1226). Since the Act's passage, AMA has opposed legislation "liberalizing" the HMO Act because the amendments would "foster the development of prepaid group practices" (CX 1681B; RX 652F; *cf.* Tr. 9851–52, 9855–58). In 1974, the AMA House of Delegates voted to seek federal legislation requiring employers offering their employees HMO coverage also to offer them coverage through standard health indemnity insurance companies or health care service plans, *i.e.,* Blue Cross-Blue Shield (CX 461Z327). AMA has supported legislation to require HMOs to obtain certificate-of-need planning agency approval before they can build or expand their medical facilities (RX 4, p. 35; Tr. 9918). AMA, however, has opposed application of such requirements to private physicians' plans to install expensive medical equipment in their private offices (Tr. 9918, 9936–37).

G. Keogh Act

29. AMA's lobbying efforts contributed significantly to the initial passage of the Keogh Act, which created substantial tax benefits for self-employed individuals, including the bulk of AMA's members (CX 245D, 998, 1532, 1533B). AMA's efforts were stated to have the most substantial impact of any of the supporters for the Keogh Act amendments adopted by Congress in 1974 (CX 1533B). These amendments permit increased tax savings for each self-employed individual and member of a professional corporation (CX 246, 1532A, 1533B). In its June 1974 annual report, the AMA Washington Office identified the Keogh Act modification bill as one of five pieces of legislation before Congress of concern to AMA (CX 1051Z13–Z14). AMA has reminded its members that each year they can save up to six times their annual AMA dues under the Keogh Act legislation which AMA "secured" (CX 246, 258C, 1532A, 1533B). In a report to its members on what it accomplished for them in 1975, AMA included a statement by former Congressman Keogh giving credit to AMA for developing the concept of the Keogh Act and working for its passage (CX 1533B). **[46]**

H. Professional Liability Insurance

30. AMA led an extensive legislative campaign in state legislatures across the country in 1975 for malpractice insurance legisla-

tion designed to stabilize premiums and ensure coverage of physicians (CX 1003A, 1102C, D). The campaign was successful in getting 30 states to pass new professional liability laws, most of them based on AMA model legislation (CX 1102D). AMA staff visited 30 state medical societies to help them develop legislative proposals designed to reduce the amount of damages plaintiffs could recover for malpractice, reduce the frequency of litigation, and make it more difficult for plaintiffs to prevail in malpractice litigation (CX 263-O, 361B, 384D, 1026G, 1102D).

I. Relicensure and Continuing Medical Education

31. Through 1977, AMA has opposed legislation at both the federal and state levels requiring relicensure, retraining, recertification or continuing medical education by physicians in order for them to continue to practice and earn a living as physicians (CX 263P, 1003A, 2586G; RX 4, p. 38, 564, p. 3044). AMA opposition was a major factor in the defeat of one proposal setting up a federal relicensure system (CX 258C).

J. Hospital Cost Containment

32. AMA has testified against passage of the Carter administration's proposal to place limits on annual increases in hospital revenues (RX 4, p. 24, 696I, J; Tr. 9918-19). The bill, if adopted, could lead hospitals to reduce their revenues by limiting the number of beds available for physicians' patients. The proposal also raises the prospect of federal government cost containment controls on individual physicians' charges (*See* Tr. 9011-12).

K. Relative Value Studies

33. In 1977, the AMA House of Delegates voted to seek legislative recognition of the medical profession's authority to develop and use relative value studies (RX 4, p. 10). Relative value studies are numerical unit designations expressing the relative value of one professional service to another that can be used by both physicians and insurance companies to determine the fees to be charged, or paid, for specific physician services (CX 260C, D). AMA has declared that such relative value studies are useful in preventing inequities and economic injustice to physicians (CX 260D). [47]

L. Allied Health Professionals

34. Through 1977, the AMA's legislative position has been that allied health professionals should practice only under the supervi-

sion of a physician, with the physician billing for their services (Tr. 9852–53, 9866–67, 8859–61, 9014–16, 9018–19, 9050–53; RX 696J, K; CX 2586G, N). AMA takes the position that physician's assistants, in particular, should practice only under the supervision and in the employ of private practicing physicians, and should not be supervised by salaried hospital physicians or be employed by a hospital (CX 461Z161; Tr. 8859–69).

Certain nonphysician health professionals, including clinical psychologists, podiatrists and optometrists, practice independently of physicians in various states (Tr. 9916–16). AMA has lobbied to bar coverage of such professionals' services in federal health programs unless a physician specifically refers the patient to the nonphysician (Tr. 9854–55, 9865–66, 9914–18). Such legislation would make clinical psychologists, for example, dependent on referrals from psychiatrists for the patronage of persons covered under government medical programs (Tr. 9916–17). AMA has also lobbied to exclude the services of certain nonphysician competitors of physicians from federal health program coverage (Tr. 8858–59; CX 2586N). For example, AMA specifically opposed inclusion of the services of optometrists in the original Medicare law (Tr. 8858–59, 9054–55; CX 2586N).

M. Professional Standards Review Organizations

35. In 1972, AMA opposed the initial passage of the Professional Standards Review Organization ("PSRO") Act (Tr. 9927). This law conditions Medicare payments to a physician on the finding of a review organization of other local physicians that the services rendered were medically necessary and performed in the least expensive appropriate setting, 42 U.S.C. 1320c–4(a)(1), c–7. The PSRO law poses a substantial economic threat to physicians (*See* Tr. 9017).

After the Act's passage in 1972, the AMA House of Delegates voted to seek its repeal (Tr. 9927; CX 461Z289). Because repeal seemed unlikely, AMA later adopted a strategy of seeking amendments to the Act, hoping to "ameliorate an otherwise objectionable program" (CX 1543P, Q, 461Z293; Tr. 9928, 9931). [48]

AMA has pressed in 1977–78 for legislation empowering local physicians to vote on whether a PSRO deserves continued recognition by the Department of HEW (Tr. 9929). AMA lobbied for repeal of a section of the PSRO law providing for imposition of financial penalties on physicians who violate their obligations under the PSRO law (Tr. 9930). AMA also lobbied in 1977 for repeal of provisions of federal law authorizing recovery of payments from those physicians who violate the PSRO law (Tr. 9931).

Even though PSROs review the services of podiatrists and dentists, as well as physicians, AMA has refused to support legislation allowing placement of a single podiatrist or dentist on either local PSROs or the National PSRO Council, both of which are composed entirely of physicians (Tr. 9931–33; 42 U.S.C. 1320c, c–12(b)).

N. National Health Service Corp.

36. AMA has supported those provisions of the National Health Service Corps law that condition the placement of salaried, federally funded Corps physicians in particular communities on the local medical society's certification that its community is a physician-shortage area (RX 652G; Tr. 9911–14; 42 U.S.C. 2546(b)(2)(A)). The local medical society can be overridden only if the Secretary of HEW makes a specific finding that the society has been arbitrary and capricious (Tr. 9913–14; 42 U.S.C. 2546(b)(2)(A)). AMA has continued to press for increased medical society involvement in the placement of National Health Service Corps physicians (Tr. 9911–14). These actions place AMA members at the local level in a position of strength to control the entry of competition from salaried National Health Service Corps physicians (*See* Tr. 8872–73, 9006).

O. Foreign Medical Graduates

37. AMA's policy on foreign medical graduates ("FMGs") draws a sharp line between FMGs who come to this country to continue their medical studies as hospital interns and residents, intending to return to their homelands, and those who wish to make a career in this country as practicing physicians (RX 564, pp. 3051–54; Tr. 8870–73, 9920–21, 9873–75). AMA has pressed for tight restrictions on those FMGs who try to stay in this country as practicing physicians and, thereby, compete with American physicians (RX 564, pp. 3052–54; Tr. 8871, 9874).

AMA has urged the Labor Department to remove preferential immigration status for foreign physicians who want to come to this country to practice (Tr. 9920; RX 564, pp. 3051–53). [49] AMA took this position in large part because of the increase in supply of American physicians (Tr. 9920–21). A report approved by AMA, and published in the December 1976 *JAMA,* urged federal administrative agencies to support changes in federal laws and to adopt safeguards to prevent the use of physician-exchange visitor programs as pathways for FMGs to immigrate to the United States on a permanent basis (RX 564, pp. 3052, 3054, 3055). The report urged the federal government to require that visiting foreign medical students

be committed to return to their home country on completing the agreed upon educational program (RX 564, p. 3052), and to limit, in general to two years, the duration of graduate medical education in this country for all visiting foreign physicians (RX 564, p. 3053).

P. Miscellaneous Legislation

38. In the 1970's AMA has favored legislation to provide cash benefits and more equitable treatment for physicians covered under the Social Security Act (CX 1050Z10, 1051Z12; RX 697D). AMA has also drafted proposed legislation that would require the Internal Revenue Service to treat professional corporations as corporations for purposes of federal income tax (Tr. 9926–27). AMA has participated in a successful nation-wide lobbying campaign to defeat a bill that would have imposed restrictions on the tax and pension advantages of professional incorporation (Tr. 9925–26).

In 1977, AMA declared its official backing for legislation authorizing collective bargaining under the National Labor Relations Act by interns, residents and housestaff physicians, which would help them obtain higher wages (RX 696G, 697D; Tr. 9000–01).

AMA lobbied unsuccessfully against the National Health Planning Act of 1974 (CX 258C, 263K), which, according to AMA, gave too much authority to a "bureaucracy. . .where emphasis will be on cost" (CX 1532A). It did succeed in removing from the Act, as passed, a provision for a governmentally imposed fee schedule for physicians' services (CX 998E).

In the 1930's, believing that there was an excess of physicians, AMA sought to reduce the supply of physicians by limiting medical school enrollments (CX 1109D; Tr. 5186–88, 8874–75). AMA still opposes legislation conditioning federal capitation grant money to a medical school on the school's agreement to increase its enrollment (RX 696A; Tr. 9004).

Over the past few years AMA has also lobbied to increase the pay scales of physicians serving in the armed forces and the Veterans Administration (CX 1004B, 1522B, 1528, 1530; RX 652C, 696P). [50]

Q. American Medical Political Action Committee

39. AMA seeks to further its legislative objectives through the American Medical Political Action Committee ("AMPAC"). AMPAC was organized by AMA in 1961, and AMA finances AMPAC's activities (*See* F. 22, pp. 35–37, *supra*). AMPAC complements AMA's legislative efforts by contributing money to congressional candidates supportive of the profession (CX 1493B, 461Z414, 1487B, 1722B). In

deciding which candidates to support, the AMPAC board relies heavily on the degree of political support for the individual candidates among the physicians residing in each candidate's district (Tr. 4788, 4791, 4823).

R. AMA's Activity with Third-Party Payers

40. AMA promotes the economic interests of its members in their dealings with third-party payers, including Blue Shield, commercial insurance carriers and government medical care programs (CX 2586H). AMA was instrumental in the creation and development of the national network of medical society sponsored Blue Shield plans that provide coverage for physicians' services (CX 2574C, D, 1435Z51–Z53, Z60–Z61, 2586H). AMA helped found the first association of Blue Shield plans, Associated Medical Care Plans, Inc. (CX 1435Z55, Z59–Z60, Z62–Z63). Until very recently, AMA representatives served on the board of the National Association of Blue Shield Plans, which develops policies that help determine physician reimbursement levels (CX 2574C, 1051Z4, 2586I).

AMA support is premised on the "Blue Shield concept," which involves medical society representation in determination of policy, medical society cooperation, freedom of choice of physician and acceptance of leadership by the medical profession (CX 2574C). Among other things, conformance to these principles assures that benefit allowances are "fair" to physicians and prevents "abuses" of physicians (CX 2574C). So long as Blue Shield plans remain committed to the "Blue Shield concept," AMA has backed them as the "economic arm of the medical profession" and as a substantial bulwark against compulsory national health insurance (CX 2574C, D).

The "foundation for medical care" is a recent development in the field of health care delivery (RX 51, pp. 25, 26; CX 461Z222–Z224). A foundation for medical care is a health care organization sponsored by a county or state medical society and controlled by physicians (RX 51, p. 26; CX 461Z222). It performs centralized billing and fee supervision for participating physicians in offering prepaid medical coverage [51] to subscribers (RX 51, p. 26; CX 461Z222). The AMA Division of Medical Practice's Department of Health Insurance provides liaison services to foundations (CX 1051Z4), and a number of AMA representatives serve on the Board of Directors of the American Association of Foundations for Medical Care (CX 1051Z4).

With respect to commercial health insurance, AMA has intervened with the Aetna Insurance Company to "improve" Aetna's "payment and communication practices," including the company's

method of informing subscribers when physicians' charges exceed prevailing fee levels (CX 404F, 1061A, B). In addition, in the 1970's, AMA has been instrumental in getting insurance coverage which has provided physicians with a greater percentage of reimbursement for their services (CX 245D, 258D). AMA has also voiced its opposition to mandatory consultation (second opinion) programs as cost containment measures by health insurance companies (RX 4, p. 14). AMA has now embarked on a program of intervening directly with insurance companies on behalf of physicians when disputes are of national significance (CX 1533B, 1524).

In dealing with the Department of HEW over the past decade, AMA has worked to assure that physicians providing services under Medicare are paid their "usual, customary and reasonable" fees (CX 1697B, C; Tr. 8852, 8887–89, 9860). AMA representatives have frequently met with HEW officials to "correct directives that adversely affect Association members" (CX 1543P, Q). In 1975, for example, AMA declared that proposed HEW regulations setting criteria for determining the reasonableness of physicians' prevailing charges were inequitable and unfair to physicians (CX 1004B). In 1977, the AMA House of Delegates voted to seek elimination of HEW reimbursement policies that AMA said established reasonable charge limits for new physicians that were too low (RX 4, p. 7).

AMA has also sought to protect the economic interests of member physicians who provide services to patients under the Civilian Health and Medical Program of the United States ("CHAMPUS") (CX 2592B, C, 404F). CHAMPUS is the Defense Department program providing coverage to military dependents, 10 U.S.C. 1071, *et seq.* In the 1950's, AMA coordinated negotiation sessions with the Department of Defense when CHAMPUS was being established (CX 404F). In 1976, the AMA House of Delegates protested CHAMPUS's reductions in physicians' fees and urged AMA members to bill their patients directly and not to accept direct payments from CHAMPUS (CX 2592B). The House of Delegates voted to negotiate a "no rollback" of physicians' fees with the Department of Defense and to maintain physicians' "usual and customary" fees (CX 2592B, C). [52]

The AMA Council on Medical Service developed and distributed five million copies of a Uniform Health Insurance Claim Form (CX 351, 245D, 1046Z7). By simplifying and standardizing the claims process, the uniform claim form, *inter alia,* reduces physicians' office practice costs in obtaining payments from third parties (CX 351E, F).

Two AMA publications, *Current Medical Information and Terminology ("CMIT")* and *Current Procedural Terminology ("CPT"),* are valuable business aids to physicians (RX 8; CX 2591B). Both provide

detailed coding information on hundreds of medical services and are useful to physicians in billing insurance companies and to insurance companies in making payments to physicians (CX 2591B; RX 8, pp. iii, xii, xiii; Tr. 4500–03). The AMA House of Delegates has acknowledged the value of *CMIT* in ensuring that physicians' services are properly defined and "fairly compensated" (CX 2591B). *CPT* provides a means for effective communication between physicians, third-party payers and patients (RX 8, p. iii). It simplifies the physician's task in reporting professional services to third-party payers (RX 8, p. xii). In 1977, a new edition of *CPT* was published which contains guidelines on how to use it in submitting insurance claims (RX 8, pp. ii, xiii). Over 50,000 copies of the previous edition were distributed (Tr. 4500).

S. Promotion of Hospital Medical Staff Physicians' Economic Interests

41. There are often sharp differences between hospital administrations and hospital medical staffs (CX 1055G), particularly where economic limitations are placed on the ability of physicians to negotiate satisfactory agreements with hospitals (CX 1543Z1). AMA promulgates ethical restrictions on contract practice which promote the economic interests of private practicing physicians (*See* F. 145–51, pp. 207–26). AMA supports medical staffs in their disputes with hospital administrations to protect members of the profession in the defense of their rights (CX 405A, 1055G, 257B) and helps them maintain control over payments made for medical services in hospitals (CX 1475B, D–H). AMA also helps hospital resident physicians pursue their economic objectives (CX 405A).

In 1977, the AMA House of Delegates renewed AMA's call for due process protection for AMA members on hospital medical staffs where their professional ability, honor, reputation or right to make a living is in question (RX 4, p. 36). AMA has also sought to increase physician representation on hospital governing boards (CX 245D, 246) [53] and has opposed hospital requirements that physicians pay a fee to the hospital in exchange for privileges at the hospital (CX 959Z57–Z58, 462Z26).

The AMA House of Delegates has voted that hospital medical staff membership should be limited to physicians and dentists, thereby excluding podiatrists, clinical psychologists and all other nonphysician health professionals from eligibility for medical staff membership (CX 461Z234). It is also AMA's official policy that allied health professionals should work in hospitals only on tasks specifically permitted by the medical staff and under the supervision or direction

of members of the medical staff (CX 461Z161), even though many allied health professionals, such as clinical psychologists, can legitimately practice on an independent basis without physician supervision (*See* F. 34, p. 47).

The AMA House of Delegates has noted that it is critical that every physician's assistant be supervised by a physician (CX 461Z161. *See also* F. 34, p. 47). It has also stated that each physician's assistant must be employed by a private practicing physician and not by a hospital with supervision provided by a full-time salaried hospital-based physician (CX 461Z161; Tr. 8859–60).

AMA is a founding member of the Joint Commission on Accreditation of Hospitals ("JCAH") and has participated in the adoption and distribution of JCAH hospital accreditation standards (CX 1965C, 344, 1963, 1964, 1943D). Seven of the twenty JCAH commissioners are AMA representatives (CX 1943C). The JCAH accreditation standards follow AMA policy by barring podiatrists and clinical psychologists from medical staff membership (CX 1965Z3), by allowing allied health professionals to work in hospitals only when under the supervision and direction of a physician and on those tasks specifically permitted by the medical staff (CX 1965Z14), by requiring hospitals to afford due process protection to medical staff physicians (CX 1965Z8–Z9) and by encouraging physician representation on hospital governing boards (CX 1964D, 246).

T. Litigation

42. AMA represents its members' economic interests by challenging government economic and regulatory policies in court. In 1974, AMA directly sought to aid its members financially by filing suit against federally imposed price controls on physicians' fees (CX 271). AMA specifically opposed governmental limitation of physicians' revenue margins on the ground that it would impose a ceiling on the maximum [54] dollar amount of the physician's "profit" from medical practice (CX 271S). AMA challenged as arbitrary and capricious the government's decision to place price controls on physicians in private practice but not on their competitors—optometrists, clinical psychologists and those physicians under contract with health maintenance organizations and hospitals (CX 271B, C, O, Q–T).

Other AMA litigation has included a suit against federal utilization review programs designed to block federal reimbursements for unnecessary surgery and hospital admissions (CX 1055F, 263I, J, 1532A, 257C; *AMA* v. *Weinberger,* 395 F. Supp. 515, 517, 520 (N.D. Ill. 1975), *aff'd,* 522 F.2d 921 (7th Cir. 1975), participation in a suit

seeking to bar a hospital governing body from changing hospital medical staff bylaws (CX 257B) and a challenge to the National Health Planning Act (CX 257C).

U. Professional Liability Insurance Activities

43. AMA's number one priority in 1975 was resolving the malpractice insurance crisis (CX 263-O, 1102B, 1026A. *See also* F. 24, p. 41). During this crisis, many AMA members have had to pay high premiums and have been threatened with loss of livelihood and financial disaster (CX 1102D, 1003A; Tr. 6450). In 1975, AMA began a major drive for the benefit of its members (CX 361B, 384C) to reduce or stabilize malpractice premiums and to make liability insurance available to physicians at a reasonable cost (CX 1042Z9, 1026A, L). AMA launched an extensive state-by-state campaign that year to obtain new malpractice insurance legislation (*See* F. 30, p. 46).

At the direction of its House of Delegates, AMA founded the American Medical Assurance Company ("AMACO") in 1975 to provide reinsurance for captive medical liability insurance companies owned by state medical societies (CX 1022A, B, 1026K, L, 1533A, 1055H). AMA made a $2 million investment in AMACO in 1976 (CX 1022B; RX 567, pp. 4, 12; Tr. 6451-52). AMACO is governed by a board of directors composed entirely of AMA officers and executive committee members (CX 1022B).

AMA's efforts to lower malpractice premiums and assure the availability of malpractice insurance at a reasonable cost, including its creation and funding of AMACO, have served the economic interests of AMA's members (RX 743, p. 7, Appendix IIC; Tr. 6364, 6450, 8869).

V. Economic Research

44. AMA promotes the economic interests of its members through the activities of its economic research department, the Center for Health Services Research and Development. [55] Data provided by the Center permits AMA to develop counter-proposals in the legislative arena (CX 2202C. *See also* CX 1543N), helped it lobby in 1974 against limits on physicians' Medicare and Medicaid reimbursements (Tr. 9785) and, in the mid-1970's, enabled AMA to induce the federal government's Cost of Living Council to reduce the impact and duration of price controls on physicians' fees during the Economic Stabilization Program (CX 1055N. *See also* F. 25, p. 43).

The Center analyzes proposals for professional standards review organizations, health maintenance organizations, foundations for

medical care and national health insurance (CX 2202C). It also undertakes projects exploring physicians' costs of doing business and ways to increase physician productivity (CX 2202C, 1051G). These include studies of the impact of prepayment programs, effective use of allied health personnel and its economic implications, economies of scale in health care, determinants of prices and profit mark-up in medical practice, proper mix of labor and capital in the physician's practice as an entrepreneur, and relationships of specialty mix and practice scales on physician productivity (CX 1051G, 2202B–C, 1052B, 1543W; Tr. 9781–82).

Much of the work of the Center provides valuable information directly to physicians interested in adjusting their fee schedules (CX 1051H–I, 197Z49–Z60, Z125–Z134; RX 18, pp. 155–71) or in relocating their practice (Tr. 4169; RX 15, 19, 21, 22, 23, 24, 28). The Center distributed information to physicians on how they could raise their fees during the Economic Stabilization Program without violating government regulations (CX 461Z21, 281B, C, 1051H). The Center also publishes and distributes *Profiles of Medical Practice* annually, which contains extensive economic data and analysis on the medical services market, including detailed breakdowns of average physician fees by specialty and region for initial office visits, follow-up office visits, hospital visits and periodic examinations (RX 18, pp. 155–71; CX 197Z49 - Z60, Z125 - Z134).

Through the Center, AMA maintains exclusive control over a unique data base on physicians (Tr. 9793; RX 562, p. 4), which enhances AMA's effectiveness in its legislative efforts (Tr. 8924–26, 9105–07, 9785; CX 1055N, 2202C, 1543W, 1360C).

W. Public Relations

45. AMA spent approximately $3 million in 1977 on public relations activities designed to boost the image of physicians (Tr. 6446–48) and increase public acceptance of AMA legislative positions supportive of physicians' interests [56] (CX 1543G–H, 2190Z37, 1541F). AMA is expanding its public relations activities (CX 232Q; RX 4, p. 48; Tr. 6466) to overcome the public's perception that the medical profession is self-centered (CX 1543G).

AMA has historically used public relations to promote its positions on issues of substantial economic concern to physicians (CX 2586R, 1050Z16). In 1950, for example, AMA spent millions of dollars in a "national education campaign" against national health insurance (CX 2598B, 2601, 1435Z61–Z62. *See also* F. 27, p. 44). In recent years, AMA has trained hundreds of physician spokesmen who have carried AMA's position on national health insurance to millions of

consumers (CX 1087, 1051Z8–Z9; Tr. 9910). In the 1970's, the public relations efforts of AMA and its constituent societies on the professional liability insurance problem have been successful in developing an atmosphere conducive to passage of legislation easing the malpractice insurance crisis (CX 1022A. *See also* F. 43, p. 54).

AMA actively counters media reports that are critical of the medical profession (CX 1051Z16, 1050Z16, 2586R, S, 1055H; Tr. 8897) or that stress the high incomes received by physicians (Tr. 9789–90). For example, AMA has challenged media reports focusing on unnecessary surgery (CX 2586R, S, 1055H), largely in order to defuse public support for stricter economic sanctions against physicians doing unnecessary surgery (CX 2586R, S).

X. Negotiations Assistance

46. The AMA Department of Negotiations aids AMA's members in private practice in their socioeconomic confrontations with third-party payers and helps hospital-based physicians further their economic interests (CX 402A, 410B, 405A, 436A, B, 437, 1543Y–Z6). The Department trains medical societies and individual AMA members in negotiating skills to help physicians obtain a reasonable return for their services (CX 405B) and lower malpractice insurance premiums (CX 410B, 1543Z2). When local disputes are of national significance, AMA will intervene to represent its members' socioeconomic interests (CX 410B).

The Department of Negotiations was established in 1975 and quickly began sponsoring a series of negotiating seminars to help physicians deal with their "adversaries" (CX 410B, C, 406, 409), which include insurance carriers making marked-down payments (CX 405B). AMA has accelerated its involvement in the negotiating realm (CX 403, 404), such as by increasing its negotiations program by 50 percent in 1977 (CX 1543Z11; RX 743, Appendix IIB, C). [57]

Y. Practice Management

47. AMA offers a variety of practice management programs (CX 1115Z12) to help its members increase the efficiency, productivity and "profitability" of their practices (CX 259N, 245D, 263Z5; Tr. 4954, 6363–65). Through publications, seminars and workshops, the AMA Department of Practice Management has guided AMA members on financial management and the business side of practice (CX 1001B, C, 1115F, Z12, 376A–Z47, 377, 1064, 380, 1077, 1105Z22–Z25. *See also* F. 20, pp. 33–34). AMA has more than doubled its practice management program in the last three years (CX 1543H–M, Z10; RX

743, Appendix IIB, C), following the AMA Division of Medical Practice's recommendation that programs which present the most tangible benefits to AMA members should be given a high priority (CX 1543Z10).

AMA advises its members on the financial aspects of opening a practice, buying insurance, improving cash flow, bookkeeping, billing and collecting fees, shortcuts in processing health insurance claim forms, how much to pay employees and how to manage, develop and invest in real estate (CX 1115I–K, 376, 1064, 1090, 1551). AMA gives detailed guidance to its members on setting fees, cautioning them that charging fees that are too low will lessen respect for physicians and advising them to peg their fees to local fee ranges (CX 376Z19–Z20). AMA suggests that each physician consider the fees of his colleagues along with his own level of experience and specialty in developing a conversion factor to be applied to a medical society relative value "fee-setting" guide (CX 376Z19–Z20).

The Department of Practice Management sponsors approximately 25 practice management seminars and workshops for physicians annually, which AMA members can usually attend at a discount (Tr. 5013–14; CX 1115F, 1090, 1064C, D). The Department also sponsors practice management training for physicians' office staffs (Tr. 5013; CX 1116, 1001). In addition to the Department of Practice Management, the AMA Council on Medical Service also sponsors health care socioeconomics conferences and programs designed to increase the productivity and efficiency of physicians' office practices (CX 1050X, 1000, 1073). These business and financial management services help AMA members avoid cash shortages and provide important economic benefits to AMA members (CX 376G; Tr. 6363–65; RX 743, pp. 6, 7, Appendix IIB, C). [58]

Z. Legal Services

48. AMA provides legal advice to its members on the business aspects of their medical practice (CX 2190Z38). AMA's Office of the General Counsel offers guidance to AMA members on estate management (CX 275), professional liability, physician partnership agreements (CX 340), fees, wills, trusts, taxes, model forms, sale and disposition of medical practices (CX 347) and avoiding unnecessary rental expenses (CX 378E). The AMA General Counsel's office also assists state and local medical societies in their disputes with governmental agencies, hospital boards and advertising health maintenance organizations (CX 392C), and provides medical societies with model malpractice legislation (CX 350).

AMA cosponsors "medicolegal" symposiums on various topics,

including HMOs, foundations, PSROs (RX 51, pp. 25–40), malpractice insurance (CX 1113G, 1067, 1068B; RX 49, pp. 27–57, RX 50, pp. 38–80), the rewards and risks of professional incorporation (CX 1113F), how to "Protect the Professional from Consumerism" (CX 1068C) and "Tax Tips" for professionals (CX 1067; RX 49, pp. 58–63).

AA. Miscellaneous Activities

49. There are various other activities of AMA which economically benefit its members. AMA operates the nation's largest physicians' placement service (CX 259D). The AMA physicians' placement service works to match physicians seeking placement with opportunities in solo practice, partnerships, associations, groups, hospitals and clinics (CX 1018B, 1019). Placement service listings run regularly in *JAMA* (Tr. 9596; CX 1270, 1279; RX 213, pp. 719, 721–22, 724–25, 729–31, 734–36, 738).

AMA publishes *JAMA* and distributes it as a free benefit of membership (RX 3, p. 1. *See also* F. 17(h), pp. 23–25). *JAMA* contains articles not only of a technical nature (RX 213, pp. 635–36, 652–75), but also on financial topics (CX 275). The technical articles provide practical benefits to physicians because they improve physicians' efficiency, productivity and skill (Tr. 5123; RX 213, pp. 663–67, 635–36).

Since 1963, AMA has sponsored the AMA Members' Retirement Plan to enable members to take advantage of the tax deductions and other benefits of the Keogh Act (CX 1030C, D, H, 332, 335). The plan is open only to AMA members, their partners and their employees (CX 335B, 259H). As of January 30, 1976, the plan held $140 million in assets (CX 1030U), over $13 million of which was invested by plan participants in the preceding year (CX 1030Z4–Z5). The plan has pecuniary benefit to AMA members because of the economies AMA gains through [59] mass purchasing of securities and guaranteed rate insurance annuities, and because AMA charges a minimal administration fee and does not charge any sales, service or redemption fees (CX 259H, 335K). The retirement plan is supervised without compensation by a committee composed entirely of AMA officers and trustees (CX 1030M, N). In addition, AMA recently began a tax-exempt income fund (Tr. 9594).

AMA sponsors a range of insurance programs offering financial benefits and savings to its members (CX 1548, 259D; RX 743, p. 7, Appendix IIC). AMA sponsors disability, office overhead, excess major medical, in-hospital, group term life and accidental death insurance; written premiums for these programs totalled over $15 million in 1975 (CX 1561B, 1548). These programs are available only

to AMA members (CX 1523, 262–O). These AMA membership insurance programs offer broad insurance coverage at the lowest available costs (CX 263Z5, 259D; RX 3, p. 13), and thereby provide economic benefits to AMA members (RX 743, pp. 6, 7, Appendix IIC; CX 1548C).

AMA publishes *American Medical News,* distributed free to all AMA members, as a vehicle to keep its membership informed on legislative, economic, legal and other nonclinical news (RX 3, p. 12; CX 896A). AMA spends over $3 million annually on the weekly paper (RX 743, Appendix IIA). One purpose of the paper is to "achieve consensus within the Federation structure" (RX 3, p. 12) on legislative and professional issues affecting the economic interests of physicians (CX 2586J, 1046Z17; RX 3, p. 12; Tr. 8920–24). AMA's increasing activity in the courts on behalf of physicians, efforts to resolve the professional liability insurance crisis, and national developments in health insurance, Professional Standards Review Organizations and health maintenance organizations were the five *American Medical News* topics specifically identified in the AMA Communications Division's annual report for the year ending June 30, 1975 (CX 1046Z17). *IMPACT,* the periodic supplement to *American Medical News,* operates in a similar fashion by dealing with socioeconomic issues of interest to physicians (CX 278A).

AMA's ethical restrictions on advertising, solicitation of patients and contractual arrangements of physicians and medical care organizations have insulated physicians from competition. This lessening of competition has significant economic benefit to AMA members. **[60]**

BB. Federal Income Tax Status of AMA

50. The AMA is treated as an organization exempt from the payment of federal income tax, pursuant to Section 501 (c)(6) of the 1954 Internal Revenue Code (Affidavit of Russel Juhre, submitted in support of AMA Motion for Summary Decision, March 24, 1976). The Internal Revenue Regulations describe a Section 501(c)(6) organization as follows:

> A business league is an association of persons having some common business interest, the purpose of which is to promote such common interest and not to engage in a regular business of a kind ordinarily carried on for profit. It is an organization of the same general class as a chamber of commerce or board of trade. Thus, its activities should be directed to the improvement of business conditions of one or more lines of business as distinguished from the performance of particular services for individual persons. (Internal Revenue Regulation § 1.501(c)(6)–1).

Section 501(c)(3) of the 1954 Internal Revenue Code exempts the following organizations from federal income tax:

> Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and which does not participate in, or intervene in, (including the publishing or distributing of statements), any political campaign on behalf of any candidate for public office. (Affidavit of John F. Kelly, Chief of the Conference and Review Staff, Exempt Organization Technical Branch, Internal Revenue Service, filed April 8, 1976 with Complaint counsel's opposition to AMA's motion for summary decision).

[61] The American Medical Association Education and Research Foundation, a subsidiary of AMA, in contrast to the Section 501(c)(6) federal income tax exemption of AMA, is exempt from federal income tax under the provisions of Section 501(c)(3) (Affidavit of John F. Kelly, *supra*).

IV. EXPERT TESTIMONY ANALYZING AMA'S BUDGET ALLOCATIONS AND EXPENDITURES

A. Identification of the Experts

51. In support of AMA's position that it does not operate for the profit of its members, AMA called as a witness Dr. Frederick Sturdivant, Professor of Business at Ohio State University (Tr. 6301, 5324–25). Dr. Sturdivant is an expert in the analysis of corporate institutions, business history, organizational theory and marketing (Tr. 6301–24, 6418). Prior to being retained in this proceeding, he had done no scholarly work relating either to the medical profession or to nonprofit associations (Tr. 6416–17). Dr. Sturdivant also acknowledged that he possessed no expertise in the areas of accounting or cost allocation theory (Tr. 6418–19).

Dr. Sturdivant was primarily responsible for writing a report, *Comparative Analysis of the American Medical Association Versus Other Associations* (RX 743), through his association with Management Analysis Center, Inc. (Tr. 6320, 6325, 6332). The study was prepared for purposes of this proceeding (Tr. 6327). The stated purpose of the Sturdivant report was "to determine whether or not the American Medical Association is organized and operated for its own profit or that of its members" (RX 743, p. 1).

In rebuttal on this issue, complaint counsel called Dr. Paul Feldstein, Professor in The School of Public Health and in the Department of Economics at the University of Michigan (Tr. 8815).

Dr. Feldstein is an expert in the analysis of business institutions, with a specialty in the economics of medical care (Tr. 8815–35). Dr. Feldstein has spent 17 years studying, teaching and working in the health care and medical economics fields, first as a director of research for the American Hospital Association and since then at the University of Michigan (Tr. 8816–23). He has also served as a consultant and advisor to various government and private organizations on the economics of health care in his area of specialty (Tr. 8826–30). He has written numerous books and articles in the health care economics field (Tr. 8825–26, 8831). In 1977, he authored a book that analyzed the implications of various legislative positions taken by [62] AMA and six other nonprofit associations in the health field, entitled *Health Associations and the Demand for Legislation: The Political Economy of Health* (Tr. 8831, 8832–35). Dr. Feldstein also prepared a report for use in this litigation, entitled *An Analysis of the Sturdivant Report* (CX 2586). He was critical of the budget analysis approach used by Dr. Sturdivant to demonstrate AMA's economic relationship to its members (CX 2586C–D).

B. The Budget Analysis Approach

52. The Sturdivant report was based on an examination of project account request forms ("project sheets") used by AMA staff members to describe their projects for budgeting purposes in 1977 (*See, e.g.,* CX 2190; Tr. 6336, 6338–39). These "project sheets" represent approved requests for funding for 1977 (Tr. 6348). The year 1977 was chosen because it was the most recent fiscal year for which figures were available (RX 743, p. 5).

Dr. Sturdivant believed that "[t]he character of an organization is best revealed by an examination of how it allocates its resources" (RX 743, p. 5). Consequently, he categorized each of the project sheets into one of four major categories. These categories were:

(A) educational, scientific and association maintenance activities (Tr. 6344);

(B) activities resulting in indirect economic benefit (Tr. 6343–44, 6363);

(C) activities resulting in direct economic benefit (Tr. 6344, 6364); and,

(D) Miscellaneous (RX 743, p. 5).

The term "economic benefit" is to be distinguished from the term "profit." Profit is a technical term, and is used in the accounting sense to describe the net surplus of income over expenses (Tr. 6365;

RX 743, p. 4). Economic benefit refers to activities that would contribute to the financial enhancement of the physician either directly or indirectly, or aid in the maintenance of that income (Tr. 6364, 8838–39; RX 743, p. 4).

A project was classified in Category A (educational, scientific and association maintenance) if it assists the medical profession in: [63]

(a) The acquisition of knowledge;
(b) The dissemination of knowledge;
(c) The certification that knowledge has been correctly taught and mastered;
(d) The delivery of medical services;
(e) The presentation of its views on issues related to the practice of medicine or the public health; or
(f) The maintenance of the association (RX 743, p. 6).

Category A was divided into eight subcategories as follows (Tr. 6353; RX 743, p. 7):

A_1 Lay Public Education - Activities designed to disseminate public health information, *i.e.,* information on mental retardation, the importance of brushing teeth, etc. (Tr. 6353–54);
A_2 Journals and Scientific Publications - Activities designed to disseminate scientific materials to professionals (Tr. 6354–55);
A_3 Scientific Policy - Activities lending to the formulation of scientific policy (Tr. 6355–56);
A_4 Other Scientific - Scientific activities not falling into the three previous categories (Tr. 6356);
A_5 Data on Physicians and Health Care - Activities relating to the generation and distribution of socioeconomic information about the practice of medicine and the status of public health in the United States (Tr. 6356–57);
A_6 Medical Quality Control and Education - Activities designed to certify that knowledge is correctly taught and mastered (Tr. 6358–59);
A_7 Government Interface - Activities designed to present the views of the medical profession on issues related to the practice of medicine and the public health (Tr. 6359–62); and,
A_8 Organizational Maintenance and Operations - Activities designed to generate and retain members and perpetuate the Association (Tr. 6362). [64]

A project which failed to fall within one of the criteria of Category A was placed in Category B, C or D (Tr. 6343–44; RX 743, pp. 6–7, 9).

As part of his analysis of whether or not the AMA is organized for

the profit of itself or its members, Dr. Sturdivant also prepared a "comparative operating ratio analysis," which compared the income and the expenditures of the AMA to the income and expenditures of other associations, in order to determine whether the AMA more closely resembled a profit-oriented association or a nonprofit-oriented association (Tr. 6370-71; RX 743, p. 10). The figures used as the basis of this comparison were taken from a document of the American Society of Association Executives ("ASAE"), entitled *The Association Operating Ratio Report* (RX 805; Tr. 6371-72). The AMA figures used were 1975 figures furnished by the AMA to the ASAE (Tr. 6375).

The ASAE is an organization comprised of the chief executives of the major trade associations and professional societies in the United States (Tr. 6127). The ASAE report was based upon data submitted by a number of ASAE's member associations. Five thousand ASAE members were sent a questionnaire prepared by Touche, Ross & Co., a public accounting firm, which requested comprehensive information about the income and expenditures of the organization. Approximately 1,300 organizations submitted completed questionnaires. The results were ultimately based upon the responses of 1,006 associations with the remaining responses discarded because the information appeared to be inaccurate or of questionable reliability (Tr. 6147). Thus, the response rate to the ASAE questionnaire was only about 20 percent. The validity of this statistical base upon which the report revolved is questionable (Tr. 8842-43).

After receiving the completed questionnaires and tabulating the data contained therein, Touche, Ross prepared data summaries for 47 different association categories. Each summary contains statistics concerning the revenue and expense characteristics of the relevant association group (RX 805, pp. 15, 19-65). Touche, Ross did not conduct a formal audit of the responses (Tr. 6199, 6382). There is a likelihood that there were substantial errors in the responses of associations to the questionnaire, as evidenced by a $7 million error found in the AMA response, an error that went unnoticed by the accounting firm that prepared the ASAE report (Tr. 6532-33) and the AMA until Dr. Sturdivant brought it to the attention of the AMA during the preparation of the Sturdivant report (Tr. 8839-40, 6531-33, 6380-83). **[65]**

Dr. Sturdivant compared the AMA with the following types of associations (RX 743, pp. 11-12; Appendices III and IV):

(a) All associations with corporate membership;
(b) All associations with individual membership;

(c) Corporate member associations in the area of manufacturing;
(d) Corporate member associations in health care;
(e) Individual member associations in the legal area;
(f) Individual member associations in the medical area; and,
(g) Individual member associations in the educational area.

The AMA figures submitted to the ASAE were adjusted by Professor Sturdivant so as to include under the rubric "Executive and Administrative Expenses" indirect costs amounting to $8,100,000 (Tr. 6378–80; RX 743, p. 11). This reallocation corrected the error in the AMA figures which were submitted to ASAE and it brought AMA executive and administrative expenses for 1975 to 24.6 percent of the budget; consequently, a proportionate downward adjustment of the other percentages for AMA expenditures submitted to ASAE was required (Tr. 6380).

Dr. Sturdivant's comparison of the various types of associations was made in terms of income and functional expenditure variables (Tr. 6384–86). The income variables utilized were income from:

(a) Dues regular;
(b) Dues associates;
(c) Special payments;
(d) Education programs;
(e) Certification, accreditation and standardization activities;
(f) Meetings and conventions; [66]
(g) Exhibits;
(h) Publications;
(i) Subscriptions to publications;
(j) Other sales of publications;
(k) Insurance programs;
(l) Grants and contracts;
(m) Investments; and,
(n) Other (RX 805, p. 19; Tr. 6384–85).

The expenditure variables utilized were:

(a) Executive and administrative costs;
(b) Membership;
(c) Public relations;
(d) Government relations;
(e) Publications;
(f) Conventions and meetings;
(g) Educational programs;
(h) Certification, accreditation and standardization activities; and,

(i) All other activities (RX 805, p. 19; Tr. 6385–86).

Also, as part of the analysis of whether or not the AMA is organized for its own profit or that of its members, Dr. Sturdivant presented what he termed a "comparative cultural analysis." In this analysis, he compared the AMA to six other associations in terms of six attributes discussed by the Commission in its opinion in *National Commission on Egg Nutrition,* 89 F.T.C. 89, 177 (1976) (RX 743, pp. 18–27; Tr. 6391, 6394–95). The attributes were:

(a) Origin;
(b) Character of membership;
(c) Sources of funding and relationships with profitmaking groups;
[67]
(d) Nature of publications;
(e) Stated purpose; and
(f) Accessibility to nonmembers (RX 743, pp. 18–19; Tr. 6394–95).

The six associations, in addition to the AMA, compared were:

(a) American Marketing Association;
(b) Association of American Geographers;
(c) American Association of University Professors;
(d) American Institute of Architects;
(e) Association of American Law Schools; and,
(f) Manufacturing Chemists Association (RX 743, p. 19; Tr. 6392–94).

Dr. Sturdivant set up a matrix analysis, wherein he assigned the values 0, 5 and 10 to each association for each of the six attributes, with 0 denoting for-profit status, 10 denoting nonprofit status and 5 being an intermediate point (RX 743, p. 21; Tr. 6398–6400).

C. Evaluation of the Budget Analysis Approach

53. For the reasons stated herein, it is concluded that the budget analysis approach is an unreliable method for establishing the purposes of an association such as the AMA. Therefore, this approach does not resolve the jurisdictional question of whether or not the AMA is organized for its own profit or that of its members.

Based upon his analysis of AMA's activities for 1977, Dr. Sturdivant testified that 66.5 percent of the Association's budget is devoted to scientific and educational activities, and 25.8 percent of the budget to organizational activities (RX 743, pp. 7–9, Appendices I and II). Consequently, he stated that 92.3 percent of the AMA's 1977 budget

went toward noncommercial activities (Tr. 6333). He concluded that AMA activities are largely devoted to scientific, educational, professional, organizational and maintenance activities (Tr. 6369–70) and, therefore, that the AMA's nonprofit activities overwhelm those activities of the AMA that might be linked to the economic interests of physicians. [68]

The Sturdivant report characterized all of AMA's legislative and so-called "government interface" expenditures as not providing any direct or indirect economic benefits to AMA members (RX 743, pp. 6–7). This view is inconsistent with the evidence, taken mostly from AMA documents, that is cited heretofore in this initial decision (F. 23–50, pp. 38–61. *See also* Tr. 8847–49). Dr. Sturdivant admitted that he had done no systematic or substantial study of health care legislation and that his knowledge of AMA's legislative activity was based on a cursory reading of AMA positions on legislation (Tr. 6454–59). On the other hand, Dr. Feldstein, who has made a career study of health care and medical economics, and has published a book on the legislative positions taken by AMA and others in the health field, was of the view that political activities are the most significant aspect of AMA's benefits to its members (Tr. 8847). While some of AMA's activities in the political arena are consistent with the public interest, the predominant interest furthered is that of economic benefit to AMA members (Tr. 8882. *See also* F. 24–39, pp. 41–50; 43–45, pp. 54–56). AMA has recognized this fact by acknowledging that one of the "major" missions of the AMA is to "act as a spokesman for physicians to the public, the government, industry and others" (CX 1042S). AMA has stated that the most important membership benefit is having AMA as the physician's "national spokesman" (CX 259Z13).

Although AMA expended less than $100,000 in 1976 on lobbying activities to seek economically favorable legislative treatment for physicians and AMA's total budget for all legislative activities amounted to about $971,000, or 2.3 percent of total expenditures (RX 3, p. 5), the economic benefit to physicians is significant to a disproportionate degree (CX 2586H). For example, in informing its membership that it had played a major role in obtaining changes in the Keogh Act, AMA stated: "This [modification] potentially saves a physician in the 40 percent tax bracket $1500 a year, which is 14 times the $110 dues to the AMA" (CX 258C–D). Similarly, in reporting on AMA testimony before Congress and on a meeting of AMA officials with President Ford to protest the possibility of a four percent ceiling being placed on physicians' annual fee increases in the Medicare program, AMA told its members that, to many

physicians, this one action was worth many times the $250 annual AMA dues (CX 1545C).

Furthermore, in its 1976 report to member physicians on where their dues dollars go (*What The AMA Dues Dollar Does - A Report To Physicians On The Programs 1976 Revenues Supported,* RX 3), it was stated that: **[69]**

> [T]he AMA is vigorously involved in basic economic research . . . . [W]ithout the data [thereby generated which] the AMA was able to bring to the many meetings of the Cost of Living Council, the controls on fees [imposed on physicians by the Economic Stabilization Act from late 1971 through early 1974] would have undoubtedly hurt more and lasted longer than in fact they did. (RX 3, p. 9).

Dr. Sturdivant classified expenditures associated with gathering such data as not benefiting AMA members economically (Tr. 6356–57). Dr. Feldstein testified that these activities had some economic benefit to AMA members (Tr. 8896–97).

The AMA also informed its members that their dues dollars go to activities such as the AMA Physician Placement Service (RX 3, p. 8) and support of AMACO, the reinsurance corporation that backs up physician-owned medical liability insurance companies, to the tune of a $2 million initial capitalization provided by AMA (RX 3, p. 6; F. 43, p. 54; 49, p. 58). The Sturdivant report did not take into account this $2 million investment (Tr. 6451–52).

Indeed, in reference to the group rates available to members in the various insurance and retirement programs offered by the AMA, members were informed, in bold-faced type: "In many cases, a physician member can save more than the equivalent of his annual AMA dues" (RX 3, p. 13).

The Sturdivant report's budgeting approach was also criticized by Dr. Feldstein because it excluded the value of physicians' volunteer time used by AMA to promote legislative and political goals as well as other activities that promote physicians' economic interests (CX 2586H–J; Tr. 8882–83). This led Dr. Feldstein to conclude that the budget allocation approach results in an understatement of the extent to which the AMA confers economic benefits on its members (Tr. 8847. *See also* F. 20, p. 34).

The Sturdivant report purported to analyze AMA's expenditures for one year; that year may not represent a typical budgetary year since economically oriented activity, such as lobbying and political efforts, is likely to vary, especially when there is a major piece of health legislation that is pending in Congress in a particular year (Tr. 8889–91; CX 2586J–L). For example, AMA spent $2.5 million in a National Education Campaign to fight President Truman's national health insurance plan in 1950 alone (F. 27, p. 44). **[70]**

Dr. Feldstein testified that in his recalculation of AMA's budget he used members' dues as the relevant expenditure base because he believed that this represented the best reflection of what an AMA member is getting for his dues dollars (Tr. 8900; CX 2586S–W; RX 3). Dr. Feldstein eliminated from the expenditure base the expenses associated with AMA's publications, as well as the income from the publications, on the basis that the income and expenses from the publications are roughly offsetting and are not supported by dues income (Tr. 8901). Dr. Feldstein also removed from dues income that portion of such income that was not spent, but was placed in a reserve, which amounted to $11.6 million (Tr. 8909).

Dr. Feldstein concluded that AMA expenditures of $11.8 million provided economic benefits to its members. Since expenditures were made from both dues and nondues revenues, he calculated two expenditure bases (CX 2586V–W). Thus, the $11.8 million figure represents 43 percent of the dues expenditure base that went to conferring economic benefits on AMA members and 35 percent if the dues and non-dues expenditure base is utilized (CX 2586X–Z; Tr. 8913).

Since the budget approach is not appropriate to measure the degree to which AMA serves the economic interests of its members, it compounds the error to compare AMA's budget to the budgets of hundreds of other associations of various types (CX 2586D; Tr. 8839). Dr. Sturdivant's comparative operating ratio analysis is premised largely on an unsupported assumption—that associations of individuals in the education field are not oriented toward promoting the economic interests of their members (RX 743R, T; Tr. 8844). The report compared AMA's budget with those of organizations in various categories without regard to organizational size (Tr. 6538–40; RX 743M–U, Z27–Z35, Z48–Z60). The information submitted in response to the ASAE questionnaires was not audited (Tr. 6199, 6382). There is a likelihood that there were substantial errors in the responses of associations to the questionnaire, as evidenced by the $7 million error found in the AMA response (Tr. 8839–40, 6531–33, 6380–83; F. 52, p. 68). The validity of the statistical base upon which the report was based is questionable since it had a response rate of 20 percent (Tr. 8842; F. 52, p. 64). AMA itself has criticized the validity of survey results even when based on a response rate of 40 percent (Tr. 9790). Thus, the comparison of AMA's budget to the budgets of other organizations is too speculative to be of value.

The Part III "cultural" analysis in the Sturdivant report is unpersuasive in its treatment of and assumptions about the other six organizations that were analyzed. The author's premised reasoning

and factual basis for making [71] various judgments about the other organizations are not documented or otherwise justified (Tr. 8845–46). For example, the report draws a sharp contrast between AMA's organizational purposes and those of another organization that had once had articles of incorporation stating that it sought to protect the "general interests" of its members (RX 743, pp. 21, 25–26). Indeed, an early section of the AMA's articles of incorporation declared, as one of the AMA's purposes, that: "The object of this Association shall be . . . for the purpose . . . of safeguarding the material interests of the medical profession" (CX 1355H).

The report also concludes that the American Institute of Architect's commitment to "elevate the architectural profession as such and to perfect its members practically and scientifically" is an indication that it may be organized for the economic benefit of its members (RX 743, pp. 21, 26), while, in another section, AMA's early commitment to the "elevation of the whole [medical] profession" is cited as an indication that AMA was not organized for the economic benefit of its members (RX 743, p. 2).

The Sturdivant report is unpersuasive in its treatment of and assumptions about the other six associations that were analyzed. For example, in applying the six criteria which the report selected as best showing the fundamental character of the organizations being studied (F. 52, pp. 66–67) the American Association of University Professors (AAUP) was described as having all the essential characteristics of an organization that is not organized for the profit of its members (RX 743, p. 21). However, Dr. Sturdivant admitted to knowing that the AAUP devoted 31 percent of its budget to collective bargaining on behalf of its members and an additional 11 percent of its budget to studying ways to enhance its members' economic status (Tr. 6552–53).

D. Conclusion

54. Dr. Sturdivant's budgetary analysis of AMA activities (RX 743, pp. 5–10), comparative operating ratio analysis (RX 743, pp. 10–18) and comparative cultural analysis (RX 743, pp. 18–27) are each premised on highly subjective judgments and are inherently problematical, as are Dr. Feldstein's conclusions about the nature of the AMA based upon his budgetary analysis (CX 2586D, E, F; Tr. 8838, 8845, 8942, 8962–63, 9055).

The intrinsic degree of subjectivity involved in the classification of AMA activities as economically oriented or noneconomically oriented gives rise to inconsistencies [72] not only between the testimony of Drs. Feldstein and Sturdivant but, even more significantly, within

each witness' budget allocation analysis. For instance, Dr. Sturdivant classified professional liability insurance as providing a direct economic benefit, but he classified an AMA project on the analysis of malpractice and professional liability as noneconomic (Tr. 8895).

A significant number of AMA's activities can be fairly characterized as both producing an economic benefit for physicians and containing a health benefit for the public (CX 2586 O–Q; Tr. 8882, 8988, 9065–79, 9082–83, 9129–30). Therefore, a budget allocation approach is unworkable in its attempt to compartmentalize activities that are both economic and noneconomic in nature. One important value of AMA to its members is that it is an existing organization with vast expertise in the medical field. Its organizational expenses, expenses of its public relations work and expenses of maintaining the organization and maintaining its membership are expenses that must be characterized as providing some economic benefit to its members since it is an ongoing organization available to assist physicians when any need arises in the political arena, or otherwise, as with the malpractice insurance crisis. One of the most important benefits, "of overriding importance," is the fact that "as a member, you have an effective and influential national spokesman to represent your views, yes *your* views, interests and rights" (CX 259Z13) (Emphasis in original).

In sum, the actual nature of AMA's activities, for purposes of determining whether or not the AMA is organized for its own profit or that of its members, cannot be ascertained by reviewing budgetary allocations based upon various income and expenditure categories (CX 2586F–L, CX 1042R; Tr. 8838, 8846–48, 8882–83), or by comparing AMA's revenue and expenses with those of other organizations about which little accurate, factual information is known. For purposes of determining the issue of AMA's profit orientation, evidence in the form of, or based upon, a budget allocation approach would be of evidentiary value only as support for, and confirmation of, findings of fact resting upon more solid footing. Since the record contains substantial actual evidence of AMA's activities, evidence based upon the subjective analysis of expenditures is of very limited value. [73]

V. ACTIVITIES OF CONNECTICUT STATE MEDICAL SOCIETY

A. Committees and Programs

55. CSMS annually holds a Scientific Assembly for the presentation and discussion of subjects relating to science and medicine. CSMS selects speakers and persons to present papers at the

Assembly on the basis of quality; CSMS does not distinguish between members of CSMS and nonmembers in the selection process (Tr. 8232, 8287–90; RCX 79, 146, p. VII).

CSMS has scientific sections in 26 specialty areas: allergy; anesthesia; dermatology and syphilology; emergency medicine; family medicine; forensic medicine; gastroenterology; internal medicine; neurology; neurosurgery; obstetrics and gynecology; occupational health; ophthalmology; orthopedics; otolaryngology; pathology; pediatrics; physical medicine and rehabilitation; preventive medicine and public health; proctology; psychiatry; pulmonary diseases; radiology; surgery; thoracic and cardiovascular surgery; and urology. Membership in CSMS scientific sections is open to CSMS members and student members who have an interest in the work of the section. The purpose of the scientific sections is to conduct the work of the annual CSMS Scientific Assembly and related work (CX 1352U–V; RCX 146, p. VII). The scientific sections meet at least once annually, at the time of the Scientific Assembly. At the section meeting, there is a general topic of discussion and/or a featured speaker (Tr. 8288; RCX 79, 146, p. VII).

CSMS has the following committees (CX 1352P–T): The CSMS committe on continuing medical education is charged with responsibility for investigating and evaluating alternatives in continuing medical education programs, the quality of courses and course materials and liaison with educational bodies concerned with continuing medical education (Tr. 8285–87; RCX 68, pp. 27–28).

The committee on the program of the scientific assembly is responsible for developing the format and program of the annual CSMS Scientific Assembly (Tr. 8287–90; RCX 68, pp. 28–29).

The committee on insurance has responsibility with respect to endorsement of voluntary health and accident insurance programs (Tr. 8291–92; RCX 68, p. 29).

The committee on professional liability has responsibility for investigating the occurrence of malpractice and matters relating to professional liability claims and insurance. The committee has worked to develop educational programs and to decrease the incidence of malpractice (Tr. 8294; CX 321A–B, 366A–C, 369A–C, 428, 431A–B; RCX 68, pp. 29–30). [74]

The Committee on peer review systems has been concerned with matters of peer review and regulation by third parties. The committee undertook a study of ways to help elderly patients by increasing the number of physicians willing to be reimbursed by Medicare solely on the basis of the assignment of patients' Medicare benefits rather than requiring extra payments by the patients. The

Committee's report was sent to the Connecticut Congressional delegation and the Department of HEW (Tr. 8301–07; RCX 68, p. 30, 102A–D, 103A–M).

The committee on third-party payments has been concerned with patients' insurance coverage and has served as a liaison for policy/philosophy interchange between CSMS and third-party payers in Connecticut. At one time, this committee worked on a relative value guide (Tr. 8307–08; CX 411–414, 418A–B, 425A–B, 426A–B, 451A–F; RCX 68, pp. 30–31. *See also* F.60, p. 83; 63, pp. 85–86).

The judicial committee is concerned with philsophical considerations such as involuntary sterilization, health care of the elderly and informed consent. It is also authorized to serve as an appellate body for members who feel aggrieved by a disciplinary action taken by a county association. Although the judicial committee is empowered by the CSMS bylaws to initiate disciplinary proceedings, the committee has not exercised original jurisdiction in at least the last 30 years (Tr. 8310–12; RCX 68, p. 31, RCX 146, p. X).

The editorial committee of *Connecticut Medicine* is responsible for supervising the publication of the CSMS monthly journal (Tr. 8321; RCX 68, pp. 31–33).

The committee on legislation is concerned with legislation related to health and medical care. In recent years, the committee has been concerned with the potential malpractice crisis, peer review, health education in the schools, immunity for persons providing Good Samaritan services, the ability of minors to secure treatment for venereal disease, reforming the State's abortion law, developing a definition of death, organ transplants and the use of extraordinary technology to prolong life. Members of the committee may, upon occasion, testify at hearings of the State legislature (Tr. 8323–26; RCX 68, p. 33). [75]

The committee on public relations is concerned with developing information on health care and health tips for CSMS to provide to the media and the public, and also with publicity for CSMS activities (Tr. 8329–31; RCX 68, pp. 33–34).

The committee on accident prevention and emergency medical services was formed to aid in the development and implementation of emergency medical services in Connecticut. The committee has been concerned with sports medicine, rape victims, standards for public vehicle operators and, along with the CSMS committee on legislation, the support of legislation which would provide emergency medical services (Tr. 8331–32; RCX 68, p. 34).

The cancer coordinating committee has coordinated activities in the fields of cancer treatment, research and education throughout

Connecticut, has worked with the committee on legislation to support legislation to maintain a cancer tumor registry, developed a booklet on follow-up cancer treatment and has emphasized physician education regarding cancer treatment (Tr. 8332–35; RCX 68, p. 35, RCX 97).

The committee on drug abuse education is concerned with educating the public with respect to drug and alcohol abuse and the treatment of alcoholic patients. Recently, it has been particularly concerned with the "sick physician" who is abusing drugs or alcohol (Tr. 8336; RCX 68, pp. 35–36).

The committee on maternal morbidity and mortality is interested in the management of obstetrical delivery in terms of the appropriateness of treatment and lowering the incidence of risk in maternal and newborn care. This committee drafted a statement setting forth professional guidelines for performing abortions when, after the United States Supreme Court decision, the Connecticut legislature failed to set guidelines (Tr. 8336–38; RCX 68, p. 36, RCX 117A–B).

The committee on medical aspects of sports focuses on injury prevention in high school sports, has published "The Team Physician" and publishes the *SportsMed* periodical (Tr. 8338–39; RCX 68, p. 36).

The committee on mental health, formed to promote the care and welfare of persons with mental health problems, works in areas that include mental health legislation, the "sick physician" problem and the evaluation of mental health programs (Tr. 8340; RCX 68, pp. 36–37). [76]

The committee on organ and tissue transfers is responsible for developing guidelines for implementing organ and tissue transfers and blood transfusions. It has worked with the committee on legislation in legislative matters relating to the definition of death and the propriety of organ and tissue transfers (Tr. 8340–41; RCX 68, p. 37).

The committee to study perinatal morbidity and mortality is concerned with the pre- and post-natal welfare of the newborn, and has sponsored symposia on care of the newborn (Tr. 8341–42; RCX 68, p. 37, RCX 80).

The committee on public health is interested in matters of public health such as immunization, venereal disease, rural health needs, health education in schools and nutrition. It has sponsored symposia and meetings on these and other public health matters, and has worked closely with State and municipal officials on matters of public health (Tr. 8342–43; RCX 68, pp. 37–39).

The committee on continuing medical care, formerly known as the

committee on aging, is concerned with the welfare of patients in extended care facilities, the transfer of medical data, the coordination of care of the elderly and legislation dealing with long term care (Tr. 8344; RCX 68, p. 39).

The areas of interest of the committee on statewide medical planning include containment of health care costs, uncovering Medicare fraud, national health insurance legislation, other health planning legislation and work on the Connecticut Ambulatory Care Study (Tr. 8345–47; RCX 68, pp. 39–40).

CSMS sponsors continuing medical education ("CME") programs. These programs are available to all physicians, regardless of membership in CSMS, and to members of other health-related professions. There is generally no fee for attending CSMS sponsored CME programs; occasionally, there may be minor registration fees, applicable to all persons attending the programs. Examples of CME programs which CSMS has sponsored are the sixth biennial perinatal seminar program (topics included fetal placental health, obstetrical anesthesia, blood gases and newborn intensive care) and the second conference on planning CME in community hospitals (program topics included planning and evaluating CME programs) (Tr. 8286; RCX 80, 82). [77]

CSMS has developed a series of seminars to study the input of the physician in health care costs and the establishment of hospital committees to work with hospital administrators toward minimizing physician related hospital costs. The CSMS sponsored seminars are given free of charge and are open to members and nonmembers of CSMS as well as the general public. These seminars have been concerned with the impact on health care costs of the use of antibiotics, respiratory therapy and the pathology laboratory (Tr. 8346–47).

B. Publications

56. CSMS publishes *Connecticut Medicine,* the journal of the Connecticut State Medical Society, on a monthly basis. The journal has been in publication since 1936. It has a physician editor as well as a CSMS committee which functions as an editorial board (Tr. 8321–23; CX 1352Q; RCX 129. *See also* F. 71, p. 91). *Connecticut Medicine* is available to CSMS members and nonmembers who wish to subscribe, as well as through public libraries. The subscription rate is $7.50/year for CSMS members and $15.00/year for nonmembers. Approximately 150 to 200 nonmembers subscribe to *Connecticut Medicine.* The members' subscription costs are allocated out of the $100 membership dues of CSMS (Tr. 8240, 8254–55). *Connecticut*

Medicine generally contains articles of educational value in clinical medicine; philosophical issues in medicine; comments of the Dean of the University of Connecticut; articles of general intellectual interest (for example, by the Connecticut Society for the Humanities); comments of CSMS officers, employees, or representatives; the proceedings of the CSMS House of Delegates; notices of scientific symposia; letters to the editor; and a physician placement service. Many of the authors of these articles are not members of CSMS (Tr. 8322–23; CX 1352A–Z85; RCX 129). The physician placement service includes listings of physicians wishing to locate in Connecticut and entities wishing to list opportunities for practice. The service is available without charge to all physicians, regardless of membership in CSMS, and to Connecticut municipalities and governmental agencies seeking physicians (Tr. 8238–40; RCX 129). *Connecticut Medicine's* costs of publication exceed the revenues obtained from advertising, subscriptions and reprints. In 1975, CSMS lost about $44,000 in publishing and maintaining *Connecticut Medicine* as the Society's journal (Tr. 8369; RCX 68, pp. 14, 16–17).

CSMS publishes *Connecticut SportsMed,* which is distributed by CSMS free of charge several times annually to team physicians, coaches, trainers and others interested in contact sports in Connecticut. *SportsMed* is primarily intended for consideration and use by people dealing with sports in the middle and secondary schools. The April 1976 [78] issue of *Connecticut SportsMed* (Vol. 3, No. 1) included articles on lateral flexion injury to the neck; cauliflower ear; athletic training; physical examinations; and, injury reporting (Tr. 8330; RCX 94).

C. Public and Governmental Interface

57. The CSMS staff writes and issues press releases to the news media on subjects such as food choking, high blood pressure, health care of the elderly, psoriasis, poisonous plants, yard and gardening accidents, hypertension and weight control (Tr. 8248–50; RCX 84, 86, 89A–B, 90, 91A–B, 92A–B, 127A–C, 128).

CSMS offers pamphlets on health related matters to the public free of charge. CSMS has distributed pamphlets relating to the Heimlich maneuver of rescuing victims of food choking, high blood pressure (in English and Spanish editions), a form regarding the use of extraordinary life supports, the identification of drug abusers, first aid chart and weight control (Tr. 8250–52; RCX 83, 85, 87, 88, 111, 125, 147).

CSMS has developed informational pamphlets and materials for use by physicians and others. Examples include "The Team Physi-

cian: A Brochure for Team Physicians, Coaches & Trainers" and "Follow-up of Cancer". These booklets have been distributed by CSMS free of charge to physicians (CSMS members and nonmembers) and other interested persons (Tr. 8333–34, 8338–39; RCX 93, 97).

CSMS receives telephone requests from members of the public seeking information about locating a physician. The CSMS staff refers to a national specialist directory which CSMS purchases each year; CSMS selects three names of specialists at random from the directory, and provides the telephone caller with the names and biographical information published in the directory. CSMS does not distinguish between members and nonmembers of CSMS in determining what physicians' names to provide to telephone callers seeking information (Tr. 8247–48).

CSMS sends designated representatives and advisors to governmental and quasi-governmental bodies concerned with health care. CSMS sends representatives and delegates to the following groups: committee on allied medical services (considering the interrelationship of care rendered by physicians and nurses); committee on hospitals; committee on cooperation with the medical schools of Connecticut (resulting in educational programs cosponsored by CSMS); liaison committee with the Connecticut Pharmaceutical Association; liaison committee with the State Department of Social Services; Connecticut Health Association; Connecticut Nutrition Council; Connecticut Advisory Council on School Health; Connecticut Advisory Committee on Food [79] and Drugs; Council of New England State Medical Societies; State hospital, pharmaceutical, dental, and nurses' associations; and several state medical associations. CSMS has two designated representatives on the Connecticut PSRO Council, which is the state-wide board responsible for the federally mandated PSRO function in Connecticut (Tr. 8347, 8349–51, 8353–54; CX 1352T, U; RCX 68, pp. 40–44).

CSMS, under a contract with the Health Services and Mental Health Administration of the Department of HEW, sponsored a Connecticut Ambulatory Care Study that began in 1972. The purpose of the study was to develop a statistical analysis and to compare the quality of care rendered in various types of medical provider settings. A final report was filed with the Department of HEW (Tr. 8351–52; RCX 68, p. 18).

CSMS contributed approximately $25,000 to the formation of the Connecticut Medical Institute, which was organized to establish four federally mandated PSRO's in Connecticut (Tr. 8353).

CSMS annually provides an $8,000 grant to the medical schools in Connecticut, to be used as a revolving loan fund for needy students.

The funds are disbursed at the discretion of the deans of Connecticut's medical schools (Yale and University of Connecticut)(Tr. 8350, 8361; RCX 68, p. 15).

In December 1971, CSMS instituted an antitrust action against the Connecticut Medical Service, Inc. (Blue Shield) seeking to enjoin that organization from requiring physicians to participate in all contractual benefit plans in order to participate in any one plan. The CSMS motion for temporary injunction was denied in December 1971, and CSMS withdrew the action in its entirety in January 1972. CSMS expended $4,249 in legal fees in connection with the suit (CX 417A–L, 2430A–J; RCX 154, 155A–C. *See also* F. 64, pp. 86–87).

CSMS has communicated with governmental officials and legislators concerning issues of health care and health care regulation in order to express its opinions regarding the delivery of health care in the State of Connecticut, including: establishing a State poison information center; State Health Department authority to regulate fishing in contaminated areas; protecting members of peer review panels; strengthening the powers of public health inspectors regarding unsanitary restaurants; fees for State Health laboratory work; licensing of clinical laboratories; reexamination of motor vehicle operators; health education in public schools; disclosure of information regarding [80] patients in mental health facilities; radiation level limits for health treatment; the practice of chiropractors; professional liability (malpractice) and the establishment of a commission to study that issue; the establishment of a separate commission on physician disability; maintenance of a State license registration fee; the practice of nursing; insurance coverage for mental or nervous conditions; disclosure of information received from the State Department of Health by the Commission on Hospitals and Health Care; defining the types of surgical practices performed by podiatrists; ear piercing; generic drug prescription; drug interchange and equivalency; procedures for the State Welfare Department payment for provider services; child abuse; motor vehicle operation; prenatal testing of pregnant women; school sports; sale of BB guns; fluoridation of water; abortion; human experimentation; optometrists' recommendation of physicians; health insurance for ambulatory care; restructuring of Medical Examining Board; and other matters referred to above in the discussion of committees (Tr. 8323–29; CX 192, 368A–F, 429, 1236A–D, 1252A–B, 1253, 1256A–B, 1257, 1263A–D, 1264, 1749; RCX 5, 10A–B, 142, 143, 144, 145. *See also* F. 64, p. 86; 66–67, pp. 88–89).

CSMS has retained a lobbyist to provide legislative counseling and representation in connection with health and medical care legisla-

tion proposed at sessions of the Connecticut General Assembly. The function of the lobbyist is to inform CSMS of health related bills, advise CSMS as to proposed positions with respect to pending legislation and facilitate contact with legislators so that CSMS can properly represent its positions to the legislators. In 1975, CSMS expended $8,731 for legal and legislative counseling, which includes the cost to CSMS of retaining a lobbyist; in 1974, the expenditure for legal and legislative counseling was $7,641 (Tr. 8360–61; CX 1255A–B; RCX 68, p. 15).

On occasion, CSMS may communicate with federal officials. In 1974, CSMS sent a mailgram to a Connecticut Congressman regarding proposed federal legislation to extend the Economic Stabilization Act (CX 1268).

D. Connecticut Medical Political Action Committee

58. The Connecticut Medical Political Action Committee ("COMPAC") is a political action committee which is registered with the Federal Election Commission. COMPAC was formed [81] on a voluntary basis by a group of Connecticut physicians in 1961 or 1962. At about that time, the CSMS House of Delegates passed a resolution which encouraged a voluntary group of physicians to form a political action committee. COMPAC's 1972 registration form filed with the United States House of Representatives listed CSMS as an "organizer" of COMPAC (CX 500A–C, 1214A–C, 2599A. *See also* F. 67, p. 89). Membership in COMPAC is voluntary. In 1975, COMPAC had a total membership of 297. COMPAC's membership in other years has been as many as 320–340 members. COMPAC is governed by the COMPAC Board of Directors (CX 458A–C, 1214B–C, 1712, 1714A–H, 1715A–H; RCX 68, p. 27).

CSMS did not contribute or grant money to COMPAC during the five-year period 1973–78, but did make financial grants to COMPAC in its early years. COMPAC administrative and clerical matters are routinely performed by COMPAC officers and do not involve CSMS (Tr. 8258–60; CX 1211, 2599D).

CSMS provides COMPAC with office space and use of a telephone line to make local telephone calls at the CSMS office free of charge. CSMS staff employees, from time to time, provide administrative or clerical services to COMPAC in connection with the processing of dues statements or the sending out of occasional pieces of mail. CSMS charges COMPAC for all postage, long distance and toll telephone charges, office supplies, printing charges and other expenses which might be incurred by, or billed to, CSMS and which are attributable to COMPAC. CSMS maintains a ledger sheet for

recording expenditures chargeable to COMPAC, and on the basis of the ledger sheet bills COMPAC for such expenditures (Tr. 8240–41, 8243; CX 2599D; RCX 123A–C).

CSMS processes dues statements on behalf of COMPAC. CSMS dues envelopes for 1975, 1976 and 1977, sent to CSMS members and prospective members in seven Connecticut counties (all but Hartford), contained a separate line entry for "Voluntary COMPAC-AMPAC Membership. . . . $25.00." CSMS charges COMPAC for the administrative costs of processing dues, in the amount of one percent of political action committee dues processed. In 1975, approximately $7,595 in political action committee dues was administratively processed by CSMS and forwarded to COMPAC; in 1976, approximately $7,295 was so forwarded (CX 1714A–H, 1715A–H, 2599C–D).

In 1974–75, 1975–76 and 1976–77, none of the COMPAC officers were officers of CSMS (CX 1352 O, 2105B, 2599B; RCX 68, p. 5). There were common officers of CSMS and COMPAC prior to these years (Tr. 8387–89; CX 1214C, 2109B). [82]

On one occasion, during the years 1975–76, and on one occasion in 1974, CSMS published an issue of a newsletter, entitled "Political Roundup," which provided information submitted to CSMS by Connecticut candidates for the United States Senate and House of Representatives; the front page of each of these two newsletters included a "message" from the COMPAC Chairman (CX 1206A–I, 1711, 2599C).

E. Insurance Programs

59. CSMS has endorsed several health and accident insurance programs. CSMS endorsement permits insurance agencies to market the programs to CSMS members. Brochures on the health and accident insurance programs are included in the CSMS membership information file which is provided to new members. CSMS expends no funds to promote these programs. Participation by CSMS members in endorsed programs is voluntary. Insurance policies written in connection with the programs are written on behalf of the individual CSMS member choosing the plan and not in the name of CSMS (Tr. 8992–94; CX 203, 205A–D, 207A–C, 208, 210A–D, 216A–C, 221, 314A–E, 316, 317, 1748; RCX 148B, F–K).

Since 1971, CSMS has endorsed a professional liability insurance program which is administered and underwritten by the Aetna Life and Casualty Company. A brochure on the Aetna program is presently included in the CSMS membership information file which is provided to new members (Tr. 8294; RCX 2B, 148N). A physician must be a CSMS member in order to participate in the CSMS

endorsed program. Participation is voluntary and subject to Aetna's determination of insurability. Policies written in connection with the professional liability program are issued by Aetna to individuals, not to CSMS on their behalf. Approximately 85 percent of the CSMS membership obtain professional liability insurance through the Aetna program (Tr. 8295, 8297, 8300; RCX 3A–E. *See also* F. 70, p. 90 *infra*).

The loss control and education programs, which were undertaken in conjunction with the professional liability program, have included sponsorship of hospital-based educational seminars which are open to physicians regardless of whether they are CSMS members, and regardless of whether they are insured under the Aetna program (Tr. 8297).

Nonmembers of CSMS, and members of CSMS who choose not to participate in the above-described Aetna program, can purchase individual professional liability insurance policies from Aetna, but at a higher rate. Other insurance [83] companies sell group professional liability insurance policies in Connecticut, but only to members of certain medical specialty societies (Tr. 8377–79, 8778).

F. Relative Value Guides

60. A relative value guide lists relative values of various medical/surgical services. A "conversion factor" is a unit value which may be used to convert relative values to dollar values for particular services (Tr. 8308–09; CX 1175D, Z–83 (pp. 3, 111). *See also* F. 55, p. 74; 63, pp. 85–86). CSMS adopted a Relative Value Scale, in 1965, as an attempt to define the relative importance of medical/surgical procedures in terms of time, experience, challenge and responsibility of the procedure. In 1971, CSMS adopted a Relative Value Guide which superseded the 1965 Relative Value Scale (Tr. 8309–19; CX 201D, 1175A–Z98; RCX 152A–F, 153A–B). At one time, CSMS distributed the relative value guide to new members. In 1975, the CSMS House of Delegates voted to make the 1971 relative value guide available to CSMS members upon request and at a charge, and the CSMS Council voted that the current usefulness of relative value guides be evaluated (CX 221, 1180). CSMS discontinued all distribution of the relative value guide in August 1977 (Tr. 8410; RCX 68, p. 19).

G. Income and Expenditures

61. In 1975, CSMS received gross income of $353,196 (less journal income). This amount included $305,442 annual dues payments from

members, less $539 in administrative charges paid to a county association for processing CSMS dues payments in that county; $35,155 special assessment of the CSMS membership to cover the funds granted by CSMS to the establishment of the Connecticut Medical Institute to implement federally mandated PSRO legislation; $18,095 interest and dividends on CSMS reserves; $5,800 rental income to CSMS from renting a portion of the CSMS building; $1,763 received from the AMA as compensation for administrative costs of processing AMA dues payments; less $13,487 loss on sale of securities; and $967 miscellaneous (Tr. 8356–57; RCX 68, p. 14).

In 1975, CSMS made expenditures of $242,229 (RCX 68, p. 14). Expenditures of $4,488 were used in the publication of CSMS Newsletters from the Executive Director's Office to CSMS members (RCX 68, p. 15); $10,386 represents the cost of sending CSMS delegates and officers to the AMA [84] conventions twice a year; $8,731 represents legal fees and the cost of retaining a legislative lobbyist; an $8,000 contribution to a financial aid fund for medical students was made; and, $2,886 was paid to a consultant to study the CSMS endorsed professional liability program (Tr. 8358–62; RCX 68, p. 15).

In 1975, CSMS expended $9,059 from a contingency fund, including expenditures for publishing *SportsMed,* a cancer handbook, a grant to the CSMS Women's Auxiliary, a study of acupuncture, mailing a continuing medical education calendar to members, emergency medical cards, sending representatives to medical conferences, etc.; $737 represented an expenditure for a "special mailing—third party payments"; $323 represented the cost of a liaison dinner with the Connecticut Hospital Association at which malpractice legislation was discussed; and, $250 represented the cost of sending CSMS representatives to a meeting with members of Congress to discuss national legislation proposals (Tr. 8362–66; RCX 68, p. 16).

In 1975, CSMS expended $7,257 in committee allotments which represented the costs of holding meetings, notifying members of meetings, secretarial work, and refreshments; $2,315 of this amount was expended for the committee on legislation. The net expense of running the CSMS annual and semi-annual meetings in 1975 was $9,091 (Tr. 8366–69; RCX 68, p. 16).

In 1975, CSMS received $56,715 in income from the publication of *Connecticut Medicine,* primarily from advertising revenues ($42,160), subscriptions ($2,996) and reprints ($11,203); the expenses incurred in publishing *Connecticut Medicine* were $100,625, for a net loss to CSMS of $43,910 (Tr. 8369–70; RCX 68, pp. 16–17).

As of December 31, 1975, CSMS had general fund reserves of

$359,697, building fund reserves of $152,442, depreciation fund reserves of $61,942 and other special fund reserves of $5,365 (RCX 68, p. 14).

VI. ACTIVITIES OF CSMS WHICH HAVE PECUNIARY BENEFIT FOR ITS MEMBERS

A. Background

62. CSMS acts on behalf of the medical profession of Connecticut, representing its professional interests and its professional responsibilities to the public, in a way [85] that it would be impossible for individual physicians to act on their own behalf (CX 192B). CSMS protects the physician in private practice whom CSMS believes should be the keystone of the Connecticut health care system (CX 892A–B). One of CSMS's long-standing "Guiding Principles and Policies" is that physicians should always have the right to charge their usual, customary and reasonable fees (CX 204B–C, 2435A–B; RCX 103I).

A key benefit of membership in CSMS is that it makes the individual physician eligible to join the AMA (CX 1105U, 221, 1748; RCX 148Q, p. 1), which in turn entitles the physician to receive the various benefits of AMA membership (*See* F. 23–49, pp. 38–59). Over half of CSMS's members are also AMA members (CX 1385A; Tr. 8244–45).

CSMS's adoption, dissemination and enforcement of its ethical principles restrains competition among Connecticut physicians, insulates CSMS's members from competition and contributes to their economic benefit.

B. Relative Value Guide

63. CSMS has published, distributed, and urged the use of the CSMS *Relative Value Guide* (CX 1175. *See also* F. 55, p. 74; 60, p. 83). The CSMS *Relative Value Guide,* a detailed coding of relative values for various medical procedures, is used by physicians in setting their fees, by medical society committees in fee related deliberations and by third-party payers in physician reimbursement decisions (CX 1175D, 204C, D, 2412B, 1181). CSMS has advised each CSMS member to use the *Relative Value Guide* to set his fees in conjunction with conversion factors (CX 1175Z85, 1171). It has suggested consultation with colleagues to determine dollar conversion factors so physicians' fees will "accommodate" with those usually charged by comparably qualified doctors in the community (CX 1171).

The first edition of the CSMS *Relative Value Guide* was adopted in

1965, and was based on AMA's publication, *Current Procedural Terminology,* and the California Medical Association's relative value scale (CX 1175D). After lengthy preparation by various CSMS committees, a new edition of the *Relative Value Guide* was published in CSMS's *Connecticut Medicine* in 1971 (CX 1175D, 381). Following its publication, CSMS regularly distributed copies of the 1971 *Relative Value Guide* to all new members (CX 1748, 221, 1171). In 1972, CSMS strongly recommended use of the CSMS *Relative Value Guide* by all third-party payers in Connecticut (CX 2434); the *Relative Value Guide* has since been used by the Connecticut Health Insurance Council to determine usual, customary and reasonable fees around the state (CX 1181A). [86]

In November 1975, the CSMS House of Delegates voted to continue distribution of the *Relative Value Guide* to members requesting copies and to print additional copies as needed (RCX 129, p. 68; CX 1180). Thereafter, continued distribution of the *Relative Value Guide* remained CSMS policy until August 1977 (Tr. 8410; RCX 68, p. 19).

C. Third-Party Payers

64. CSMS promotes its members' economic interests in dealings with third-party payers by opposing policies of government agencies and medical insurance carriers that compensate physicians at rates below their "usual" fees (CX 417K, 418A, 422A–B, 451A, B, E, F, 450, 204B–C, 2430, 2435A–B; RCX 103I). CSMS's official policy is that government medical care programs should pay physicians on the usual and customary fee basis, and should not make "reduced or substandard payments" to physicians (CX 2435A). CSMS attempts to eliminate administrative policies that offer "reduced or substandard" reimbursement (CX 2435B) and to oppose state government "economizing" on physicians' fees in the Medicaid program (CX 420A). CSMS representatives have sought increases in Medicaid payment schedules (RCX 68, p. 42, 103I), and warned the insurance carrier administering the program that "reasonable" must not be defined as "cheap" in the company's fee reimbursements to Connecticut physicians (CX 422B). Through its representatives on the Medical Advisory Committee to the Connecticut Welfare Commissioner, CSMS has also pressed on behalf of its members for prompt payment of claims owed to them for medical services rendered to Medicaid patients (CX 431A, 432A).

CSMS actively opposed the "Century Contract" adopted by Connecticut Medical Service, the Connecticut Blue Shield Plan, under which the maximum payments the Blue Shield Plan made to physicians were lower than the levels of usual and customary

charges then being received by CSMS member physicians and, therefore, deemed unacceptably low by CSMS (CX 420A, 417, 418, 2430). Acting in behalf of and representing its members, CSMS joined in a lawsuit in 1972 challenging the Blue Shield contract—after the contract had been approved by the state insurance comissioner—in an effort to protect CSMS members from suffering "substantial competitive disadvantage," undergoing loss or damage to their businesses and being deprived of their ability to determine the level of compensation for their services (CX 2430B, D, E). In the year the suit was filed, CSMS [87] allotted $4,249 to "Legal Fee—special litigation" and $1,009 to "Third Party Payments" committee activities, a total of $5,258; it allotted only $5,289 to all the rest of its committees (RCX 155C).

CSMS has opposed health insurance company cost containment measures involving determinations that certain physicians' charges are not usual, customary and reasonable if the insurer does not clear its procedures with CSMS (CX 450; 451A, B, E, F). CSMS strenuously objected when the Aetna Life and Casualty Company adopted a policy of paying physicians' fees up to the prevailing fee levels that Aetna had determined and, then offering assistance to policyholders who wished to contest any additional charges by their physician (CX 450, 451A–F). The CSMS Council voted down a resolution reminding physicians to "discuss their fees with patients *before* rendering services" so as to avoid disagreements with patients over fees that exceed the patients' health insurance coverage limits (CX 451F) (emphasis in original). The Council specifically endorsed an AMA resolution calling on insurance carriers to consult with "duly constituted representatives of organized medicine" before determining usual, customary and reasonable fees, and calling on the insurers to utilize physician-controlled peer review mechanisms to resolve differences with physicians regarding fees (CX 450, 451A–F). CSMS supports such medical society peer review committees, in part because they protect the physicians (CX 204B), and provide a forum consisting exclusively of physicians (RCX 129, pp. 34, 68) where physicians can press claims that insurers' reimbursements have been inadequate (CX 411–14).

D. Foundations for Medical Care

65. The CSMS Council voted that foundations for medical care are more acceptable to it than HMOs, partly because of CSMS's concern for protecting the physician in private practice (CX 892A). The Council has urged the CSMS component medical societies to consider forming foundations for medical care on a county-by-county

basis, each foundation to serve as the negotiating agent for contracting physicians in all matters having to do with third-party payments to physicians (CX 892A–B, 2414C). CSMS has issued a $4,999 interest-free loan to the New Haven County Foundation for Medical Care to be repaid "when feasible" (RCX 68, p. 17).

Foundations "owned, controlled and administered by organized medicine" and incorporating fee-for-service medicine as a basic principle are one means available to [88] medical societies to protect the interests of practicing physicians (CX 388A, B, E, F). They provide physicians with a "common front in meeting the socioeconomic pressures facing the practice of medicine," such as presented by HMOs, where fees are not necessarily controlled by doctors (CX 2412E, F).

E. Efforts to Influence Governmental Action

66. CSMS seeks to exert influence on the course of legislative proposals of interest to physicians (CX 1255A). The CSMS Committee on Legislation lobbies primarily at the state government level, and also lobbies in cooperation with the AMA at the federal level (CX 192A, 1255A). In 1971, 1974 and 1975, CSMS's allotment to state and national legislation committee activities was over twice as large as its budgetary allotment for any other committee (RCX 155C, 68, p. 16).

CSMS opposed price controls on physicians' fees (CX 192, 1268). CSMS's Executive Director declared, in 1974, that by contacting Connecticut's two Senators and six representatives, and obtaining their support, CSMS was instrumental in terminating Phase 4 price controls on physicians' charges (CX 192A).

CSMS pressed for repeal of the Connecticut law requiring physicians to pay an annual registration fee of $150 (CX 1236D, 1256A–B, 430, 1257), announcing that its primary concern with the statutory registration process for Connecticut physicians was the amount of the annual fee physicians had to pay (CX 1256A). Consistent with its announced concern about legislation which it believes would place one modality of medical practice at a competitive disadvantage with respect to others (RCX 5A), CSMS has opposed legislation that would waive the registration fee requirement for non-fee-for-service, salaried physicians (CX 1256A).

CSMS has also lobbied for adoption of malpractice insurance legislation (RCX 68, pp. 29–30; CX 1749A, E) to forestall continued premium increases in physicians' liability insurance costs (CX 1252A, 1749A). A number of CSMS's legislative proposals, in 1974 and 1976, were specifically designed to make it more difficult for

plaintiffs to prevail in malpractice litigation and to reduce the size of malpractice liability awards against physicians (CX 1262, 1263; Tr. 8324).

In 1974 and 1975, CSMS lobbied for increases in and faster payment of physicians' claims under the Medicaid program in Connecticut (CX 431A, 432, 1236C; RCX 68, p. 42, 103I; Tr. 8396–97). CSMS has also opposed the charging of [89] fees by the State Health Laboratory, questioning whether the state government should compete with the private sector (CX 1264), and has opposed legislation expanding the scope of practice of podiatrists (CX 1236C) and chiropractors (CX 192A).

F. Connecticut Medical Political Action Committee

67. CSMS organized COMPAC to support CSMS's legislative activities by contributing money to candidates for public office (CX 500A–C, 458A, 1214A. *See also* F. 58, pp. 80–82). COMPAC's activities are designed to "stem the tide" of governmental actions adversely affecting Connecticut physicians, such as price controls on physicians' fees, increased physician license registration fees, liability awards against physicians and national health insurance (CX 454). COMPAC serves as the "political arm" and "tool" of the medical profession in Connecticut (CX 223, 1711, 1206A), seeking to protect and enhance the private practice of medicine in concert with the American Medical Political Action Committee ("AMPAC") (CX 1214A–B).

CSMS made financial grants to COMPAC in its early years (Tr. 8258–60; CX 1211), and COMPAC officials have attended CSMS Committee on Legislation meetings (CX 458A). Various physicians have served simultaneously as officers of COMPAC and as officials of CSMS (Tr. 8387–89). For example, in 1971, the physician who chaired both the CSMS Public Affairs Division and National Legislation Committee was also the chairman of the COMPAC board (CX 1214C, 2109B). CSMS's president, president-elect, vice president, treasurer, the chairmen of the CSMS judicial, public relations and third-party payments committees and three other CSMS officials all were on the COMPAC board that year (CX 1214C, 2109B). Promoting membership in COMPAC has been one of the two main goals of the CSMS public affairs committee (CX 1258B). CSMS endorses COMPAC and acts as its collection agency, soliciting contributions to COMPAC and AMPAC in the annual dues statements sent to CSMS members (CX 1214C, 1714, 1715, 312). CSMS provides office space and local telephone service to COMPAC at no charge and receives reimbursement from COMPAC for other administrative services CSMS pro-

vides for COMPAC (CX 2599C, D). The two organizations are in close liaison (CX 1206A), and work together (CX 1214C). COMPAC reports to the CSMS Council twice a year (Tr. 8383–84) and files reports with the CSMS House of Delegates (RCX 129, p. 68; CX 458B). [90]

G. Membership Services

68. CSMS provides a physicians' placement service (CX 1285B; Tr. 8238–39). This program benefits CSMS members who are interested in making a geographical change in their practice and those members who are seeking professional associates (CX 192A). Placement assistance to out-of-state doctors seeking opportunities within Connecticut enhances the potential for increased membership in CSMS and has considerable public relations value (CX 1285C).

CSMS offers a variety of other services to its members. These include scientific assemblies held twice a year (CX 213B, 991I) and estate planning and settlement advice (CX 355; RCX 129, p. 71).

H. Public Relations

69. The CSMS public relations program is designed to "maintain constructive and dignified relationships" with the public and other groups in the health care field (CX 213B). It includes efforts to "enlighten and direct" the public on issues relating to HMOs, foundations for medical care and PSROs (RCX 5C, 148Q, p. 3).

I. Insurance Programs

70. CSMS sponsors a variety of group insurance programs available exclusively to its members, the most significant being the Professional Liability Insurance Program (RCX 2D, 68, p. 29; CX 192B, 206F. *See also* F. 59, pp. 82–83). This program, underwritten by the Aetna Life and Casualty Company, is designed to assist CSMS members caught in the "expensive bind" of rising malpractice costs (CX 367U, 1235, 1328). The program is available only to CSMS members (Tr. 8299; CX 1328, 309, 317), and is the only group malpractice insurance available in Connecticut with the exception of policies available to members of certain medical specialty societies (Tr. 8378–79, 1722–23; CX 1328). A Connecticut physician who is ineligible for a group policy can obtain malpractice insurance only by purchasing a nongroup, individual policy from Aetna at a higher rate than that charged to CSMS members under the sponsored program (Tr. 8778). Approximately 85 percent of CSMS's members subscribed to the program, and CSMS intervenes with Aetna on behalf of CSMS members who protest initial determinations by

Aetna refusing coverage of them (Tr. 8295, 8297, 8300; CX 428; RCX 2D, 148N, 3A-E). [91]

Other group insurance plans sponsored and endorsed by CSMS and available only to its members (CX 314, 317), include a life insurance program at substantial savings (CX 207B; RCX 148H), office disability insurance to provide "continuing income in the event of disability" (CX 210B; RCX 148K), office overhead insurance to "save money" (CX 314C; RCX 148J), health and accident insurance (CX 216, 213B; RCX 148F), in-hospital indemnity insurance (RCX 148B) and major medical insurance (CX 205, 213B; RCX 148G, I), all offered at lower rates than would be available in individual policies (RCX 148B, F).

J. Publications

71. CSMS publishes *Connecticut Medicine* and distributes it as a benefit of membership (RCX 146, p. 9, 129Z, p. 76. *See also* F. 56, p. 77). The journal contains scientific articles, articles on socioeconomic, legal, governmental and ethical issues (RCX 68, p. 32), and articles of economic interest to Connecticut physicians on PSRO's, governmental health systems agencies, malpractice insurance, the Connecticut Commission on Hospitals and Health Care (RCX 68, p. 32), financial entitlements of physicians who have contractual arrangements with hospitals (RCX 129, p. 27) and estate planning (RCX 129, p. 71). *Connecticut Medicine* includes a section of physicians' placement listings (RCX 129, pp. 73–74). The articles on medical subjects in the magazine are not only of scientific value, but also provide practical, economic benefits to improve physicians' efficiency, productivity and skill (RCX 129, pp. 13–14).

CSMS has utilized *Connecticut Medicine* to keep its members informed on such economic issues as compulsory insurance, prepaid medical insurance, group practice, licensure of foreign medical graduates, proposed legislation on social security for physicians, professional liability insurance, corporate practice of medicine, use of the CSMS *Relative Value Guide* and CSMS official policy statements on physicians reimbursement and payment mechanisms (RCX 129, pp. 41–50, 68; CX 2412, 204).

K. Source of Funds

72. CSMS's total income in 1975 was $409,911, of which $340,058 (83.0 percent) was derived from membership dues and assessments, and $56,715 (13.8 percent) was derived from *Connecticut Medicine* (RCX 68, p. 18). A very small portion, if any, of CSMS's income comes

from contributions and grants from disinterested parties (RCX 68, p. 18). [92]

L. Federal Income Tax Status of CSMS

73. CSMS is exempt from federal income taxation under Section 501(c)(6) of the Internal Revenue Code (CX 1393. *See also* F. 50, pp. 60–61).

VII. ACTIVITIES OF NEW HAVEN COUNTY MEDICAL ASSOCIATION

A. Committees and Programs

74. The NHCMA bylaws establish the following standing committees: Board of Censors and committee on third-party payments, which together comprise the peer review committee; credentials and orientation; medical ethics and deportment; legislation; program; nominating; and policy and procedure. In addition, NHCMA has committees on public relations, bylaws revision, insurance, finance and liaison to the Woman's Auxiliary (Tr. 8436, 8441–47; CX 995E–M; RNHX 139, pp. 7–15).

The Board of Censors is the committee which initially investigates and hears matters of complaint made regarding the conduct of an NHCMA member, including any allegation of misrepresentation, deception, unethical practice or provision of inadequate care. This committee serves an "ombudsman" function in receiving and responding to inquiries and complaints made by members of the public (Tr. 8462–63, 8475–76).

The third-party payments committee is concerned with matters relating to insurance plans and other plans of third-party entities. This committee meets with the Board of Censors to comprise the peer review committee, which reviews all fee related complaints and inquiries made to NHCMA by the public and third-party payers (Tr. 8442; RNHX 139, pp. 10, 15).

The committee on credentials and orientation is responsible for reviewing and ensuring the authenticity of statements made on applications for membership in NHCMA, and also conducts an orientation program for new members (Tr. 8442–43; RNHX 139, pp. 11–12).

The committee on medical ethics and deportment is concerned with claims of malpractice (Tr. 8443; RNHX 139, p. 12). [93]

The committee on public relations has two functions: to improve internal relations within NHCMA and between NHCMA and others; and to educate the public with regard to health care matters. This

committee is also responsible for the publication of *Issues and Insight* (Tr. 8443, 8524).

The committee on legislation is responsible for keeping abreast of legislative matters relating to health care (Tr. 8443; RNHX 139, pp. 12–13).

The program committee is responsible for planning the arrangements, dinner and speaker for the NHCMA annual and semi-annual meetings (Tr. 8443–44; RNHX 139, p. 13).

The nominating committee meets once a year to nominate a slate of officers to be voted upon at the NHCMA annual meeting (Tr. 8445; RNHX 139, pp. 13–15).

The committee on policy and procedure, composed of present and past officers, is concerned with long range planning and recommendations of future policy for NHCMA (Tr. 8445; RNHX 139, p. 15).

The insurance committee has responsibility with respect to the endorsement of health and accident insurance programs (Tr. 8446).

The finance committee supervises the formulation of the NHCMA budget and ensures that the budget is adhered to (Tr. 8447).

NHCMA formed a liaison committee with the Yale University Medical School in order to develop mutual cooperation between academic and practicing physicians (Tr. 8454; CX 995J).

B. Income and Expenses

75. In 1975, NHCMA received gross income of $107,239. This amount included $95,845 annual dues payments from members; $1,268 from tickets to the NHCMA annual and semi-annual meeting; $2,816 interest on NHCMA reserves; $975 received from insurance companies for reviewing third-party payments questions ($25 per case reviewed); $1,598 revenue from advertising placed in the NHCMA publication, *Issues and Insight;* $4,011 reimbursement [94] from the New Haven County Foundation for Medical Care, Inc. for consultant's administrative services; $726 reimbursement from the Professional Standards Review Organization for administrative services and office equipment.

In 1975, NHCMA had expenditures of $95,027 (Tr. 8513–17; RNHX 138C). NHCMA expended $54,186 as Executive Office expenses, including salaries, pensions, health insurance and payroll taxes (Tr. 8517–18; RNHX 138C). NHCMA expended $12,952 to hold meetings of NHCMA (annual and semi-annual) and its committees. This amount included $9,077 to hold its annual and semi-annual meetings; $2,261 to hold Board of Governors meetings, Executive Committee meetings and special meetings; $524 to hold meetings of the NHCMA standing committees; $353 to hold meetings of the Board of

Censors; and $737 in secretarial, postage and printing costs of the credentials and orientation committee to consider membership applications and prepare certificates of membership (Tr. 8518–20, 8525; RNHX 138C). NHCMA expended $9,900 to retain an outside public relations consultant, and an additional $766 for expenses incurred by the consultant (Tr. 8520–24; RNHX 138C). NHCMA expended $3,454 in direct costs of publishing and distributing *Issues and Insight,* and expended $200 as an honorarium to its physician editor. The duties of the public relations consultant included aiding in the production and publication of *Issues and Insight.* NHCMA expended $788 in direct costs of publishing and distributing the NHCMA President's Newsletter to members. The duties of the public relations consultant also included aiding in the production and publication of the newsletter (Tr. 8524–25; RNHX 138C). NHCMA expended $997 to cover the Clerk's office equipment, cost of travel to meetings elsewhere in Connecticut, etc. and a $400 honorarium to the NHCMA President. NHCMA expended $340 as a miscellaneous reserve or "emergency" fund and $319 as a donation to the NHCMA Woman's Auxiliary to help defray the costs of holding the Auxiliary's annual scholarship dance (Tr. 8525–26, 8529; RNHX 138C). NHCMA expended $9,627 in maintaining its office, including the cost of rent, utilities, janitorial services, telephone and answering service, insurance, office equipment and supplies, printing and postage. NHCMA expended $600 for auditor's services and $120 for legal services (Tr. 8526–30; RNHX 138C). NHCMA expended $372 for the Executive Secretary's attendance at an AMA leadership conference in Chicago on current topical issues such as medical care for jail populations and the control of "the sick doctor" (Tr. 8527–28; RNHX 138C). NHCMA had a net excess for the year of $12,212 (RNHX 138C). [95]

C. Public and Governmental Interface

76. NHCMA has sent representatives and advisors to several community-oriented health organizations such as the New Haven Alcohol Council, the Cancer Society and the American Heart Association. NHCMA sends a representative to the Health Systems Agency which is a federally mandated health-planning organization designed to determine and make recommendations concerning the adequacy of presently available medical care. NHCMA sent a representative to the South Central Connecticut Comprehensive Health Planning, Inc., which was the predecessor of the Health Systems Agency (Tr. 8452–57; CX 995I). In 1971, the NHCMA Executive Committee met with chiefs of staff of hospitals in New

Haven County to discuss topics of mutual interest (CX 447A–E). In 1972–73, NHCMA had an *ad hoc* committee on staff appointments at Yale-New Haven Hospital. This committee met with a committee of the New Haven city medical association to discuss three physicians' efforts to obtain staff privileges at Yale-New Haven Hospital (CX 442, 443, 445, 446A–C). In 1975, representatives of NHCMA met on two occasions with representatives of the New Haven County Bar Association in exploratory meetings aimed toward improving relationships between the two organizations (CX 995M). NHCMA does not have a physician placement service, but has endorsed plans covering major medical, hospitalization and disability insurance (CX 339, 1280, 1281, 323A–F, 324A–F, 327A–F, 328A–B, 329A–B; Tr. 8446–47).

D. Publications

77. NHCMA publishes a quarterly periodical, *Issues and Insight,* which is a 10–12 page publication designed to keep the NHCMA membership and others informed as to current issues of interest regarding health care and physicians in New Haven County. *Issues and Insight* has a physician editor and is published in conjunction with the NHCMA public relations committee (Tr. 8457–58, 8524; CX 995H,J). *Issues and Insight* is available free of charge to members of NHCMA, and also to nonmembers upon request. The costs of publishing and maintaining *Issues and Insight* as an NHCMA publication exceed the revenues obtained from advertising, resulting in a loss to NHCMA of approximately $2,000 in 1975 (Tr. 8524–25; RNHX 138C).

E. COMPAC

78. COMPAC is a voluntary political action committee registered with the Federal Election Commission (*see* F. 58, pp. 80–82; 607, p. 89). COMPAC is not a committee of NHCMA [**96**] and NHCMA granted no money, funds or property to COMPAC in 1975 and 1976, and provided no administrative services to COMPAC (Tr. 8574; CX 500A, 2599A, D). NHCMA members are not required to join COMPAC. As of the end of 1974, 94 members of NHCMA chose to belong to COMPAC. As of April 1975, 74 members of NHCMA had chosen to do so (CX 312, 996B, 1214B, 1712, 2599A). On occasion, a COMPAC member may make a brief oral statement to NHCMA or its Board of Governors regarding the purpose of COMPAC and the importance of participating in the electoral process. The phrase, "Join COMPAC," was printed on the back side of one NHCMA

meeting notice in 1973, one notice in 1975 and one meeting agenda in 1976 (Tr. 8570, 8573–74; CX 173C, 988C, 996B, 998D, 1221A, 1391A, 2599D).

VIII. ACTIVITIES OF NHCMA WHICH HAVE PECUNIARY BENEFITS FOR ITS MEMBERS

A. Background

79. NHCMA's bylaws commit NHCMA to an official purpose of defending and supporting the maintenance of reasonable and prevailing medical fees (CX 1404A; RNHX 139, p. 1). One of NHCMA's goals is to be an advocate for better working conditions for New Haven County physicians (CX 2422B).

NHCMA's adoption, dissemination and enforcement of its ethical principles restrains competition between and among Connecticut physicians, insulates NHCMA's physician members from competition and contributes to their economic benefit.

A key benefit of membership in NHCMA is that it makes the physician eligible to join CSMS and AMA (CX 991D) which, in turn, enables the physician to obtain the benefits of membership in CSMS and AMA (F. 23–49, pp. 38–59; 63–72, pp. 85–91).

NHCMA's total income in 1975 was $107,239, of which $95,845 (89.4 percent) was derived from membership dues (CX 1361C). Very little, if any, of NHCMA's income comes from contributions and grants from disinterested parties (CX 1361C).

B. The New Haven County Foundation for Medical Care

80. NHCMA has promoted the economic interests of its members by organizing and sponsoring the New Haven County Foundation for Medical Care ("Foundation"). By definition, the Foundation is an organization of practicing fee-for-service physicians sponsored by the medical society, which offers medical coverage to the public on a prepaid basis (CX 2413A; Tr. 8549–50). [97]

In April 1971, the NHCMA third-party payments committee discussed medical care foundations and, in November 1971, the NHCMA long range planning and development committee meeting included a discussion of medical care foundations (CX 2415A–B, 2422A–B). At its 1973 annual meeting, NHCMA voted to establish the New Haven County Foundation for Medical Care. The Foundation was incorporated as a separate entity in May 1973 (CX 998C, 2424C; Tr. 8549). Following their incorporation of the Foundation, NHCMA's officers elected the original Board of Trustees (CX 2604D, 2428C, 2416, 443). Thereafter, NHCMA selected two members of the

Foundation's trustee nominating committee (CX 992E, 994D, 2428E). In 1975, every NHCMA officer and executive committee member also served on the Foundation's Board of Trustees (CX 994D; RNHX 2). NHCMA officials were the Foundation's chairman of the board, secretary and treasurer in 1975 (CX 994D; RNHX 2). Currently, the Foundation president is the NHCMA vice-president (Tr. 8550).

NHCMA has loaned the Foundation $4,999 on an interest-free basis (RNHX 138B; Tr. 8550). NHCMA, through its officers and its public relations committee, promotes membership in the Foundation (CX 2418, 2416D, 998G, 1276A–B; Tr. 8522–23, 8564). Until the Foundation's bylaws and articles of incorporation were amended in 1977, membership in the Foundation was limited to members of NHCMA and other county medical societies (CX 2428A, 2604B). Its membership meetings have been held at the same time and place as NHCMA membership meetings (CX 2428B, C). NHCMA and the Foundation still share the same building (Tr. 8550). The Foundation is now acquiring acceptance and getting final approval for operation, and has signed up 580 participating physicians (Tr. 8548; RNHX 152, 155; CX 994C, 998C, 2424B). Participating physicians will be compensated on a fee-for-service basis for services rendered to Foundation subscribers where the services are covered by the foundation health plan (CX 2416B, 2424B, D, G).

The Foundation is designed to serve as a spokesman for physicians by presenting a unified front in negotiations with third parties (CX 2414A, C, 2416A). It will require that third party carriers agree to follow fee guidelines based on physicians' usual and customary fees and on the 1971 CSMS *Relative Value Guide* (CX 2413A, 2424C). In addition, participating physicians will receive the advantage of direct payment, thereby reducing their collection problems (CX 2424D). [98]

The Foundation provides a means for NHCMA's primarily fee-for-service physicians to confront the competitive threat of closed-panel health maintenance organizations (CX 2415A, B, 2424D). NHCMA's early plans for the Foundation show this motivation:

> Currently, HMO's are springing up everywhere. The neighborhood corporations in New Haven will soon probably get a grant to create an HMO. At the moment, HMO's are approaching the doctors as individuals. What is needed is a foundation to give the physicians a unified roof to come under. A foundation gives the doctors a big voice in policy. HMO's gives [sic] doctors virtually no voice. (CX 2415A).

The Foundation is also designed to put its participating physicians "in a secure position to continue their current private fee for service practices" in the event Congress passes national health insurance legislation incorporating independent practice association HMO's

(CX 2424K). Through the Foundation, physicians participate in the development of standards for quality control and peer review, rather than having them "imposed from outside sources" (CX 2424D), thereby retaining "control of medicine's destiny in the hands of the practicing physician" (CX 2413A).

C. Peer Review Activities

81. NHCMA's Board of Censors and the Third Party Payments Committee together comprise the NHCMA Peer Review Committee (Tr. 8442), which assists NHCMA's members by helping resolve disputes between physicians and third-party payers and between physicians and patients (CX 1354A, B, 2433, 995F, 429; Tr. 8442, 8467). With the possible exception of the NHCMA Executive Committee, the Peer Review Committee is by far the most active of NHCMA's committees (Tr. 8465). In 1975, the Committee received about 90 complaints; approximately two-thirds of the complaints were fee related (CX 429, 995F).

Pursuant to an official vote by the NHCMA membership that physicians should be reimbursed on the basis of their usual and customary fees (CX 1177C), the Committee handles the complaints of patients and of insurance companies that challenge physicians' charges (CX 1365, 995F). To resolve complaints that a physician's fees are too high, the [99] Committee has relied largely, at least through 1976, on the CSMS *Relative Value Guide* (CX 1354A, 2425, 2433, 1178; Tr. 8472) and a conversion factor geared to what NHCMA considers to be the usual and customary fees among its members (CX 1176A, B, 453; Tr. 8472–73). The Committee resolves the vast majority of its cases in favor of the physician where fees are concerned (CX 2425, 2433; Tr. 8535–36, 8546). As a rule, the Committee's suggested fee is usually at or near the maximum, according to the 1971 CSMS *Relative Value Guide* (CX 2425). According to the chairman of the NHCMA Peer Review Committee, the CSMS *Relative Value Guide* plays an important role in maintaining and solidifying loyalty among members of the medical profession (CX 1178B). The NHCMA membership adopted a resolution in October 1975, reaffirming its support of the CSMS *Relative Value Guide* and urged CSMS to print new copies and distribute them to all new CSMS members (CX 988D).

NHCMA members have been kept informed of the conversion factor used by the Committee (CX 455). When the Committee feels it is appropriate, the conversion factor has been adjusted upwards to accommodate for increases in the consumer price index (CX 995F, G,

1358). Patients who have submitted grievances about physicians' fees are not invited to Peer Review Committee meetings (RNHX 112A).

The Committee's 1974 annual report stated that the problems almost exclusively relate to medical fees and the majority of grievances stem from third-party payers. Further, the Committee stated, "The hour has come for forthright dialogue with insurance companies in regard to medical fees . . . The payor wants to call the tune but we continue to base our consideration of fees on the Connecticut *Relative Value Scale* adopted in 1971" (CX 1354).

D. Efforts to Influence Government Action

82. NHCMA and its officials actively promote the economic interests of NHCMA's members through lobbying and legislative activities. In 1974, NHCMA wrote to Congress opposing extension of Economic Stabilization Act controls on physicians' fees, protesting that optometrists, opticians and psychologists were exempt from controls while opthalmologists, psychiatrists and other physicians were not exempt (CX 1277). NHCMA also protested that health maintenance organizations were being given special treatment [**100**] not available to private practitioners (CX 1277). The NHCMA Board of Governors wrote an official letter to nine state senators and 37 state representatives in 1974 urging repeal of the $150 annual physicians' license registration fee in Connecticut (CX 1276A, B, 1278, 441). NHCMA issued a newsletter, "Call to Action," urging its members to join the NHCMA leadership in a grassroots effort against continued price controls on physicians' fees and against the licensing fee of $150 (CX 1278).

In 1975, NHCMA maintained an active legislative program at the state level to resolve the malpractice crisis by seeking limits and ceilings on the liability of the practitioner (CX 995B, L, 674B).

In a 1972 letter to the Connecticut Commissioner of Insurance, NHCMA protested against Connecticut Blue Cross marketing efforts for a closed-panel HMO "in direct competition with the rank and file of taxpaying practitioners" (CX 962). In 1974, NHCMA urged the Department of HEW to deny extension of grant money to a closed-panel non-fee-for-service health maintenance organization (CX 966; Tr. 8569). NHCMA supported increased federal funding for a professional standards review organization sponsored by NHCMA and directed by a former NHCMA president (Tr. 8451; RNHX 2A, C; CX 440).

NHCMA's executive secretary urged the CSMS Councilor representing NHCMA to press the Connecticut Welfare Department to bring the Medicaid program up to "usual, customary and reason-

able" levels and to make fee payments "acceptable to the average physician" (CX 448B). NHCMA's president urged its members to contact their state legislators in opposition to extension of a seven percent sales tax on professional services (Tr. 8567–68).

In its semi-annual report to NHCMA members issued in October 1975, the NHCMA Board of Governors reported on NHCMA's lobbying and legislative activities, stating: "Comments generally reflecting AMA policy continue to be directed to the Secretary of the Department of Health, Education and Welfare, and various Senators and Representatives. The NHCMA's voice is being heard in Washington and we believe it to be influential" (CX 995B). That same year, NHCMA's president reminded its members that because AMA had gone "to bat for all of us," there were improved Keogh Act benefits, but no price controls on physicians' fees, no national licensure and no precertification of hospital admissions (CX 247). [101]

E. Other Activities

83. NHCMA operates an active public relations program (CX 1361C; Tr. 8562–67). NHCMA's public relations activities serve to enhance the image of physicians and NHCMA, to promote the New Haven County Foundation for Medical Care and to keep NHCMA members informed on legislative and economic issues affecting the private practice of medicine (CX 2418; Tr. 8564–65, 8566–67). Aside from executive office salaries, NHCMA spends more on public relations than it does on anything else (CX 1361C; Tr. 8562).

NHCMA sponsors valuable insurance programs for the benefit of its membership (CX 329A, 324B, 327A, B; 243A). These include income protection insurance (CX 995K, 329A), in-hospital insurance (CX 324A) and major medical and group protection insurance (CX 323A, 327).

NHCMA intervenes with local hospitals on behalf of local physicians to assist them in getting hospital privileges (CX 442, 443, 445, 446, 447).

The president of COMPAC, Dr. John Mendillo (RCX 68, p. 2; Tr. 8389), has served simultaneously as an NHCMA and Foundation official (CX 247, 323, 994D, 1391B, 2604D). He reports on COMPAC's activities at NHCMA meetings (CX 173C, 998D, 988C), urging NHCMA's members to support COMPAC and stressing the impact on physicians of legislation passed in Congress and the state legislature (CX 998D, 1391C, E).

F. Federal Income Tax Status

84. NHCMA is exempt from federal income taxation under Section 501(c)(6) of the Internal Revenue Code (CX 1393. *See also* F. 50, pp. 60–61).

IX. RESPONDENTS' ETHICAL CODE AND ITS ENFORCEMENT

A. The Ethical Code

85. According to AMA publications, the earliest written code of ethical principles for medical practice was conceived by the Babylonians around 2500 B.C. That document, the Code of Hammurabi, set forth in considerable detail from that era of history the nature of conduct demanded of the physician. The Oath of Hippocrates, [102] conceived some time during the period of Grecian greatness, probably in the fifth century B.C., has come down through history and remained in Western Civilization as an expression of ideal conduct for the physician. The most significant contribution to ethical history subsequent to Hippocrates was made by Thomas Percival, a physician of Manchester, England, who published his *Code of Medical Ethics* in 1803 (CX 462E).

At the first real meeting of the AMA in Philadelphia, in 1847, a Code of Ethics based on Thomas Percival's Code was adopted. The language and concepts of this original Code have remained the same throughout the years despite revisions. In 1957, AMA's House of Delegates adopted a shortened version of the Code, known as the "Principles of Medical Ethics," consisting of 10 brief sections. This version, which remains in effect today, preserved the basic ethical principles of the earlier versions, eliminating only certain items dealing with professional manners and etiquette together with prolixity and ambiguity (CX 462E, F; RX 1, pp. 3–5). Promulgation and enforcement of this ethical code has been a significant function of the AMA since its inception (CX 959Z28).

The AMA Principles of Medical Ethics ("Principles") apply to all physicians, "be they group, clinic or individual and be they great and prominent or small and unknown" (CX 462I, 517B). The AMA Judicial Council stated, in 1971, that a physician "must be as scrupulous in observing his principles of ethics as he is in observing principles of law" (CX 519E). The Principles apply to the entire country—"[A] procedure unethical in one part of the country cannot be ethical under the same circumstances in another" (CX 461I, 517B).

The Judicial Council, a standing committee of AMA's House of Delegates (CX 990U), exercises the judicial power of AMA (CX 990X). Its five members are physicians nominated by AMA's president and

elected by its House of Delegates (CX 990V, 1769A). The AMA Bylaws state that "[t]he [Judicial] Council shall have jurisdiction on all questions of medical ethics" (CX 990X). The Judicial Council's role is to interpret the Principles and to review and hear actions based on infractions of the Principles (CX 1769B, 486A, 462Z48–Z49). AMA publishes the Judicial Council's ethics interpretations periodically under the title, *Judicial Council Opinions and Reports ("Opinions and Reports")* (CX 462–67). Many of the ethics interpretations published in *Opinions and Reports,* including many of those governing advertising and contract practice, [103] have been adopted or approved by AMA's House of Delegates (*Compare* CX 462I, J, Z–5 through Z–15 *with* CX 463F, G, P–W). In December 1975, when the complaint in the instant proceeding was issued, the 1971 edition of *Opinions and Reports* was in effect (CX 462; Motion of Respondent American Medical Association for Reconsideration of Issuance of the Complaint in this Docket, filed January 14, 1977, at p. 9). A revised edition was issued in March 1977 (RX 1, Tr. 4335). AMA has distributed thousands of copies of both the Principles and *Opinions and Reports* to medical societies, individual physicians and medical students (Complaint and AMA, CSMS and NHCMA Ans. ¶ 7; Response of American Medical Association to Motion of Complaint Counsel to Determine the Sufficiency of its Responses to Request for Admissions, dated July 26, 1977, at p. 106, Request #19(a); CX 482, 667, 1774–76, 1779, 1788–89).

CSMS has widely distributed the AMA Principles and interpretations of them to its members. It has included copies of the Principles in the information packets supplied to new members (CX 202, 1748, 212; Tr. 3714–15), distributed copies of the Principles and interpretations of them directly to county medical associations, CSMS members, NHCMA members and others (CSMS Adm. 19(b), (c), filed June 20, 1977 and July 29, 1977), and published the Principles or interpretations of them from time to time in the CSMS publication, *Connecticut Medicine,* which is sent to CSMS members (CSMS Adm. 19(b), (c), filed June 20, 1977 and July 29, 1977).

NHCMA has distributed copies of the AMA Principles and interpretations of them to its members and others (NHCMA Adm. 19(d); filed June 20, 1977 and July 28, 1977), and has published these ethical pronouncements from time to time in the NHCMA publication, *Issues and Insights,* which is sent to NHCMA members (NHCMA Adm. 19(d), filed June 20, 1977 and July 28, 1977). In response to NHCMA's request, AMA has sent copies of its 1971 *Opinions and Reports* and and its guidelines for telephone directory listings to NHCMA (CX 1787, 672, 673).

AMA's 1974 *Report on Physician-Hospital Relations* (CX 959) contains most of AMA's ethical restrictions on physicians' contractual arrangements with third persons, some of which also are printed in the 1971 *Opinions and Reports* (CX 959Z63–Z64, 462Z12–Z13). The *Report on Physician-Hospital Relations,* approved by the AMA House of Delegates in 1974 and copyrighted in 1975 (CX 959B, C), was included in the Proceedings of the House of Delegates, summarized in *American Medical News* (distributed to every member of AMA), published separately in booklet form (over 5,000 copies distributed) and sent to each state and large [104] county medical society (Motion of Respondent American Medical Association for Reconsideration of Issuance of the Complaint in This Docket, filed January 14, 1977, at p. 7).

B. The Ethical Code Enforcement Process

86. AMA, CSMS, NHCMA and most of AMA's other constituent and component medical societies have made adherence to the AMA Principles of Medical Ethics a condition of membership (CX 990I, 991D, 1404I). AMA's constituent and component societies have adopted bylaws which provide that the AMA's Principles of Medical Ethics shall govern the conduct of their members and that unethical conduct shall be grounds for expulsion (*see* Appendix A attached hereto). The AMA's House of Delegates has adopted a resolution making state medical societies' own ethical principles binding upon the respective association's members provided that the principles are not inconsistent or in conflict with the Constitution and Bylaws of AMA (CX 1435Z20). NHCMA's bylaws specifically provide that its members are governed by the AMA's Principles of Medical Ethics "as reflected in the [AMA] Judicial Council" (CX 1404I). AMA has declared it the duty and obligation of its local medical societies to initiate enforcement of AMA's ethical standards and to insure full compliance with the spirit and intent of the Principles of Medical Ethics (CX 462Z9 [Sec. 5, Op. 20]). AMA has frequently urged its constituent and component societies to fulfill this obligation (CX 462Z1 [Sec. 4, Op. 9], Z2 [Sec. 4, Op. 14], Z5–6 [Sec. 5, Op. 9], Z6 [Sec. 5, Op. 11], Z6–7 [Sec. 5, Op. 12], Z7 [Sec. 5, Op. 13], Z9 [Sec. 5, Op. 20], Z10 [Sec. 5, Op. 23], Z40 [Sec. 10, Op. 4], Z45 [Sec. 10, Op. 13], 26B, 54, 488B–C, 489, 662B–C, 673A, E, 845, 1392C, 1810). AMA has declared that when a physician disregards "local custom," as determined by the local medical society, he has acted unethically (CX 1439, 462Z9–Z10, 27). AMA advised one local society that compliance with AMA's ethical principles should be achieved through "education prospectively and disciplinary action retrospectively" (CX 662B). NHCMA

and other component societies of AMA frequently investigate alleged breaches of AMA's ethical standards and convey their concern to the physicians involved by letter, telephone or personal meeting (*see, e.g.*, F. 95, p. 119; 98-100, pp. 124-32; 103-07, pp. 135-43; 110-11, pp. 145-46; 112, pp. 147-48; 113-14, pp. 148-52; 117, pp. 154-56; 119, p. 160, 120-22, pp. 160-71; 123, pp. 172-73; 136-37, pp. 194-98). [105]

AMA acts as a clearinghouse to promulgate, interpret and enforce ethical restrictions by conveying its ethical policy statements to the state and local medical societies and by conveying statements of various local medical societies to other medical societies (CX 54, 91, 1287, 1435Z33, 2121; Tr. 4919, 4939); by referring complaints and inquiries to the appropriate constituent or component medical society for action (CX 23, 168, 667, 768B, 820B, 1293B-D, F, G, 1295, 1296, 1299, 1316, 1763, 1764, 1776); and by sponsoring national and regional conferences on medical ethics (CX 1769C, 1791, 1792, 1793, 1796, 1797, 1798). AMA constituent medical societies, including CSMS, provide ethics guidance, refer complaints to appropriate local societies and sometimes trigger local enforcement activity by filing complaints themselves (CX 718, 113, 114A-B, 976, 971A-B, 969A, 975A, 2572E, 825, 1868, 859A, 2563-65, 2544, 123, 127, 132A-B, 61, 62, 68, 723, 725, 2035, 8, 10, 848, 850).

If a physician persists in an alleged ethics violation or the conduct is considered serious enough, a local society can discipline the physician through formal proceedings (CX 662B, C, 1789A, B). If found guilty the accused physician has the right to appeal to the state medical society (CX 1764A). CSMS's bylaws provide for such appeals (CX 991L). If the state society's decision is also adverse and the accused physician is a member of AMA, then the physician may appeal to AMA's Judicial Council (CX 990K).

The Judicial Council has both original and appellate jurisdiction (RX 2, pp. 20-21). The Judicial Council has original jurisdiction in all disciplinary proceedings involving direct members of AMA (CX 990K) and in all controversies arising under the Principles to which AMA is a party (CX 990X). The Judicial Council also has discretionary power to investigate, and by request to the President, initiate formal proceedings regarding complaints or evidence of unethical conduct of greater than local concern (CX 990X, Y). A state medical society can request the AMA Judicial Council to institute disciplinary action against a physician who violates the Principles (CX 990K). The Judicial Council's decision is final (CX 990X, 1435Z27, B).

In the last 35 years, the only case brought under the original jurisdiction of the Judicial Council, *Matter of Earl F. Hoerner* (1965), involved a charge of plagiarism of a scientific paper presented at an

international medical [106] association meeting (Tr. 4320–21; RX 275A–C). The appellate jurisdiction of the Judicial Council has been invoked in approximately one case per year over the past 35 years (Tr. 4325). Appellate review, which is initiated by the filing of an appeal from a decision of a state medical society, is limited to questions of law and procedure (Tr. 4326–27).

In the past 35 years, the Judicial Council has decided only one case touching upon the issues in this proceeding, *Matter of Ben E. Landess, M.D.* (1955) (Tr. 4328). At issue in *Landess* was the ethical propriety of two newspaper advertisements and a promotional brochure for H.I.P., a prepaid group medical plan which contracted with physicians to provide services for a fixed salary (RX 274A–B). The state and local medical societies had each concluded that, by continuing in association with H.I.P. despite knowing of the advertising in question, Dr. Landess had engaged in the "unethical solicitation of patients" (RX 274A). The Judicial Council of the AMA disagreed (RX 274C).

The Connecticut respondents have a system by which complaints are referred by local societies to CSMS in appropriate cases (CX 136B). For instance, in February 1977, NHCMA referred to CSMS the complaints of competing ophthalmologists that a New Haven opthalmologist's telephone directory listings were unethical (CX 136C–F, 137).

AMA also regularly engages in informal actions to apply and enforce its ethical code. The Judicial Council staff, including the former Department of Medical Ethics (CX 1769A, C, 1766A), works closely with state and local medical societies on ethics matters (CX 1766A, 1767A, 1769C, D). The Judicial Council and its staff frequently provide guidance, which includes suggesting specific courses of action to constituent and component medical societies who have requested advice on ethics issues. AMA responds to frequent inquiries from individual physicians and others as to whether a particular activity is ethical (CX 8, 23, 25, 109–10, 117, 119, 170A, 798–99, 814–15, 820, 830–31, 841, 868–69, 1196, 1349, 1753). In these opinion letters, AMA often refers the inquirer to the appropriate local society after indicating AMA's position on the activity in question, which is normally based on the Principles and the Judicial Council's *Opinions and Reports* (CX 23, 109, 667, 798, 820B, 830B, 1295, 1349, 1753B). Many of these letters were written by Edwin J. Holman, the long-time Secretary of the Judicial Council and Director of the Department of Medical Ethics (*see, e.g.,* CX 1768, 557A, 505A, 1475A, 1349). AMA Field Service representatives [107]

have also been used to coordinate ethics enforcement on a nationwide basis.

87. The constitutions and bylaws of AMA, CSMS, NHCMA and most of AMA's other constituent and component medical societies provide for the disciplining of any member who violates the AMA Principles of Medical Ethics. Medical society disciplinary proceedings may culminate in reprimand, censure, suspension or expulsion; if the alleged ethics violator is not a member, then denial of any application for membership may be ordered (*e.g.,* CX 990K, X–Y, 991D, L–M, 1404I–J, 477L–P, 748N–O, 14H, L, 47G–I, M–P, 1825E–F, L–M, 473U, X–Z4, 472C–D, F–H, R, 475H, I, M–N, 474B, F–G, J–K, 1413A, 1418B–C, 1421, 1422, 1426; Tr. 1346–47). Expulsion or exclusion from a component medical society often leads automatically to exclusion from the state medical society and AMA because, generally, a physician must be a member of a local medical society in order to be a member of a state medical society, and a member of the state society in order to be a member of AMA (*see* F. 4, p. 6).

AMA and its constituent and component societies have exercised their authority under their respective bylaws to impose formal sanctions on their members with regard to many areas relating to medical practice, including those involving questions of medical ethics (*see* F. 99, pp. 130–31; 110, p. 145; 120, p. 160–66; 122, pp. 168–71; 148, pp. 211–12; CX 493, 511A–B, 515C–D, 518, 525C–D, 531D–F, 543B–C, 553A–B).

Constituent and component societies of AMA have taken formal disciplinary actions against members who allegedly have violated the restrictions on advertising and solicitation in the AMA Principles and the *Opinions and Reports.* (*See, e.g.,* F. 98–100, pp. 124–32; 110, p. 145; 112, pp. 147–48; 113–14, pp. 148–52; 120–22, pp. 160–71; 136–37, pp. 194–98; 148, pp. 211–12).

AMA and its constituent and component medical societies have frequently taken informal action to enforce AMA's ethical restrictions on advertising, solicitation, and contract practices (*see, e.g.,* F. 95, pp. 118–21; 96, pp. 122–24; 101, p. 133; 102–07, pp. 134–43; 109, p. 144; 111–12, pp. 146–48; 115–17, pp. 152–56; 118–19, pp. 157–60; 123, pp. 172–76; 132–33, pp. 187–91; 134, p. 192; 135, pp. 192–94; 137, p. 198; 138, p. 199; 148–49, pp. 212–21; 151, pp. 223–26).

The threat of disciplinary action by medical societies is extremely effective, for membership in the medical society is an important and valuable asset to the physician (CX 503M. *See also* F. 23–49, pp. 38–59; 62–72, pp. 84–91; 79–83, pp. 96–101). Actions to enforce AMA's ethical standards may deprive the disciplined physician of valuable

rights and affect his or her reputation, professional status or livelihood (CX 462Z2, Z3 [Sec. 4, Op. 15]), including: [108]

(a) Possible loss of malpractice insurance (*see* F. 98, p. 129; 110, p. 145; 121, p. 167; 149, p. 221; CX 1328, 1331A; Tr. 5472–73);

(b) Withholding of claims reimbursement by health insurance carriers (*see* F. 113, pp. 148–50);

(c) Possible loss of referrals and other patronage (Tr. 5473. *See* F. 98, pp. 124–29; 100, pp. 131–32; 103–04, pp. 135–38; 106, pp. 140–41; 111, p. 146; 117, pp. 154–56; 120, pp. 160–66; 122, pp. 168–71).

(d) Possible loss of hospital staff privileges (CX 1977, 1907, 143, 1965G–I, L, 1965Z3, Z4, 1964M, 1963J; Tr. 5528–29, 5531, 286, 288–91, 1908. *See* F. 114, pp. 151–52; 122, pp. 168–71).

(e) Inability to deliver papers and display exhibits at professional society meetings (F. 120, pp. 164–65);

(f) Time spent away from practice and attorney expenses (F. 98, p. 129; 104, p. 138; 121, p. 168; 122, p. 169); and,

(g) Professional disgrace, embarrassment and humiliation (F. 99, pp. 130–31; 110, p. 145; 113, pp. 148–50; 121–22, pp. 167–71; 136, pp. 194–97; CX 73B, 123, 984, 975C; Tr. 1925, 1927).

Actions to enforce AMA's ethical restrictions on solicitation, advertising and contract practice have deterred reputable physicians from repeating the conduct which allegedly violated the restrictions (F. 98–100, pp. 124–32; 103–07, pp. 135–43; 110–11, pp. 145–46; 112, p. 147; 113–14, pp. 148–52; 117, pp. 154–56; 121, pp. 167–68; 123, p. 172; 132, p. 187; 135–37, pp. 192–98; 148, pp. 213–15). Most physicians abide by medical society ethics (CX 516D, 1392B, 1407; Tr. 9535, 554, 5787).

C. State Medical Licensing Boards

88. Robert C. Derbyshire, M.D., Secretary-Treasurer of the New Mexico Board of Medical Examiners testified in this proceeding (Tr. 6723, *et seq.*). He has been president of the Santa Fe County Medical Society, the Bernalillo County Medical Society and the New Mexico Medical Society (Tr. 6725). He has also served as president of the Federation of State Medical Boards of the United States, [109] the association of state medical licensing and disciplinary boards (Tr. 6727–28). He has written extensively on the subjects of medical discipline, education and licensing, including a book entitled *Medical Licensure and Discipline in the United States* (Tr. 6730–31). In 1977, the Federal Trade Commission commissioned Dr. Derbyshire to prepare an analysis of the relationship between state medical

licensing boards and state medical societies, and the effectiveness of state regulation of medical disciplinary cases.

Dr. Derbyshire sent questionnaires to each of the state boards and prepared a report for the staff of the Federal Trade Commission (Tr. 6734–35), entitled "Functions of State Licensing Boards in the United States" (RX 80ZA–Z34; Tr. 6734–35). Dr. Derbyshire concluded in his report that members of state boards of medical examiners are selected in one of four ways. In three states, members are elected by the state medical society. In another 14 states, the governor appoints members from a list of physicians submitted by the state medical society. Members in the remaining states are appointed by the governor with or without the aid of a list provided by the state medical society, and occasionally subject to legislative approval. In 10 of these states, the governor is required to consider a list of candidates submitted by the medical society but is not bound by their recommendations (Tr. 6738; RX 802E–G).

The responsibilities of state medical licensing boards include issuing medical licenses either by endorsement or examination, administering examinations, monitoring the continuing education of physicians where state law so provides, publishing directories and exercising investigatory and disciplinary functions (Tr. 6741–42. *See* Appendix B, 310–12, *infra* [*State Statutes Regarding Physician Advertising and Solicitation*]). The most common problem with which state licensing boards must contend is narcotics addiction among physicians. Other primary concerns in the area of medical discipline include narcotics prescription violations, mental or physical incompetence, obtaining a license by fraudulent transfer, fraud, conviction of felony and alcoholism (Tr. 6742–44; RX 802Y–Z). State licensing boards have seldom taken disciplinary action against physicians for the dissemination of false or misleading advertising (Tr. 6744–45). **[110]**

Dr. Derbyshire testified that the funds and staff received by the New Mexico Board are sufficient to allow it to carry out its duties (Tr. 6749); however, 20 of the state boards which responded to Dr. Derbyshire's questionnaire stated that they lack adequate resources to enforce the laws within their jurisdiction. Dr. Derbyshire was of the opinion that medical society regulation of physician advertising would be of great assistance to state licensing boards (Tr. 6751–53).

X. RESPONDENTS AND OTHERS HAVE RESTRAINED PHYSICIANS' SOLICITATION AND ADVERTISING

A. Present Sources of Information about Physicians

89. The choice of a physician is an important decision for a consumer to make (RX 656, p. 5). There are differences among physicians and forms of medical care delivery (CX 718E); thus, consumers need as much information as possible on which to base this decision (Tr. 2370). Specific fee information is important to consumers in comparing and choosing among physicians (RX 267, p. 7; RX 666 inside front cover and pp. 1, 5; Tr. 9320–21, 5771–72, 2290, 2312, 2479, 2528–29, 2548, 2370). There are variations in physicians' fees for similar services (RNHX 149; RX 407, 666 Appendix C; Tr. 633–36, 1815).

Older citizens, who often live on fixed incomes, need to know whether or not a physician will accept Medicare reimbursements as payment in full for services rendered (Tr. 2479, 2481–84; RX 666, pp. 5–6). Numerous other items of information are helpful to consumers in choosing a physician, including (RX 267, 489, 526, 656, 666, 677; RNHX 149; Tr. 2479, 2289, 2312–13, 2548, 2528–29, 2370):

(1) Physician specialty;
(2) Solo or group practice;
(3) Physician age and number of years in practice;
(4) Medical school, internship, residency, and fellowships;
(5) Specialty board certification or eligibility; [111]
(6) Teaching positions;
(7) Hospitals to which physician admits patients;
(8) Office hours and after-hours coverage;
(9) Appointment required;
(10) Acceptance of new patients (any minimum or maximum age);
(11) Willingness to make house calls;
(12) Proximity of public transportation;
(13) Availability of free parking or other parking facilities;
(14) Availability of ramp, elevator, wheelchair; whether office access requires climbing stairs;
(15) Prescription of birth control devices;
(16) Performance in office of x-rays, electrocardiograms, blood tests, urine tests, pregnancy tests, throat cultures and pap smears;
(17) Prescription of drugs by generic names;
(18) Fees for particular services and tests;
(19) Acceptance of Medicare and Medicaid patients;
(20) Acceptance of Medicare reimbursements as payment in full;
(21) Acceptance of credit cards;
(22) Languages spoken; and
(23) Willingness to make patient's records available to the patient. [112]

Hospital and business institutions, like individual consumers, need information about physician and other medical services. Hospitals, for example, need information on the comparative costs and other features of available pathology services (Tr. 295, 304). Many companies need information on occupational health programs to improve the working conditions of their employees (Tr. 2061, 2064-65, 1028-29, 1931-32, 9328).

90. Consumers lack access to sufficient information to make an informed choice of a physician (Tr. 5759; 5415-16, 2367-68, 2523; RX 267, p. 1, 489, p. 1a, 666, p. 1; CX 679F). Physicians generally do not advertise except for occasional announcements, in some localities, of the opening, closing or moving of an office, the addition of an associate to a practice or a physician's limitation of practice to a specialty (Tr. 9539, 5812, 7253, 7590, 5291-93, 5483, 5886-87, 9318).

Yellow Pages telephone directory listings of physicians provide only the name, address, telephone number and, in some locations, the specialty and office hours of physicians (Tr. 2368, 2526-27, 2492, 2551, 5760-61, 2291). Also, while the Yellow Pages may list physicians who have died, retired or moved away, it frequently fails to list physicians who have recently established practices (Tr. 2526-27).

Some medical societies have referral services which supply consumers with the names, addresses, telephone numbers and specialties of physicians from a rotating list. They generally do not provide information about the physicians' fees, education, hospital affiliations or accessibility. The limited information may not be adequate to satisfy all consumer needs (Tr. 2293-94, 2295, 2301-02, 2310-11, 2525-26, 2530, 2552, 2368, 8247-48; RX 296A-B).

Directories of physicians, such as AMA's *American Medical Directory* (RX 11-14) and the national *Directory of Medical Specialties* (Tr. 2368-70), provide general, although limited, information about physicians. Some of the information in these directories may be out of date—the current edition (Tr. 4000-01, 4003) of the *American Medical Directory* is based on 1973 data (RX 12, p. ii). At $125 a copy (RX 12, p. ii), the *American Medical Directory,* the only directory of all physicians in the United States, be they members or nonmembers of the AMA (Tr. 3997), is prohibitively expensive and impractical for most consumers. [113]

There is record evidence about several local directories of physicians which have been prepared and distributed in recent years. In each instance, there was a perceived need, usually by physicians and medical societies, for such a directory to provide consumers with information about physicians and medical care (Tr. 5759 [Pima County, Tucson, Arizona], 5415-16 [Lane County, Eugene, Oregon],

2367–70 [Catawba County, Hickory, North Carolina], Tr. 7566 [Northwestern Denver, Colorado], Tr. 5958 [Allegheny County, Pittsburgh, Pennsylvania], Tr. 9596 [New Haven, Connecticut]; RX 267, p. 1 [Hennepin County, Minneapolis, Minnesota], 489, p. 1a [Lane County, Eugene, Oregon], 666, p. 1 [Allegheny County, Pittsburgh, Pennsylvania]). Except in isolated instances (Tr. 5845–46, 5770–72, 5950; RX 666), physicians' directories sponsored by local medical societies frequently omit information relating to individual physicians' fees, acceptance of Medicare reimbursements as payment in full, special facilities, and other aspects of physician availability and services (RX 267, 489, 526, 656, 677). The directories may contain information which, because of publishing lag time, is out of date and possibly inaccurate (RX 407, p. 1, 489, p. 1a, 656, p. 5); publication of updated editions is not assured (Tr. 7556–57, 5470). In any event, these directories have received little attention from consumers in the service areas that they purport to cover. In the Denver metropolitan area, with a population of approximately two million people, only about 700 copies of a medical society-sponsored physician directory were sold to consumers in the first nine months after publication (Tr. 7551–53, 7573). Dissemination of other physician directories also has been minimal (Tr. 5774, 5779, 2398, 5468, 5888–89, 5987–90). Advertising that directories are available is needed (Tr. 9355).

Personally contacting a number of individual physicians' offices to obtain sufficient information about doctors is time-consuming and can be frustrating (Tr. 2311–12, 2145, 2526–27). The search time involved in finding a physician through a telephone canvass of physicians' offices is increased in communities where many physicians are not accepting new patients (Tr. 2311, 2145, 2484, 2527, 2535, 5811, 2719), or where a consumer is looking for a physician who offers a particular service in a particular georgraphic area (Tr. 2291–92).

Information on physicians obtained by word-of-mouth does not in itself provide an adequate basis for selecting a physician (Tr. 2525, 2552–53, 2292, 2297, 9319–20). [114] The small number of physicians a consumer can learn about from his friends and relatives may not provide the type of services that the consumer is seeking or be in a location convenient to the consumer (Tr. 2525, 2552–53). For a newcomer in a community of newcomers, word-of-mouth information may be largely unavailable (Tr. 2292, 2297). Moreover, word-of-mouth information spread from one consumer to another is anecdotal (Tr. 9537), reflects the speaker's personal preferences (RX 297, p. 1) and may prove faulty (Tr. 9320).

Information about health care systems is also needed by consum-

ers, but sources and types of information are limited or lacking (Tr. 9318, 9354, 9409). Information that health care delivery systems can make available to consumers is limited by ethical restrictions (Tr. 478–81, 498–506, 520–29, 547–48, 846–52, 870–76, 1031–48, 1115–42, 1555–62, 1812–30, 2061–76, 9190–91). Dr. Ebert, former dean of the Harvard University Medical School (Tr. 9312–14), testified in regard to health care systems and consumers' need for information about such systems as follows:

> It is very hard, it seems to me, today for patients to know very much about how they get into that system. Obviously, one way is through advertising. When I say different systems, there are groups of physicians that provide a complete range of services on a fee for service basis and there are so-called medical foundations that do this on, to some extent, on a prepaid basis and there are the so-called HMO's and these all have certain qualities about them and it seems to me that advertising would permit a far greater access to information of the general public so it is for that reason I state I am in favor of it (Tr. 9318–19. *See also* Tr. 478–81).

Dr. William Davis, an AMA witness who testified about the preparation and publication of a directory of physicians in the Tucson, Arizona area, summed up the inadequacy of current sources of information on physicians when he testified that the greatest single problem in American medicine is that medicine is really not in the marketplace—that the consumer has no way to shop for health care and that consumers need to be able to identify health care providers (Tr. 5759). [115]

B. AMA's Ethical Standards Restrict Advertising and Solicitation by Physicians

91. The AMA Principles of Medical Ethics ("Principles"), the 1971 AMA *Opinions and Reports* and other AMA medical society interpretations of the Principles prohibit solicitation of patients and severely restrict advertising and solicitation of patients by physicians. Section 5 of the AMA Principles of Medical Ethics states that a physician "should not solicit patients" (CX 462Z4; RX 1, p. 5).[4] Opinions 6, 11, 12, 13, 18, 23, and 29 of Section 5 in AMA's 1971 *Opinions and Reports* also contain absolute prohibitions on solicitation of patients or patronage, whether directly or indirectly, by a physician or by groups of physicians (CX 462Z5–Z11). For example, Opinion 6 states, *inter alia,* "Solicitation of patients, directly or indirectly, by a physician or by groups of physicians, is unethical"

[4] Section 5 of the Principles of Medical Ethics reads as follows:

> A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

(CX 462Z5). Opinion 12 states, *inter alia:* "The ethical principle remains: No physician may solicit patients. A physician may not do indirectly that which he may not do directly. He may not permit others to solicit patients for him" (CX 462Z7). In its 1971 *Opinions and Reports* (CX 462Z13) and 1974 *Report on Physician-Hospital Relations* (CX 959Z64), AMA defined "solicitation" as "to seek professional patronage by oral, written or printed communications either directly or by an agent." This definition has been adopted by the AMA House of Delegates (*Compare* CX 463V *with* CX 462Z13).

92. AMA's ethical ban on solicitation has included a ban on almost all advertising. Advertising, by its very nature, is a method of soliciting business (Tr. 9716-18). In 1973, the Assistant Secretary of AMA's Judicial Council (CX 512A) stated that, "The Principles of Medical Ethics strictly proscribe the solicitation of patients by physicians. This, of course, includes advertising" (CX 778A). [116]

AMA's 1971 *Opinions and Reports* confirms that a physician who advertises is in violation of the ethical ban on solicitation. Opinion 6 of Section 5 declares that the ban on solicitation "protects the public from the advertiser . . . by establishing an easily discernible and generally recognized distinction between him and the ethical physician" (CX 462Z5). Opinion 4 of Section 10 provides, *inter alia:*

> The refraining from or the employment of advertising is the clearly defined difference between a reputable physician and a quack . . . .
>
> * * * * * * *
>
> . . .[T]here is every reason why the medical profession shall keep up its barriers against the self-advertising of individuals for selfish purposes and no adequate reason why these barriers should be let down. (CX 462Z39-Z40).

Opinion 13 of Section 7 states that, "The medical profession must oppose any prepayment on postpayment program that might result in advertising or solicitation of patients by physicians. . ." (CX 462Z22).

93. In May 1975, the Chicago Medical Society's Ad Hoc Committee on Advertising sent draft guidelines on advertising to the Society's Council in a report, stating: "In its deliberations the committee recognized that there was no mention of the word, 'advertising,' in the Principles of Medical Ethics of the American Medical Association. The term, 'solicit,' however, does appear. It is a simple transition to suggest that advertising is one method of solicitation of patients" (CX 2121A).

Statements of a number of AMA's member societies further show the sweeping nature of the ethical prohibition of physician advertis-

ing. In 1972, respondent CSMS's executive director declared that, " 'Advertising' is prohibited by medical ethics" (CX 30, 31).

In October 1973, the Judicial Commission of the Michigan State Medical Society stated in an ethics advisory letter that "individual physicians or groups of physicians are not [117] permitted to advertise their services under the provisions of the American Medical Association Code of Ethics. . ." (CX 1602G). In May 1974, the Judicial Commission's members reiterated "[t]he ethical principle that physicians are not allowed to advertise under any circumstances. . ." (CX 1607B).

In May 1974, the Chattanooga and Hamilton County (Tennessee) Medical Society wrote to a physician that a particular "announcement in the newspaper should be so worded as to avoid the appearance of advertising, which, as you know, is unethical according to the AMA Code of Ethics" (CX 108).

The president of the Allegheny County Medical Society in Pittsburgh wrote, in December 1974, that "it is considered unethical for doctors to advertise or to compete for patients. . ." (CX 2182A, B).

In April 1975, the Tennessee Medical Association's House of Delegates adopted a resolution, "That the Tennessee Medical Association and its component county medical societies re-emphasize and insist upon the ethical practice of medicine, that physicians may not advertise their services individually or collectively" (CX 1868).

In May 1975, the minutes of the proceedings of the Massachusetts Medical Society reported that the chairman of its Committee on Ethics and Discipline stated, in response to a question, that it was unethical for a group of physicians to advertise just as it was unethical for an individual physician to advertise (CX 877A).

94. AMA's 1971 *Opinions and Reports* permits only limited exceptions to AMA's ban on advertising by physicians (CX 462Z6, Z9). AMA has issued ethics interpretations setting forth the parameters within which its component medical societies can judge physician advertising and has suggested specific courses of action for the medical societies to follow. Opinion 20 of Section 5 in AMA's 1971 *Opinions and Reports* declares:

> The component medical society must, in the final analysis, determine what practice is in accord with local custom, but in so doing, it should exercise great caution to insure full compliance with the spirit and intent of the Principles. The practice of medicine [118] should not be commercialized nor treated as a commodity in trade. Respecting the dignity of their calling, physicians should resort only to the most limited use of advertising . . . . (CX 462Z9).

In 1967, the Secretary of the AMA Judicial Council advised a

component society inquiring about a large sign on a physician's lawn advertising certain medical treatments that it "suggest to the physician that this sign was, in the opinion of the Society, contrary to the honor and dignity of the profession and should be removed . . ." (CX 91).

In June 1975, AMA advised a component society that:

> Advertising of course, should be kept to an [sic] minimum. If permitted at all it should be permitted only under the most rigid requirements established by the county medical society. Some societies have adopted the position that a small dignified announcement . . . may be made on not more than two consecutive weekly occasions. (CX 54).

AMA's 1971 *Opinions and Reports* declares that when a physician disregards "local custom," as determined by the local component medical society, he has acted unethically and may be subject to disciplinary action (CX 462Z9 [Sec. 5, Op. 20], Z10 [Sec. 5, Op. 23], Z7 [Sec. 5, Ops. 13, 14], I–J [Preamble, Op. 4]).

C. Restrictions on Dissemination of Information about the Price, Type and Availability of Medical Services

1. *Restrictions on Dissemination of Price Information*

95. In 1974, an organization in Bergen County, New Jersey, specializing in preventive medicine, submitted to the local medical society a proposal to send a form letter to the Mayors and Councils of the 72 communities in the county (CX 112B). The proposed form letter offered physical examinations for the communities' firemen, police [**119**] and volunteer ambulance corpsmen at $50 each (CX 112B). A local medical society official forwarded the proposal to AMA, commenting: "I question the ethics involved and feel that it borders on solicitation. However, in all fairness to the group, they do have a tremendous investment and do need to get their message out" (CX 112A). Edwin Holman, Director of AMA's Department of Medical Ethics, responded: "I agree with you that this letter is out and out solicitation of patients or patronage as proscribed by Section 5 of the Principles of Medical Ethics and Opinion 11 thereunder, a copy of which is enclosed" (CX 111).

In 1969, a Minnesota physician wrote to AMA stating that he was contemplating running a pap smear clinic for one week during which he would reduce his fee for a pap smear and pelvic examination by one-fourth. Stating that he wished to alert the community to the program through newspaper and radio announcements, the physician asked AMA for its opinion (CX 170A). The Assistant Secretary

of the AMA Judicial Council (CX 524A) cautioned the physician against sponsoring the newspaper and radio announcements:

> The kind of public announcements which are necessary could be made by the local medical society but should not be made by individual practicing physicians. This should be a project open to all physicians in the community. Ethically you can notify only your own patients. Announcements to the general public should be made only by the medical society. (CX 170).

In 1972, respondent CSMS referred a complaint to the Fairfield County Medical Association, one of its component societies, about a physician's newspaper box advertisement stating that patients could attend two evening sessions at his smoking clinic for $35 (CX 78B, C). The county society then advised the physician to cease and desist from advertising in violation of accepted principles of ethics and sent him pertinent pages from the AMA's 1971 *Opinions and Reports* on the subject of advertising and clinics (CX 78A). The county society forwarded a copy of its informal opinion letter to CSMS (CX 78A). [120]

In 1972, CSMS's executive director advised a local Chamber of Commerce in Niantic, Connecticut, that " 'Advertising' is prohibited by medical ethics, and hence any public listing of physicians who had signed up for a '10% discount program,' however worthy in purpose, would be considered unethical" (CX 30). CSMS advised the president of the group considering the senior citizen discount program that "discounting, in general, is a *business* practice rather than a *professional* one. For this reason, it is contrary to the recommendation of the Judicial Council of the American Medical Association that physicians do not employ business practices in conducting their professional activities" (CX 30)(emphasis in original).

In 1975, a group of internists in Virginia asked AMA whether it would be ethical for them to include their fee schedules in a brochure describing their practice that was designed strictly for the patients being seen by the group (CX 110). In response, the Secretary of the AMA Judicial Council stated he was "negative" on the proposal, since it "might very well be interpreted or looked upon by your colleagues . . . as a suttle [sic] and indirect form of solicitation[,]" that "[T]here might be some question as to weather [sic] or not a brochure such as this is in keeping with the traditions and ideals of the medical profession" and "it might very well be thought of as a commercialization of the profession" (CX 109A–B).

At a meeting of an ad hoc committee of the Chicago Medical Society charged with preparing guidelines on physician advertising, it was mentioned that fees should not be listed in physician announcements (CX 2117A, B). The guidelines subsequently issued

by the Chicago Medical Society in 1975 omitted fees from the list of items of information which a physician or health plan could include in newspaper announcements (CX 2122B, C; 2121). Edwin Holman, Director of the AMA Department of Medical Ethics, attended meetings of the ad hoc committee as an AMA consultant and approved the committee's final report (CX 2121; Tr. 4919, 4939).

The Illinois State Medical Society drafted "Guidelines for Consumer Information Materials (Physician Directories)" in 1975 for its component medical societies to apply in their communities (CX 718). Quoting the AMA Judicial Council's 1974 opinion on physician directories, which [121] forbids inclusion of "self-aggrandizing" statements in directory listings (CX 718B, 507B, D; F.134, pp. 191–92), the Guidelines stated that a physician directory "should not be a comparison of fees" (CX 718B). The Guidelines also declared that "ISMS does not recommend publishing individual physician's fees" (CX 718G). Other AMA member societies have opposed the inclusion of fee data on individual physicians in community directories (CX 2178C, 2179A, 680, 2035, 2186A, D, 2303B, 2304; RX 887; Tr. 2383–84, 2410, 5460–63).

Mount Auburn Hospital, in Cambridge, Massachusetts, placed a full-page advertisement in the February 26, 1976, edition of a Cambridge newspaper (CX 880B, C). Subsequently, the Massachusetts Medical Society's Committee on Ethics and Discipline met with the hospital's executive director "concerning the appropriateness of the newspaper advertising" (CX 882). With respect to the same advertisement, the chairman of the Ethics and Discipline Committee advised a Boston area health maintenance organization in August 1976 that it was "not acceptable to include reference to . . . amounts of charges . . . in any sort of publication of this type" (CX 882).

The Santa Clara County (California) Medical Society approved a policy on physician advertising and promotional activities in February 1976, stating that, "[a]dvertising for the purpose of self-aggrandizement or solicitation of patients is prohibited. This pertains to . . . statements regarding. . . cost. . ." (CX 751A, E).

In August 1976, the state medical society in Maryland published a compendium of ethical pronouncements which begins with the AMA Principles of Medical Ethics (RX 308, pp. 27–66). One such pronouncement, citing the AMA Judicial Council as authority, stated that "[p]rofessional notices are permissible, provided they do not carry listing of fees or any other material not in keeping with the dignity of the medical profession" (RX 308, p. 31).

In numerous instances, physicians have been admonished by their local medical societies for sending out brochures and letters which

included fee or billing information among other things (F. 99, pp. 130–31; 110, p. 145; 112, pp. 147–48; 136, pp. 194–97).

Physicians establish "usual" fees for the services, procedures and tests they perform (F. 40, p. 51; Tr. 7726–30; RX 267, pp. 7–8; CX 2186D, 705H; RX 407, p. 5; RX 526, p. 7; RNHX 149C; CX 738, 979C, 4A, 1866C–E; RX 251B). [122] These services, procedures, and tests are identified and coded in standardized terminology and relative value guides used by physicians, respondent medical associations, insurance companies and governmental agencies (F. 40, p. 52; 63, pp. 85–86; 81, pp. 98–99; RX 18, pp. 155–71; Tr. 7729–30). During the period of federal price controls in the 1970's, federal regulations required all medical practitioners to post a sign in their facilities announcing the availability for public inspection of a schedule showing their customary prices for those services which accounted for 90 percent of their aggregate annual revenues (CX 2602). From this evidence, it is concluded that physicians' fees are readily capable of being publicized in a nondeceptive manner.

2. *Restrictions on Dissemination of Other Information on Individual Physicians' Services*

96. In 1969, two obstetrician-gynecologists in St. Paul, Minnesota, drafted a five page office brochure describing their facilities, hours, office procedures and hospital affiliations (CX 114B–G). The physicians planned to distribute the brochure to new patients who came to their office and not through the mail. They wrote to the Minnesota State Medical Association for clarification of any possible ethical problems before using the brochure (CX 114B). The Medical Association's executive director sent the brochure to the Director of the AMA's Department of Medical Ethics with a request to "give your opinion and advise me so I can inform the physicians" (CX 114A). The AMA official replied:

> In 1954 and at other varies [*sic*] times since then the Judicial Council has reviewed drafts like this. It has expressed the opinion that they are contrary to the spirit of the Principles of Medical Ethics. The brochure extols the facilities, qualifications and services of individual physicians and in the opinion of the Judicial Council this amounts to advertising which is comparable to the advertising of commercial services. (CX 113).

In June 1972, a physician in San Francisco wrote to an insurance company offering to perform medical examinations for it. The letter briefly described the physician's [123] services and facilities and invited a representative of the insurance company to inspect his office (CX 25B). A claim analyst at the insurance company sent the

letter to the AMA's Department of Medical Ethics for its opinion (CX 24, 25A). AMA responded that the physician's letter constituted solicitation in violation of Section 5 of the Principles of Medical Ethics (CX 23). AMA also urged the claim analyst to send a copy of the physician's letter to the San Francisco County Medical Society for whatever action would be considered appropriate (CX 23).

In 1973, the president of the Erie County (Ohio) Medical Society wrote to AMA regarding the ethics of a small advertisement that a board certified thoracic surgeon had placed in newspapers and distributed by mail (CX 51C). The announcement contained only the doctor's name, address, telephone number and the statement that he was opening "a laboratory for Cardio-Pulmonary and Heart Catheterization diagnosis and office for the practice of Thorasic-Cardiovascular [*sic*] Surgery and Internal Medicine and Cardiology on July 1, 1973" (CX 53). The Secretary of the AMA Judicial Council responded by enclosing a copy of the 1971 *Opinions and Reports* and calling the local society official's attention to Opinions 16 and 17 of Section 5 (CX 52, 462Z8). He stated in his letter that:

> [A]ccepted practice would be for a committee of the local medical society to call this physician and politely advise him that his advertising is not in keeping with the custom of the local medical society, and ask him if he would refrain from advertising in such a way in the future. (CX 52).

In August 1975, the Director of the AMA's Department of Medical Ethics responded to a letter from a St. Louis physician asking how he could ethically notify industry of an increase in his office hours. The AMA official indicated it would be acceptable for the physician to advise patients currently on his active list of the increase in his office hours. However, the AMA official stated: "A physician may not solicit patients. To the extent that a notice to industry is considered solicitation by one's peers in the county medical society it is ethically unacceptable." A copy of this letter was sent to and received by the St. Louis County Medical Society (CX 1349). [124]

Further instances of action taken by local medical societies that restricted the dissemination of information on individual physicians' services may be found at F. 133–35, pp. 187–94).

3. *Restrictions on Dissemination of Information about Innovative and Alternative Forms of Medical Care Delivery*

97. AMA's 1971 *Opinions and Reports* provides that AMA's ethical principles, including those restricting advertising and solicitation, apply to medical clinics and groups as well as individual physicians (CX 462I, J, K, Z5, [Preamble, Ops. 2, 6, 8; Sec. 5, Op. 8]),

and that contractual arrangements between a physician and any health care organization that seeks professional patronage by oral, written, or printed communications are unethical (CX 462Z12, Z13 [Sec. 6, Ops. 2, 3]). In December 1974, the AMA's House of Delegates adopted a resolution declaring unethical any advertising by a prepaid medical care plan or a health maintenance organization which identifies any physician providing services to the plan's members or subscribers (CX 951). These ethical restrictions have been applied, *inter alia,* to prepaid group health plans, including health maintenance organizations, medical clinics offering specialized services and preventive medicine programs.

a. Innovative Clinics and Preventive Medicine Programs

Dr. Joseph LaDou-Peninsula Industrial Medical Clinic ("PIMC")

98. At least up to the trial of this proceeding, the Santa Clara County (California) Medical Society ("SCCMS"), an AMA component society, was prohibiting an industrial medical clinic from seeking new client companies through mailings or other direct contacts with company executives. As authority, SCCMS cited restrictions on solicitation and advertising in AMA's Principles and the 1971 *Opinions and Reports.* SCCMS's actions were prompted by complaints from competing medical clinics supplying similar medical services in the same area. SCCMS's actions have limited the growth of industrial medical clinics and hindered the potential extension of occupational health and safety services to hundreds of companies. [125]

There is increasing recognition that the workplace frequently creates health hazards for workers (Tr. 2053–54), a problem which Congress acknowledged in passing the Occupational Safety and Health Act of 1970, 29 U.S.C. 651 (a)(1970). Occupational medicine is the practice of caring for and preventing worker injuries. It includes industrial hygiene, health physics and safety (Tr. 2052). "We have learned in the last 30 to 40 years that the workplace creates a great deal of disease, and a specialty of medicine has developed to attempt to control the amount of exposure to stress and to toxic materials" (Tr. 2053). The occupational specialist works on "in-plant consultation, setting up programs of prevention of injuries in the first place, advising industry on how to monitor the health and safety of their workers and then to provide a treatment program for the injuries if they occur" (Tr. 2054).

Many small companies have failed to develop in-plant health and

safety programs for employees (Tr. 2061, 2064–65). They have given little attention to preventive programs and have relied largely on hospital emergency rooms for the treatment of injuries (Tr. 2061–62, 2065–66). Emergency rooms provide virtually no follow-up care (Tr. 2061). Santa Clara County, California, is a growing industrial community with a large number of small companies (Tr. 2057, 2061). It is estimated that only five percent of local industry has in-plant occupational safety and health programs (Tr. 2063).

PIMC was founded in 1969 by Dr. Joseph LaDou and three other physicians (Tr. 2054). It offers a package of services to local industry, *i.e.,* in-clinic services of preventive medical exams, care for worker injuries and illnesses and in-plant consultative and educational programs. PIMC, located in Sunnyvale, California, has on its staff four physicians in general medicine with an interest in emergency room care, three orthopedic surgeons, a neurologist, psychiatrist, dermatologist, cardiologist, radiologist and five physicians from Stanford University who operate an evening shift (Tr. 2055). It also has a group of para-professionals. The whole staff consists of about 80 persons. PIMC has 1200 active clients representing about 70,000 workers (Tr. 2056). Potential clients include about 10,000 employers in the immediate area that have no such program. PIMC is one of only three clinics offering local industry a comprehensive package of occupational health services; [126] the other clinics which compete with PIMC are the Sunnyvale Medical Clinic and the Palo Alto Medical Clinic (Tr. 2055, 2057–59, 2063).

PIMC's medical director, Dr. LaDou, who testified in this proceeding, is a board certified specialist in preventive medicine who has studied occupational medicine at the Stanford Research Institute (Tr. 2047–52, 2064–65). Dr. LaDou is a member of SCCMS and AMA (Tr. 2051).

In 1969, shortly after the founding of PIMC, Dr. LaDou was visited by a member of SCCMS's Ethics Committee (Tr. 2066). The official informed him that a physician member of Sunnyvale Medical Clinic had expressed concern at high levels in the Medical Society that PIMC's initial success at caring for local companies might cause some harm to Sunnyvale's occupational health program and to its physicians' private medical practices (Tr. 2067). The official reviewed with Dr. LaDou a suspicion that he was soliciting business, and directed his attention to the provisions in AMA's Principles and the 1971 *Opinions and Reports* dealing with the definition of unethical behavior and the solicitation of patients by physicians and clinics (Tr. 2067).

As a result of this contact by the SCCMS, Dr. LaDou felt it

necessary to obtain the Medical Society's guidance on promotional matters (Tr. 2066). Consequently, in August 1973, Dr. LaDou wrote to SCCMS for comments on a PIMC plan to send a general mailing to newly established companies in the area offering them a program of comprehensive occupational medical services (CX 758). SCCMS responded to PIMC's letter by stating that a general mailing to nonphysicians soliciting business was not acceptable (CX 757). This response effectively prevented PIMC from obtaining access to the vast majority of smaller companies in PIMC's service area which may have been in need of PIMC's services (Tr. 2070–71).

In October 1974, Dr. LaDou complained to the SCCMS that a clinic which competed with PIMC was soliciting lay executives of Santa Clara area firms in a manner which the Medical Society had told PIMC was impermissible in 1973 (CX 760). Dr. LaDou stated that if the Medical Society allowed the competing clinic to continue this solicitation, it would only be fair to permit PIMC to do the same (CX 760). The Medical Society responded by calling Dr. LaDou and the medical director of the competing clinic to a meeting of its Professional Standards [127] Committee (Tr. 2072–73). The Committee reviewed specific passages from the AMA's 1971 *Opinions and Reports* and gave the two physicians copies of the *Opinions and Reports,* with several provisions referring to restrictions on solicitation and advertising underlined (Tr. 2973–74).

In an April 1975, letter to Dr. LaDou, the SCCMS's Professional Standards Committee announced guidelines prohibiting outside industrial physicians from making any direct contacts with companies through personnel officers or other executives (CX 759). In a July 1975, letter to Dr. LaDou, the Medical Society's Professional Standards Committee stated that the guidelines also applied to nonphysician sales agents of industrial physicians (CX 1751). The letter quoted in full Opinion 6 of Section 5 of AMA's 1971 *Opinions and Reports,* entitled *"Solicitation of Patients, Direct or Indirect"* (CX 462Z5), and stated that the Committee "trusts that you will conform to the ethical standards of our medical community" (CX 1751).

Dr. LaDou interpreted the 1975 Medical Society guidelines to prohibit PIMC from talking to lay people about occupational health and safety programs and to deny PIMC totally the opportunity to expand occupational safety and health coverage in smaller industry in its area (Tr. 2076). Dr. LaDou and PIMC have abided fully by the guidelines with respect to nonclient companies (Tr. 2077). The only lay representatives PIMC has dealt with directly were the approximately 50 existing client companies of PIMC; Dr. LaDou testified

that he deals frequently enough with them such that he knows there will be little likelihood of his being reported to the local medical society (Tr. 2077). Due to fear of disciplinary action against him, Dr. LaDou has never made the general promotional mailing to Santa Clara area companies which he proposed in his August 1973, letter to the Medical Society (Tr. 2077–78).

In July 1976, the Santa Clara County Health Department asked PIMC to participate in the national Swine Flu Immunization Program by contacting both client and non-client companies in the county about PIMC providing immunizations to their employees (CX 762). PIMC accepted the invitation and mailed an announcement of immunization services to a number of area companies (Tr. 2083; CX 763). Physician members of the Palo Alto Medical Clinic and the [128] Sunnyvale Medical Clinic complained to SCCMS about PIMC's Swine Flu Program announcement (Tr. 2057–58, 2084–85). In October 1976, Dr. LaDou was called to a meeting at which three SCCMS officials informed him of the complaints against PIMC and again showed him a copy of AMA's *Opinions and Reports* (Tr. 2085–86).

In November 1976, SCCMS's Professional Standards Committee wrote Dr. LaDou regarding his involvement in the Swine Flu Program:

> While the Committee agreed that in the particular instance in question you exercised poor judgment, they did concur that your actions were not unethical to such a degree that disciplinary action would be justified at this time. They felt most strongly that, should the Committee learn of your involvement in any future incidents even *suggestive* of solicitation, they will be obliged to take more definitive action. (CX 765)(Emphasis in original).

Dr. Melvin Britton, chairman of SCCMS's Professional Standards Committee and author of the November 1976, letter, quoted above, is a partner in the Palo Alto Medical Clinic, which competes with PIMC (CX 765; Tr. 2057–58, 88). Upon inquiry, Dr. Britton informed Dr. LaDou that copies of the letter of reprimand had been sent to both the Palo Alto and Sunnyvale clinics (CX 766; Tr. 2092). Dr. LaDou expressed concern that the two complaining clinics could use the Medical Society letter to his detriment, both professionally and in business (Tr. 2091–92). Specifically, Dr. LaDou feared the impact which the letter might have on potential clients of PIMC:

> I find the client companies relying heavily on the local medical society. They call it the AMA. They say when they are looking for a new source of medical care, they will call the AMA and find out who is legitimate and who they would recommend. What they are in fact calling is the Santa Clara County Medical Society, [129] which is what the telephone operator would give you if you asked for the AMA. Under the circumstance like that, to show a letter, a stern warning to me for unethical behavior

to a potential industrial client would be very damaging in a competitive situation. (Tr. 2094).

Dr. LaDou wrote to Dr. Britton and requested that the letter be retracted because it was so damaging. To Dr. LaDou's knowledge, the letter has never been retracted (Tr. 2095). As a result of the SCCMS's actions, PIMC has reduced its marketing activity (Tr. 2077–78) and largely curtailed its in-plant consultative program both with large and small industry (Tr. 2097–98). It is estimated that PIMC's growth rate has been cut in half due to the Medical Society's restrictions (Tr. 2097–98).

The SCCMS's actions have also harmed Dr. LaDou. They have consumed a great deal of his time and have adversely affected him financially by drastically altering the way in which PIMC operates (Tr. 2096). The Medical Society's actions also have caused him a good deal of concern regarding his career in occupational medicine (Tr. 2096). Dr. LaDou particularly feared expulsion from SCCMS, which Dr. Britton told him had been considered in connection with the Swine Flu Program letter (Tr. 2096). Dr. LaDou testified that:

> [Expulsion] would be a terrible black mark in the career of a physician in my field . . . . In Santa Clara County, it is an impossibility in my specialty to buy malpractice insurance unless you buy it through the County Medical Society which controls the negotiation for its purchase. I am not at all sure I could practice without my membership in the Santa Clara County Medical Society (Tr. 2096–97).

The SCCMS's restrictions on the marketing activities of PIMC and other industrial medical groups have hurt consumers of occupational medical services in Santa Clara County. The Medical Society's actions have perpetuated an environment in which many industrial firms continue to have virtually no occupational safety and health programs for their employees (Tr. 2098). [130]

Dr. James Warren

99. James Warren, M.D., head of the Department of Obstetrics and Gynecology at Washington University Medical School, St. Louis, Missouri, testified in this proceeding. In his capacity as Department head, Dr. Warren is also medical director of the Washington University Center for Outpatient Gynecological Surgery ("Center"), which is staffed by members of the Department who perform various surgical procedures such as tubal ligations and pregnancy terminations on an outpatient basis (Tr. 721–23). In January 1975, to publicize the Center, assist its patients and clarify the guidelines under which pregnancies were being terminated, Dr. Warren prepared a brochure describing its facilities, services, specific fees

and office and billing procedures (CX 979A–E; Tr. 723, 725). At that time, the Center was unique among facilities performing abortions in St. Louis in that it was immediately adjacent to a complete hospital (Tr. 726–27). This enabled the Center to transfer quickly to a hospital operating room any patient developing complications in the course of outpatient surgery (Tr. 726). The brochure was distributed to physicians in the St. Louis area using the St. Louis Medical Society's facilities and mailing list; it was not distributed to the lay public (Tr. 724).

Several staff members at the Washington University Hospital objected to the brochure. They complained to Dr. Warren that the brochure implied that the clinic and its pregnancy termination procedures were sponsored by the entire medical school. Others told him that the mailing of a brochure was "low class" (Tr. 742–43). Dr. Warren, having "heard noises" (Tr. 744), on February 12, 1975, sent a letter addressed "To All St. Louis Area Physicians" apologizing for any misunderstanding the brochure may have caused and further stating that the brochure was not intended to imply that the clinic, the medical school or the hospital was taking a stand on abortion (Tr. 742–43, 764; CX 984). This letter was sent to approximately two-thirds of the physicians on the mailing list of the St. Louis Medical Society (Tr. 766).

In early February 1975, the Council of the Missouri State Medical Association passed a resolution providing, with respect to the Center's brochure, that "Washington University was to be reminded by the . . . Council that advertising and solicitation of patients was unethical" (CX 976). A week later, on February 14, 1975, the Council wrote to the dean of the Washington University School of Medicine declaring that the brochure "constitutes a breech [*sic*] of medical ethics regarding solicitation" (CX 971A). The letter referred to, and enclosed copies of, Opinions 6, 7, 8, 11 and 12 of Section 5 of AMA's [131] 1971 *Opinions and Reports* (CX 971A–B, 462Z5–Z7). At a meeting on February 14, the Ethics Committee of the St. Louis Medical Society considered the brochure and Dr. Warren's apology, and decided that the brochure was "patently unethical" advertising and solicitation (CX 969A). The Committee recommended that the Medical Society censure Dr. Warren (CX 969A).

In April 1975, the chairman of the Medical Society's Censors Committee wrote to Dr. Warren to inform him of the ethical charges of solicitation (Tr. 730–33). He enclosed a copy of AMA's Principles of Medical Ethics (Tr. 732–33; CX 982). At a meeting with Dr. Warren later that month, the Medical Society official told him that the controversy over the Center brochure could be put to rest if Dr.

Warren wrote a second apology letter (Tr. 737–42). In May, Dr. Warren sent a letter to the Censors Committee chairman apologizing for his actions and assuring the members of the Medical Society that he would not repeat them (CX 975C). Characterizing Dr. Warren's letter as one "in which the physician recants, repents and promises in the future not to repeat this action," the Censors Committee reported to the Medical Society's Council that the matter had been resolved (CX 975B). In early June 1975, the president of the Medical Society sent a form letter to all Medical Society members enclosing copies of Dr. Warren's letter of apology and the Censors Committee Report (CX 975A).

The medical clinic with which Dr. Warren is associated has never again put out a brochure about its activities (Tr. 754–55).

Dr. Richard Hansen

100. Richard A. Hansen, M.D., who testified in this proceeding, is the medical director of the Wildwood Sanitarium and Hospital, a rural hospital sponsored by the Seventh Day Adventists located on the outskirts of Chattanooga, Tennessee. Sometime in 1973, the hospital instituted a program at the local YMCA for residents of the Chattanooga area. The program, under the direction of a board certified internist specializing in cardiology, consisted of various tests to assess a patient's risk of experiencing a heart attack or other coronary disease (Tr. 1810–14). In the fall of 1973, the hospital's former medical director attended a meeting of the Chattanooga and Hamilton County (Tennessee) Medical Society to seek the Society's endorsement of the program (Tr. 1838). While the Society generally approved of the program, it declined to endorse it (Tr. 1839–40; RX 262). [132]

The program, called "Operation Heartbeat," charged each patient $25 for the package of tests, approximately half of what a hospital or private doctor in the area would have charged to administer the same tests (Tr. 1813, 1815). It received free publicity on radio, television and in the newspapers, and local stores placed posters announcing the program in their windows (Tr. 1812, 1815–16). Some of the printed publicity carried the name and picture of the program's cardiologist (CX 2005; Tr. 1816, 1821). The program was held three or four times in the fall and winter of 1973–74 (Tr. 1818). In 1974, the Medical Society summoned Dr. Hansen to a meeting of the Society's Board of Governors to inform him that the inclusion of the cardiologists' name and picture in Operation Heartbeat's publicity violated an AMA *Opinions and Reports* section on advertising (Tr. 1822–23). Dr. Hansen was told by a Medical Society official that it

was cardiologists in the area who had raised the objections about the program's publicity (Tr. 1820–21). After the meeting, the Medical Society sent Dr. Hansen a letter recommending that, if the program were held in the future, a physician licensed in Tennessee should conduct the program and that any future announcements of Operation Heartbeat should be worded so as "to avoid the appearance of advertising, which, as you know, is unethical according to the AMA Code of Ethics" (CX 108). Dr. Hansen dropped the program shortly after receiving the letter (Tr. 1829).

About a year later, Dr. Hansen sought the advice of the AMA as to whether the Operation Heartbeat advertising program was ethically permissible (CX 107). The AMA answered Dr. Hansen's inquiry and noted that "it is virtually impossible to evaluate a specific local program from the national level" (CX 106). It was suggested that Dr. Hansen seek the advice of his local medical society, which could "fully evaluate *all* the information in accordance with local practice . . ." (CX 106)(emphasis in original).

In 1977, the program was reinstituted but, because of the problems with the Medical Society in 1974, they have used no paid radio, television or newspaper advertising (Tr. 1833, 1835–36). The 1977 program is attracting only one-fourth to one-third of the enrollment averaged by the 1973–74 program (Tr. 1836). The lower enrollment may be attributable to the fact that the program has not been promoted (Tr. 1837). [133]

101. In November 1972, the Executive Director of the AMA component society in Toledo, Ohio, directed an ethics inquiry to AMA regarding circulation of physicians' names:

> Recently the Medical College of Ohio at Toledo sent a list of all of their specialists to all physicians in Northwestern Ohio. It is the feeling of the physicians in our community that this is a type of solicitation in that it was sent out to all physicians asking for referrals.
>
> Is there anything in the AMA Code of Ethics that covers this point? (CX 1752).

The Director of the AMA Department of Medical Ethics replied in December 1972:

> As you know, Section 5 says that the physician should not solicit patients. It is axiomatic that a physician may not do indirectly that which he cannot do directly. The mere fact that the College solicits patients on behalf of the specialists does not change the nature of the act.
>
> This is a situation that has occurred infrequently in several widely scattered college communities. Experience has very definitely indicated that beyond question that the best way to resolve situations like this is to convince the College that its practice is in

derogation of medicine's long established ethical principle, and demeaning to the profession as a profession and is unacceptable to physicians as individuals (CX 768).

Further instances of action taken by local medical societies resulting in restrictions on the dissemination of information about innovative and preventive medicine programs may be found at F. 111, p. 146; 112, pp. 147–48; 114, pp. 150–52; 115, pp. 152–53; 117, pp. 154–56. [134]

b. HMOs and Other Prepaid Group Practice Plans

102. Prepaid group practice plans, such as health maintenance organizations ("HMOs"), compete with the traditional fee-for-service system of delivering medical services, including private physicians and health insurance carriers (F. 28, p. 54; Tr. 484, 550). Advertising is important to HMOs in their early years as they try to build enrollment and reach a financial break-even point (Tr. 482–84).

AMA has promulgated several restrictions on prepaid group practice plans' advertising and solicitation activities, in addition to extending the ban on solicitation to physician groups and clinics and prohibiting contract medical practice involving solicitation (*See* F. 97, p. 124). AMA's 1971 *Opinions and Reports* declared that "[t]he medical profession must oppose any prepayment or postponement program that might result in advertising or solicitation of patients by physicians. . ." (CX 462Z22 [Sec. 7, Op. 13]). In 1973, and again in 1974, the AMA Judicial Council ruled that although a health maintenance organization could advertise its payment or insurance aspects, it could not ethically solicit patients (CX 512C–D, 510B–C). The Council noted that where one practice ends and the other begins may require astute investigation of the facts of the particular case (CX 510C).

The AMA House of Delegates addressed the issue of health plan advertising in a December 1974 resolution, declaring:

It is not unethical for a physician to provide medical services to members of a prepaid medical care plan or to members of a health maintenance organization which seeks members (or subscribers) through advertising its services, facilities, charges or other non-professional aspects of its operation as long as such advertising does not identify, refer to or make any qualitative judgment concerning any physician who provides service to the members or subscribers (CX 951).

Constituent and component medical societies of AMA which require their members to abide by the AMA Principles of Medical Ethics have issued further ethics interpretations restricting advertising [135] and solicitation by HMOs and other group prepaid health plans. The Tennessee Medical Association adopted a resolu-

tion, in April 1975, stating that "affiliation by physicians with health maintenance organizations or other medical or pseudo-medical facilities from which they receive patients by referral or for which they diagnose and/or treat patients for a consideration of any sort is unethical if the facility solicits or advertises in any way. . ." (CX 1869).

In February 1976, the Santa Clara County (California) Medical Society adopted guidelines for health plan advertising which prohibited public disclosure of the names of individual physicians, hospitals, university clinics or other facilities (CX 751D). The guidelines also included a provision stating:

> Physicians contracting for services with a health care plan should include a contractual statement to the effect that "both parties agreed that any requirements under this contract shall not jeopardize compliance with the American Medical Association's Code of Ethics or local Medical Society guidelines on advertising and solicitation of patients." (CX 751D–E).

Similar standards adopted, in mid-1975, by the Chicago Medical Society in consultation with Edwin Holman, the Secretary of the AMA Judicial Council, contained an almost identical provision (CX 2122B–C; F. 95, p. 120).

Florida Health Care Plan

103. Throughout the 1970's, the Florida Medical Association ("FMA") and one of its components, the Volusia County Medical Society ("VCMS"), have opposed the marketing activities and contract practice arrangements of the Florida Health Care Plan ("FHCP"), a federally qualified HMO in Daytona Beach, Florida (*See* F. 149, pp. 220–21). They have cited as authority for their actions various AMA pronouncements, including the Principles of Medical Ethics, which both medical societies have adopted as governing standards for their members (CX 2543K, 1916K; F. 149, pp. 220–21).

Medical society opposition to FHCP's operation has made it almost impossible for FHCP to recruit full-time staff physicians from the local pool of doctors (F.149, pp. 220–21; Tr. 9182, 9239). The necessity of hiring out-of-town physicians has interfered with FHCP's marketing because some potential subscribers have been reluctant to join an HMO whose staff physicians were unknown locally (Tr. 9182–83). Interference with FHCP's marketing has altered its cash flow to the point [136] that it has had difficulty hiring any new physicians. Trying to balance the number of staff physicians with the number of enrollees has caused financial problems for FHCP (Tr. 9182–83).

Dr. E. D. Davis, President, Chief Operating Officer, Chairman of

the Board and Medical Director of FHCP, testified in this proceeding (Tr. 9146, *et seq.*). In the spring of 1973, he discussed FHCP at a local meeting of the Rotary Club (Tr. 9187). In May, VCMS sent Dr. Davis an FMA Judicial Council opinion on HMO patient solicitation which stated:

> A physician who has any connection whatever with a health maintenance organization should take all reasonable steps at this [sic] disposal to prevent the use of his name, either directly or indirectly, in a manner which might influence the decision of any individual or group of individuals to subscribe to the services of the HMO (CX 2554, 2587).

VCMS advised Dr. Davis not to personally promote enrollment in the Florida Health Care Plan, Inc., and alerted him to the potential for formal disciplinary action against him on the basis of the FMA ethics opinion (CX 2587).

As a result of the VCMS letter, Dr. Davis gave no further talks on FHCP, regardless of the circumstances, and forbade other FHCP doctors from taking part in public discussions concerning HMOs (Tr. 9190). Since that time, FHCP physicians have not participated in the marketing efforts of the plan because they did not want to incur the displeasure of VCMS or FMA. The VCMS admonition put a damper on FHCP's marketing efforts. Having a physician involved in marketing activities would help FHCP establish credibility with subscribers and provide a source of answers to the technical questions which potential subscribers ask (Tr. 9191).

FHCP placed an advertisement in a newspaper at the time it received federal certification in 1975 (Tr. 9193–94). Since then, FHCP has not advertised or placed a listing in the Yellow Pages of the telephone directory because it could not get any clarification on the ethics of advertising in Volusia County and did not want to incur the displeasure of the state or local medical societies (Tr. 9194). As [137] required by federal law, FHCP has printed a list of its staff physicians and a brochure, but it never mails them out to the general public (Tr. 9192–93).

FMA has also challenged the ethics of FHCP's contractual arrangements with physicians (F. 149, pp. 220–21). As a result of the ethical restrictions on its marketing activities and contractual arrangements, FHCP has experienced increased operating costs and its development has been hampered (Tr. 9211–12).

Arizona Health Plan

104. The Maricopa County Medical Society, the AMA component organization in Phoenix, Arizona (CX 1568E), has hindered the

marketing efforts of two local HMOs through the application of ethical restrictions based on AMA's 1971 *Opinions and Reports.* The Arizona Health Plan ("AHP"), a state-certified HMO in Phoenix, supplies physician, hospital and other health services to approximately 40,000 subscribers on a flat-prepayment, non-fee-for-service basis (Tr. 78–79, 84). The Maricopa County Medical Society opposed AHP's early development, in 1970 and 1971, because it felt that the Plan was no different than a Kaiser-type closed panel system and was "unacceptable" to organized medicine (CX 1569, 1570A–B; Tr. 91–92). The Medical Society wanted the efforts to promote AHP terminated, in part to prevent it from competing with the Medical Society's own Maricopa Foundation (CX 902; Tr. 96–98). The Maricopa Foundation offers subscribers a plan for financing medical services obtained from privately practicing physicians on a fee-for-service basis (Tr. 97–99). The Foundation stated, in a December 1976 letter to its over 1200 participating physicians, that it is a "competitive alternative" to HMOs in Maricopa County and that it seeks to keep patients in the private practice sphere (CX 933).

The Maricopa County Medical Society has limited AHP's advertising and solicitation efforts. In 1972, the Medical Society issued a "Radio-Press and TV Code," which restricts individual physicians' and health plans' dissemination of information on their services (F. 120, pp. 160–66). In late 1972, after reviewing the AMA *Opinions and Reports* and the Medical Society's code, AHP's medical director, Dr. David F. Schaller, who testified in this proceeding, issued a set of guidelines limiting AHP sales representatives' distribution of the Plan's list of staff physicians in their marketing activities (CX 905; Tr. 105–07). AHP's marketing staff abided by these restrictions (Tr. 109). The restrictions impeded AHP's marketing efforts because potential subscribers frequently asked about AHP's physicians at sales presentations (Tr. 109–10). [138]

In 1974, the Medical Society adopted "HMO Guidelines," which prohibit most dissemination of HMO physician lists and forbid the inclusion of names or addresses of physicians or physician groups in HMO advertising (CX 898H–J). The Guidelines also require preclearance by the Medical Society of all HMO brochures, advertisements, sales talks and other sales materials, and generally prohibit HMOs from holding open houses for potential subscriber-patients (CX 898I–J).

The Medical Society's 1974 HMO Guidelines have handicapped AHP in its marketing efforts (Tr. 129, 142, 272). AHP has refrained from distributing lists of its staff physicians to potential subscribers (Tr. 114–15). The restriction on the holding of open houses has made

the recruitment of federal employee subscribers difficult for AHP (Tr. 130–31). Compliance with the advertising pre-clearance requirement has been time consuming and has hindered the scheduling of AHP's advertising program (Tr. 131–32).

Throughout the fall of 1975, the Medical Society sent letters to AHP declaring that certain aspects of its limited newspaper and radio advertisements violated the HMO Guidelines (CX 911, 913–16, 1966). Several of these communications were prompted by complaints about AHP advertising received from the chairman of the board of Blue Shield of Arizona, which owned another group prepaid health plan in Phoenix competing with AHP (CX 915B; Tr. 135). Complaints were also received from a private physician in Phoenix, who wrote the Medical Society:

> It [AHP] is in direct, open competition with me and every other private practitioner in the valley. The inevitable result of such advertising is that the group involved will gather more and more patients, getting stronger and stronger . . . . I frankly do not see why I shouldn't advertise. If they are permitted to . . . . While I think it better if no one did, I will not allow these people to have this advantage over me (CX 916B–D).

In a letter to AHP's medical director following up on both complaints, the Medical Society stated that the advertisements (CX 916D, 917E) "virtually disregard" the Society's HMO Guidelines (CX 1966). [139]

ABC–HMO

105. The Maricopa County Medical Society has also restricted the marketing efforts of the other group prepaid health plan in Phoenix, ABC–HMO, sponsored by Arizona Blue Cross-Blue Shield. In November 1972, several years after the founding of ABC–HMO, the Medical Society complained to the head of the physician group which staffs the health plan that two of its newspaper advertisements (CX 918B–C) "were definitely not in keeping with the professional ethics of the Maricopa County Medical Society" (CX 918A). The Society's letter quoted from its 1972 Radio-Press and TV Code (F. 118, p. 158) and from Opinion 8 of Section 5 of AMA's 1971 *Opinions and Reports,* restricting advertising and solicitation by physician groups (CX 462Z5, 918A). The Society underlined on the enclosed advertisements as objectionable certain references to the name of the HMO's physician group and the number of physicians participating in the plan (CX 918C). In response to the Society's complaint, the head of the HMO's physician group, Dr. Joseph Marcarelli, stated that "we have no desire or need to act contrary to the Society's code" (CX 920B).

In August 1975, two local physicians complained to the Maricopa County Medical Society about ABC–HMO newspaper advertisements which described the health plan's benefits and supplied the addresses and phone numbers of its five facilities (CX 924B–E). One of the complainants stated that physicians supplying the same type of medical care as ABC–HMO, but on a fee-for-service basis, could not advertise in the same fashion, and he called ABC–HMO's advertisements unfair (CX 924B). The chairman of the Medical Society's Professional Committee forwarded the complaints to Dr. Marcarelli and to Dr. John Foster, president of Blue Cross-Blue Shield of Arizona, for their comments (CX 922, 925). The Society official stated in a cover letter that the inclusion of the addresses of the HMO's facilities in its ads violated the Society's HMO Guidelines (CX 922). He noted that the HMO ads' emphasis on what the plans offer, particularly regular physical examinations, health education and immunizations, was something that physicians in private practice could not advertise (CX 922). In response, Dr. Foster stated that ABC–HMO had attempted to be very cautious in what it said in the ads and had had the ads reviewed by the County Medical Society staff before inserting them in the papers (CX 925). The Medical Society reiterated that its ethics guidelines prohibited inclusion [140] of the addresses of HMO facilities in advertisements (CX 927). Dr. Foster responded that ABC–HMO would see to it that its advertising did not include the addresses of its medical center locations (CX 928).

Harvard Community Health Plan

106. The Massachusetts Medical Society ("MMS") has restricted the advertising of the Harvard Community Health Plan ("HCHP"), an HMO in the Boston area, since the Plan's founding in 1969. When HCHP opened its doors to the public that year, its facilities and staff were equipped to serve 10,000 subscribers; yet, the health plan had enrolled only 88 subscribers (Tr. 450–51). The public was totally unfamiliar with HCHP's method of financing medical services (Tr. 478). Advertising could serve to familiarize the consuming public with HCHP's services and to help build enrollment (Tr. 478, 482–84). Blue Cross/Blue Shield and other fee-for-service health insurance carriers with which HCHP competes (Tr. 484–86) had long advertised their benefits regularly in the media (Tr. 486–87). Such advertising gave them a competitive advantage (Tr. 487).

In 1970, Blue Cross, with which HCHP was then affiliated (Tr. 451), placed several advertisements in the news media to promote the new health plan (Tr. 454–55). MMS received a number of letters

from physicians complaining that the HCHP advertising was attracting patients away from private practitioners (CX 2148, 2151B, 2153) and was unethical (CX 2147–51). The Society's Ethics and Discipline Committee discussed the complaints with HCHP and expressed concern over the ethics of pursuing advertising and widespread solicitation through the newspapers, television and radio (CX 2133). In 1971, HCHP agreed to refrain from advertising in the future (CX 2139–40) and instructed Blue Cross not to advertise on its behalf (Tr. 460).

Other MMS pronouncements in the next few years continued to restrict the content of HCHP's promotional materials. In response to an inquiry from the Secretary of AMA's Judicial Council in 1973, the MMS reported that HCHP had never distributed a list of its staff physicians to the general public (CX 874A). The Society stated that its Committee on Ethics and Discipline had stood firm in its belief that the names of participating physicians should not appear in any advertisements, whether in the newspaper or over the radio, and that HCHP was cooperating with this restriction (CX 874B). [141]

In 1974, HCHP's president, Robert Biblo, who testified in this proceeding, tried to persuade HCHP's physicians to authorize an advertising campaign (Tr. 466). The basic reason that no advertising was placed was because HCHP physicians refused, some feeling that "they did not need any hassle with the Massachusetts Medical Society" — that is, they did not want to experience a letter exchange with MMS and the bad publicity that would result, and a possible Society vote of condemnation (Tr. 468).

In May 1975, MMS printed in its own Council proceedings AMA's December 1974, resolution restricting HMO advertising (CX 877; F. 102, p. 134). Later in 1975, the Society's ethics committee objected to certain items in an HCHP brochure which HCHP subsequently removed (CX 879). In August 1976, MMS informed HCHP that "it was not acceptable to include reference to individual physicians' names, amounts of charges and references to the quality of care in any advertisements" (CX 882, 880–81).

In late 1976, the HCHP physicians, taking into consideration the instant FTC proceeding among other things, reversed their position and authorized the health plan to advertise in the media (Tr. 474–75). The medical director of HCHP proposed guidelines for the advertising which incorporate the AMA and MMS restrictions on HMO advertising (CX 883C, 877, 880A; F. 102, p. 134). The guidelines declare that HCHP advertisements should avoid qualitative statements about the professional staff and/or services offered and should not mention the names of staff physicians or the medical schools or

hospitals at which they trained (CX 883B). Prospective subscribers sometimes telephone HCHP to ask whether a particular physician is on HCHP's staff (Tr. 547). HCHP does not give out such information because giving out the names of staff physicians to nonsubscribers is "an unethical form of advertising" (Tr. 547–48). Mr. Biblo, HCHP's president, would like to see a "less bland" advertising approach, one which discusses the differences between HCHP's services and costs and those of fee-for-service physicians (Tr. 478–79, 481). HCHP does not do this sort of advertising today because it would prompt ethical objections among HCHP's physicians based partly on their feelings about how the Ethics and Disciplinary Committee of the MMS would react (Tr. 479, 481).

Metro Health Plan

107. Two private physicians complained to the Michigan State Medical Society, in April 1973, that Blue Cross-Blue Shield advertisements on behalf of its HMO in Detroit, the [142] Metro Health Plan ("MHP"), constituted unethical solicitation of patients (CX 1598, 1596). The physicians' letter asked the Medical Society to join them "in condemning this method of solicitation which is an attempt to drive the private practitioner and individual physician out of private practice in a very noncompetitive and ruthless style" (CX 1598). The Medical Society wrote to Blue Shield (Michigan Medical Service) about the ethics complaint (CX 1494), and Blue Shield submitted copies of its MHP advertisements for the Society to examine (CX 1583).

After reviewing MHP's advertisements, the Society's Judicial Commission notified Blue Cross-Blue Shield and the complaining physicians in October 1973, that:

> [S]ince individual physicians or groups of physicians are not permitted to advertise their services under the provisions of the American Medical Association Code of Ethics, neither is advertising in their behalf ethically acceptable, regardless of who is sponsoring or financing the advertising.
>
> Therefore the Commission adopted the following motion: "That the printed and spoken advertising for participation in the Metropolitan Health Plan of Michigan Medical Service is in fact advertising by physicians and that such advertising is in violation of the ethics of the American Medical Association and the Michigan State Medical Society" (CX 1602G–I).

The latter motion was published in the Michigan State Medical Society's November news bulletin (CX 1731A). Blue Shield asked the Medical Society to identify those references in the HMO's advertising—newspaper or radio—which it found disturbing (CX 1602K). The

Society responded that it was not the specific wording of the advertisements that was in question, but rather the entire concept that physicians were advertising (CX 1602L).

In March 1974, the Medical Society's Judicial Commission wrote to MHP, noting that MHP had not stopped advertising (CX 1602E). The Judicial Commission expressed its hope that MHP would stop advertising so that the Judicial Commission would not be forced to consider ethical charges against the [143] specific doctors participating in the Plan (CX 1602E). Following a Judicial Commission meeting attended by MHP representatives, the Judicial Commission, in June 1974, reaffirmed its earlier opinion that advertising by both physicians and HMOs was unethical and could lead to disciplinary action against the physicians involved (CX 1602B). The Judicial Commission relied for authority on AMA's Principles of Medical Ethics and Opinions 6 and 8 of Section 5 of AMA's 1971 *Opinions and Reports* (CX 1602B, 462Z5). In October 1974, the Medical Society's Judicial Commission reported that, as far as it was able to determine, MHP's unethical advertising had ceased (CX 1605).

D. Restrictions on the Methods Physicians Can Use To Advertise and Solicit Patronage

108. AMA and its constituent and component medical societies have restricted the methods physicians can use to seek patronage, including announcements, form letters and brochures (F. 109–12, pp. 143–48), newspaper advertising (F. 113–15, pp. 148–53), radio and television advertising (F. 116–17, pp. 153–56), publicity in the news media (F. 118–22, pp. 156–71), Yellow Pages listings (F. 23, pp. 171–76), business and consumer directories (F. 131–35, pp. 186–94), direct contact with institutions and physicians (F. 136–37, pp. 194–98) and others (F. 138–39, pp. 198–99).

1. *Announcements, Form Letters, and Brochures*

109. AMA and its constituent and component medical societies have severely restricted physicians' use of announcements, form letters and brochures to publicize their practices and the services they offer.

Opinion 16 of Section 5 of AMA's 1971 *Opinions and Reports* declares: "Announcements of the opening of an office should not be mailed indiscriminately to all persons in the community, nor should commercial mailing lists be utilized" (CX 462Z8).

Opinion 11 of Section 5 of AMA's 1971 *Opinions and Reports* permits "dignified" announcements, provided they do not amount to

solicitation, which is a question of fact to be determined locally by the local medical societies. Opinion 11 limits the content of such announcements to name, type of practice, location of office, office hours and the like (CX 462Z6).

Opinion 14 of Section 5 permits a doctor to send announcements regarding the need for follow-up care only to his own bona fide patients (CX 462Z7). The interpretation further provides: [144]

> They should be in good taste and should not serve to advertise the doctor or extol his abilities. Certainly no ethical physician would wish to use this device as a subterfuge for solicitation of patients, nor would he wish to engage in this practice if it were considered contrary to local customs and usages (CX 462Z7).

Opinion 17 of Section 5 provides that an announcement concerning the opening or removal of a physician's office is ethical if it is in keeping with the ideals of the profession and is a simple statement of fact without undue embellishment (CX 462Z8).

Opinion 20 of Section 5 declares that disregard of local medical society custom regarding circulation of professional cards violates AMA's own ethical standards. This Opinion states that physicians should resort only to the most limited use of advertising (CX 462Z9).

Constituent and component societies, which have adopted the AMA Principles of Medical Ethics as their code of ethics (*see* Appendix A, pp. 306–09, *infra*), have issued their own interpretations of AMA's ethical restrictions on physicians' announcements. In 1975, the Chicago Medical Society published guidelines on advertising, formulated in consultation with Edwin Holman, Director of the AMA Department of Medical Ethics (F. 95, p. 120). The guidelines quote Opinion 17 of Section 5 of AMA's 1971 *Opinions and Reports* regarding the permissible form and contents of announcements (CX 2122A–B, 462Z8). The guidelines restrict the distribution of new physician announcements to colleagues and pharmacists, specifically prohibiting distribution of them in or by pharmacies (CX 2122B).

The Hartford County (Connecticut) Medical Association has adopted "guideposts" permitting announcements to be sent only to friends, physicians, allied professionals and patients of record, and prohibiting any use of announcements as paid advertisements in the public press or any other media (CX 79A–D). The guideposts declare that the Hartford County Medical Association is governed by the AMA Principles of Medical Ethics and the *Opinions and Reports* of the AMA Judicial Council (CX 79C).

In numerous instances, the AMA and local societies have invoked the ethical restrictions on advertising resulting in the restraint of member physicians' distribution of announcements, form letters and

brochures (F. 110–12, pp. 145–48), even to other physicians (F. 110, p. 145; 112, pp. 146–47). [145]

Dr. Charles Arnold

110. In January 1973, Dr. Charles Arnold of Tacoma, Washington, sent a form letter to other physicians in Washington, Oregon, and Idaho, announcing the availability of his clinic to perform abortions (CX 126B–C, 126A, 122, 124). The form letter reported the clinic's hours and fees and enclosed a set of instructions for patients (CX 126B–C). Shortly thereafter, local medical societies in Oregon and Idaho wrote to Dr. Arnold and the Washington State Medical Association ("WSMA") to question the ethics of the form letter, which they termed "advertising" (CX 126A) and "solicitation" (CX 124), specifically noting that the cost was not excessive.

In March 1973, the Ethics Committee of the Pierce County Medical Society ("PCMS"), the AMA component society in Tacoma (CX 135A, B, 475H, K) of which Dr. Arnold was a member (CX 123), reported to the Society's president that the form letter was clearly an unethical practice and that the physician should be censured (CX 122). The next month, an official of the WSMA telephoned Dr. Arnold to discuss the matter (CX 123, 127). Dr. Arnold responded in writing that he regretted sending the form letter very much and would never do such a thing again (CX 123).

In December 1973, the Board of Trustees of PCMS charged Dr. Arnold with violating the Principles of Medical Ethics (CX 129). The Society accused him of mailing the form letter, permitting publication of an article describing his clinic and its fees in a local newspaper, and writing a letter published in a nationally distributed magazine complaining that the telephone company had refused to list his specialty (CX 129B–G). In charging Dr. Arnold with a violation of the Principles, PCMS quoted Opinion 6 of Section 5 in AMA's 1971 *Opinions and Reports,* entitled "Solicitation of Patients, Direct or Indirect" (CX 129B, 462Z5).

The PCMS Board of Trustees heard evidence on the charges and, on January 15, 1974, notified Dr. Arnold that the charges of unethical conduct were sustained and that the Board had recommended that he be expelled from PCMS (CX 131).

In January 1974, in response to a telephone call from Dr. Arnold, WSMA stated that, if PCMS revoked his membership, he would also lose his membership in WSMA and in AMA (CX 132B). WSMA also noted that Dr. Arnold would not be eligible to renew the WSMA Professional Liability Insurance Program sponsored by the Aetna Insurance Company if he lost his membership in the county and

state societies (CX 132B). In June 1974, Dr. Arnold withdrew his membership in PCMS (CX 133). [146]

Anthropometrics

111. Anthropometrics, Inc., a New Jersey firm based in the greater Philadelphia metropolitan area, operates a heart clinic and other medical facilities for the diagnosis and treatment of cardiac problems (Tr. 1020, 1022–27). In 1974, Anthropometrics established an Executive Fitness Control Center to provide comprehensive physical examinations and follow-up therapy to corporate executives in the Philadelphia area (Tr. 1028–29, 1031). To market the program, Anthropometrics placed three advertisements in the *Wall Street Journal* in July 1975, and mailed form letters to the presidents of 50 to 60 corporations (Tr. 1032; CX 744B, C). Included on the letterhead (CX 744B), but not in the advertisements (RX 368–70), were the names of the physicians who would be administering the program; this was done to establish the credibility and reputation of the program and show that it was "not just a health spa" (Tr. 1047–48). Anthropometrics' president, John J. Aglialoro, testified in this proceeding (Tr. 1017, *et seq.*).

In September 1975, the Philadelphia County Medical Society sent Anthropometrics a letter declaring that the form letters constituted unethical solicitation (CX 740). Two other AMA component medical societies in the metropolitan area, the Camden County Medical Society and the Gloucester County Medical Society, wrote Anthropometrics to request removal of the physicians' names from the firm's letterhead on ethics grounds (CX 741, 743). All three medical societies have adopted AMA's Principles of Medical Ethics as their codes of ethics (CX 756A, 747R, 1736A, B, 1889 O–P. *See also* Appendix A, pp. 307–09, *infra*).

In response, Anthropometrics stated that it would remove the physicians' names (CX 742), which it subsequently did (Tr. 1047). Anthropometrics also decided not to continue promoting the executive fitness program directly to corporations due to concern that the medical societies might censure the physicians associated with it (Tr. 1048). After receiving the letters from the medical societies, the firm phased out the program, partly because of the opposition of the medical societies to physician "solicitation" (Tr. 1051–52). Anthropometrics relies on referrals from local physicians for its patients (Tr. 1025).

Other Incidents

112. In 1971, AMA advised the Pennsylvania Medical Society that a physician who had recently acquired new specialized skills could not ethically publicize the fact by sending out form letters to other physicians (CX 120-21). [147]

In December 1972, the AMA's Department of Medical Ethics advised the Academy of Medicine of Toledo and Lucas County that a medical school's sending of a list of its specialists to physicians in the area constituted solicitation in derogation of medicine's long-established ethical principles (CX 768).

In March 1975, a radiologist serving as both an associate CSMS Councilor representing NHCMA and as the Secretary of the Radiological Society of Connecticut (CX 784A, 782), filed with the NHCMA Executive Committee a letter that had been sent by a radiology group practice to other physicians (CX 784A, B). The letter was intended to eliminate some of the questions that patients had had in the past concerning bills from the group's office (CX 784B). . .The NHCMA Executive Committee questioned the "medical ethics involved" and forwarded the letter to the NHCMA Peer Review Committee for review (CX 784A). The Peer Review Committee could find no strict interpretation applicable in AMA's *Opinions and Reports* (CX 786), and the Committee's chairman wrote to the AMA Medical Ethics Department for an opinion (CX 785). AMA responded in April 1975, that if the radiologists' letter constituted solicitation of business by means of seeking referrals from other physicians it was objectionable (CX 783A). Relying on the AMA letter as "substantive for our guidance," the NHCMA Peer Review Committee ruled that because the letter had been sent only to physicians who had already referred patients to the radiology group, it was not improper, but that such letters would be "faulted" as "advertisement" if sent to non-referring physicians (CX 781, 782).

In June 1975, NHCMA's Executive Secretary advised a physician that the NHCMA Executive Committee had voted unanimously to limit newspaper announcements of physician office openings and relocations to one day only (CX 81, 82). After receiving the NHCMA letter, the physician in question attempted to reduce from three to one the number of times his newspaper announcement was to appear (CX 82). He was unable to stop the second printing but succeeded in eliminating the third insertion (CX 82).

In 1975, a San Antonio, Texas, clinic specializing in treating athletic injuries, published a brochure describing its hours, services, office procedures, and billing arrangements (CX 2070). The Bexar

County (Texas) Medical Society's Board [148] of Censors summoned the clinic's physician to a meeting to discuss whether or not medical ethics had been violated by the brochure (CX 2070A). After the meeting, the Chairman of the Board of Censors wrote the physician:

> The Board of Censors is of the opinion that the folder, regardless of your fine intentions in publishing it, borders on advertising and is, therefore, contrary to the principles [sic] of medical ethics of the A.M.A. We realize that you intended for it to merely notify the patients of office procedures, etc., but it is our opinion that pamphlets of this nature invariably fall into the hands of the general public and then become solicitation of patients as frowned upon in Section 5 of the *Opinions and Reports of the Judicial Council of the A.M.A.* (CX 2071).

The letter then quoted Opinion 8 of Section 5 in AMA's 1971 *Opinions and Reports* (CX 462Z5), and ended by stating that the brochure should be recalled and not distributed (CX 2071).

In 1976, Innervisions, Inc., a mental health clinic in the Detroit area approved by Blue Cross, Medicare and Medicaid, published a brochure describing its facilities, services and staff (CX 1727B–S). In response to an inquiry from the Michigan Psychiatric Society (CX 1727A), the Judicial Commission of the Michigan State Medical Society ("MSMS") declared that this material did not appear to be in conformity with principles laid down by AMA and MSMS (CX 1726).

Further instances of actions taken by the AMA and local medical societies which have resulted in severe restrictions on physicians' use of announcements, form letters and brochures to publicize their practices may be found at F. 95, p. 120; 96, pp. 122, 123; 99, pp. 130–31.

2. *Newspaper Advertising*

Dr. Cyril Lundvick

113. In 1975, two medical societies in Washington State (CX 474B, 475H, K) relied on AMA's 1971 *Opinions and Reports* in an ethics action to stop a physician, new to the area, [149] from advertising in the newspaper. In late 1974, an ophthalmologist from Tacoma, Washington, Dr. Cyril Lundvick, moved his office to Kitsap County, Washington, and applied for a transfer of his medical society membership to the Kitsap County Medical Society ("KCMS") (CX 58–60). In January 1975, the ophthalmologist's name, specialty and address appeared in a one-inch space at the bottom of an optical dispensary's advertisement in the local newspaper (CX 61B). Early the next month, the physician, who chaired the local hospital's Department of Ophthalmology, wrote to the Executive Director of the Washington State Medical Association ("WSMA") stating that the advertisement might be a breach of professional ethics (CX 61A).

In February 1975, the Executive Director of WSMA wrote to the Executive Secretary of KCMS regarding the physician complaints about the ophthalmologist's advertisement (CX 62). The WSMA official called KCMS's attention to Opinion 6 of Section 5 of AMA's 1971 *Opinions and Reports* and stated that Dr. Lundvick's ad appeared to be contrary to it (CX 62).

The Kitsap Physicians Service is the local medical services insurance carrier (CX 838B, E). The Kitsap Physicians Service accepts as participating physicians only members in good standing of KCMS or other component medical societies of WSMA (CX 838E). In 1975, the Secretary-Treasurer of the Kitsap Physicians Service, Michael B. Merwick (CX 56A), was also the Executive Secretary of KCMS (CX 62). The President of KCMS, Dr. Michael Gass (CX 69), was a Director of Kitsap Physicians Service (CX 56A). Dr. Thomas Schubert, the partner of the physician who had filed the advertising complaint against Dr. Lundvick (CX 61A), was the President of Kitsap Physicians Service (CX 56A). On February 25, 1975, the Board of Directors of the Kitsap Physicians Service voted to withhold payment of Dr. Lundvick's patient insurance claims until the medical society completed its study of the ethics question regarding the advertising (CX 56B, 63).

KCMS determined that Dr. Lundvick's advertising was unethical (CX 64–65), and WSMA wrote to Dr. Lundvick to call his attention to the Principles of Medical Ethics, as they appear in the AMA's 1971 *Opinions and Reports* (CX 68). In its letter, WSMA quoted Opinion 20 of Section 5 in AMA's 1971 *Opinions and Reports,* which reads in part: "The practice of medicine should not be commercialized nor treated as a commodity in trade. Respecting the dignity of their calling, physicians should resort only to the most limited use of advertising. . ." (CX 68, 462Z9). **[150]**

The original complainant and a second ophthalmologist sent new complaints to KCMS about Dr. Lundvick's advertising in April 1975 (CX 66–67). The KCMS Ethics Committee summoned Dr. Lundvick to a meeting in May, at which time he stated that he would stop all advertisements placed by himself or the optician (CX 70). Dr. Lundvick submitted a letter to KCMS apologizing for "the entire affair" and stating that "this situation will never happen again" (CX 73B). Kitsap Physicians Service then stopped withholding payment of, and again began processing, Dr. Lundvick's patient insurance claims (CX 72).

Dr. Ralph Robinson

114. In 1976, a local medical society in Knoxville, Tennessee,

prohibited physicians from affiliating with clinics which advertised in the public media. The ruling, based on the advertising restrictions in AMA's 1971 *Opinions and Reports,* led a reputable abortion clinic in Knoxville to curtail its advertising efforts.

In the latter half of 1975, several abortion clinics, including the Volunteer Medical Clinic, were operating in Knoxville, Tennessee, and advertising in the Knoxville newspapers (Tr. 690, 652–53, 7598, 7600). The Volunteer Medical Clinic, staffed by Drs. Ralph Robinson and Catherine Gilreath (Tr. 636–37), was receiving referrals from Planned Parenthood (Tr. 7632) and the county health department (Tr. 640). The Clinic had not been the subject of any substantiated complaints regarding the quality of care it provided (Tr. 7630–31, 7676). A wholly unrelated facility (Tr. 7600), the Volunteer *Abortion* Clinic, was raided by the police, in August 1975, for performing "abortions" on women who were not pregnant (Tr. 7609–10). The local district attorney has since obtained felony convictions against several staff members of the Volunteer Abortion Clinic (Tr. 7617–18, 7625–26).

In August 1975, a Knoxville orthodontist complained about abortion clinics in a letter (CX 39) to the chairman of the Ethical Relations Committee of the Knoxville Academy of Medicine, the local AMA component society (Tr. 7648; CX 47A, Z2, Z3). The orthodontist wrote: "Since at least one of the physicians involved with the local abortion clinics (Dr. Catherine Gilreath of the Volunteer Medical Clinic) is a member of the Knoxville Academy of Medicine, cannot pressures be brought to bear upon your own society members which would help solve some of these problems?" (CX 39). **[151]**

At a meeting to discuss abortion clinic advertising on November 18, 1975, the Knoxville Academy's Judicial Council adopted a motion announcing that it "strongly supports" Opinions 6, 7, 8, 9 and 12 of Section 5 of AMA's 1971 *Opinions and Reports* relating to solicitation and advertising (CX 40A, 462Z5 - Z7). On January 20, 1976, the Academy's Judicial Council voted to go on record as being opposed to any member of the Knoxville Academy of Medicine performing medical or surgical procedures with any organization that advertises or solicits patients in the nonmedical media (CX 41). By letter of February 3, 1976, the chairman of the Judicial Council conveyed the January 20th motion to Drs. Gilreath and Robinson of the Volunteer Medical Clinic and to other physicians associated with Knoxville abortion clinics (CX 1932, 49, 41). That same day, Dr. Gilreath resigned from the Volunteer Medical Clinic, sending carbon copies to the Knoxville Academy and to Baptist Hospital (CX 43A).

Dr. Gilreath's resignation hindered the Volunteer Medical Clinic's operation. Complications are rare with first trimester abortions (Tr. 633); however, it sometimes becomes necessary to hospitalize a patient undergoing such a procedure (Tr. 650). Dr. Gilreath's resignation left no physician on the Clinic's staff with admitting privileges at any Knoxville hospital (Tr. 716–17, 657). The Clinic could get other doctors to admit its patients to hospitals, but this method was not preferred since it might result in unnecessary surgery if the patient was referred to a doctor who was not familiar with the case (Tr. 650–51, 716).

In early 1975, Dr. Robinson had applied for staff privileges at Baptist Hospital, partly to be in a position to hospitalize complicated cases from the Volunteer Medical Clinic on his own (Robinson 650). Dr. Robinson, who testified in this proceeding, is a board certified obstetrician-gynecologist, a consultant to several pharmaceutical manufacturers and the State of Kentucky and a twice elected president of his own Bell County (Kentucky) Medical Society (Tr. 625–28). The hospital rejected his application in late 1975 (Tr. 651–52), stating in a letter to him:

> [W]e understand your practice in this community will be largely related to one of the abortion clinics. Our Executive Committee questions the propriety and ethical considerations of the daily newspaper ads. Our concern is based upon the *Judicial Council Opinions and Reports* of the American [152] Medical Association; namely, on pages 24–25 [CX 462Z6, Z7] and I quote: 'The ethical principle remains: no physician may solicit patients. A physician may not do indirectly that which he may not do directly. He may not permit others to solicit patients for him.' Our By-Laws clearly state that any member of our staff must abide by the Code of Ethics of the American Medical Association (CX 48).

The Volunteer Medical Clinic receives approximately one-third of its patients through referrals from local physicians (Tr. 705). The Clinic has curtailed its marketing efforts due to concern about agitating doctors in the community (Tr. 640–42). Fearing that its activities would be considered advertising by the medical profession, the Clinic has refrained from distributing its newsletter or brochures to the general public (Tr. 639–42, 716), and has omitted fee information and the names of the Clinic's staff physicians from its newsletter (Tr. 643, 646). In June 1977, the Clinic stopped advertising in the newspapers and other mass media because of objections of local physicians and the opinion by the Knoxville Academy of Medicine that it was unethical (Tr. 671–73, 675).

In the absence of the ethical prohibition against advertising, the Volunteer Medical Clinic would like to advertise its services and fees in newspapers and on radio and television (Tr. 644–45, 674). An

abortion performed at a Knoxville hospital costs between $450 and $600; an abortion performed at the Clinic costs $175 (Tr. 634–36).

Additional Newspaper Advertising Incidents

115. In late 1974, the Secretary of the Medical Society of the County of Chautauqua, New York, wrote the Chairman of the AMA Judicial Council to ask whether or not a government funded, not-for-profit health clinic, sponsored by the county health department and designed to provide screening services and general practice medical care in a rural setting, could ethically post notices in the public media listing services, hours, telephone numbers, etc. (CX 770). The Secretary of the AMA Judicial Council responded that, under the AMA's Principles of Medical Ethics, a physician may not solicit patients, directly or indirectly (CX 769). The AMA official stated that the only proper announcement regarding this clinic from the ethical point of view would be an announcement by the medical society itself advising that such services are available for the type of clientele entitled to use the facility (CX 769). [153]

In 1973, the Travis County (Texas) Medical Society sent to the Texas Medical Association a copy of a small advertisement by a company performing physicial examinations which had been published in a local newspaper (CX 725). The medical society stated that the ad was soliciting medical examinations and was a violation of the ethics of the American Medical Association (CX 725). Noting the "ethical implications of this solicitation practice," the Texas Medical Association referred the complaint to one of its district councilors to resolve the matter with the medical director of the organization which had placed the advertisement in the newspaper (CX 723).

Acting on a referral from respondent CSMS and relying on AMA's *Opinions and Reports,* the Fairfield County Medical Society advised a physician in 1972 to cease and desist from running a newspaper box advertisement that patients could attend his smoking clinic sessions for $35 (F. 95, p. 119).

In March 1976, the Chairman of the Massachusetts Medical Society's ethics committee announced that a hospital's newspaper advertisement of its facilities and services would be unethical if done by doctors (CX 880–81).

As of early 1978, the Maricopa County Medical Society in Phoenix would not permit advertisements announcing even the opening of a physician's office (Tr. 7254).

AMA and various of its member medical societies have also restricted the newspaper advertising of health maintenance organi-

zations and other group prepaid health plans during the 1970's (F. 103–07, pp. 135–43).

3. *Radio and Television Advertising*

116. AMA and local medical societies have restricted physician advertising on radio and television. In 1969, a physician wrote to AMA asking whether it would be ethical to announce on radio and in the newspaper his plan to sponsor a "pap smear clinic" to promote preventive medicine. The physician and his associates proposed to offer pap smears and pelvic examinations at a reduced fee for a week (CX 170A). The AMA Department of Medical Ethics responded that the kind of public announcements which were necessary should not be made by individual practicing physicians, and that ethically the physician could notify only his own patients (F. 95, p. 119). **[154]**

James Martin

117. In 1973, Medi-Call, Inc., a firm in Johnson County, Kansas, near Kansas City, Missouri, initiated a commercial physician house-call service (Tr. 1546–47). James Martin, President of Medi-Call, testified in this proceeding. He stated that, for an annual fee of $50, Medi-Call offered to residents of northeastern Johnson County up to two night house-calls by a physician, when needed, at no charge, and subsequent visits for $25 each (Tr. 1548, 1550). Medi-Call hired physicians to provide the coverage (Tr. 1554). Before Medi-Call launched its house-call service, a resident of northeastern Johnson County needing medical attention at night generally had to go to the area's one hospital emergency room. Overcrowding there made for long waits and the emergency room's charges were usually greater than Medi-Call's fees (Tr. 1549–51). Private physicians in the area generally did not make house calls (Tr. 1550).

Medi-Call officials decided that extensive advertising would be needed to get the enterprise started (Tr. 1556). To avoid antagonizing local doctors, Medi-Call officials contacted the Johnson County Medical Society to make sure the advertising would be ethical (Tr. 1556–58). The medical society replied that the advertising would be ethical as long as it included no physicians' names (Tr. 1558). Medi-Call started an advertising campaign in July 1973, to promote the house-call service through radio, television, newspapers and billboards (Tr. 1558–59). Medi-Call did not identify physicians in the advertising and refrained from giving the names of participating physicians to persons over the telephone (Tr. 1559–60).

In August 1973, Medi-Call's attorney received a letter from the

Area Medical Council declaring that the firm's advertising was not only unethical but illegal (CX 737D–F). The Area Medical Council consisted of the top officers of four AMA component medical societies, including the Johnson County Medical Society (CX 2020A, L), Jackson County (Kansas City) Medical Society (CX 1908A, D; Tr. 1561) and two additional physician organizations in the region (CX 737A). In 1973, the Jackson County Medical Society was the largest contributor of operating funds to the Area Medical Council; the Society staffed the Council and the Society's immediate past president was the Council's chairman (Tr. 5717–21). The Jackson County Medical Society was the first group to object to Medi-Call's advertising and encouraged the Area Medical Council to send the letter to Medi-Call (CX 2163B–C, 2154B, 2155A, B). The Society based its position on the Principles of Medical Ethics and the possibility that the activity might violate state statutes (CX 737C, 2154B). [155]

The Area Medical Council simultaneously sent to all hospitals in the Greater Kansas City Area copies of its letter to Medi-Call (CX 737E). The Council wanted the hospital administrators to be able to place copies in the hands of each resident and intern for their information and appropriate action if they were affiliated with Medi-Call (CX 737E). Upon receipt of the Area Medical Council's letter, Medi-Call ceased all advertising. The decision was based on the letter's assertion that Medi-Call physicians were putting their professional careers in jeopardy if Medi-Call continued to advertise (Tr. 1563, 1564).

In response to an inquiry from Medi-Call, the Attorney General of Kansas issued an opinion declaring that the firm's operations and advertising were legal (CX 737I–K). The Kansas Board of Healing Arts subsequently sent Medi-Call a letter also stating that its "operation is not considered in violation of the law" (CX 2158).

At a meeting with Medi-Call representatives in October 1973, the Area Medical Council was informed of the Kansas Attorney General's opinion but the Council declared that Medi-Call's advertising was nonetheless unethical (CX 2156B, E, L; Tr. 1566, 1569, 1576). Dr. C. Y. Thomas, President of the Jackson County Medical Society (CX 737F), stated at the meeting:

> [T]he legal opinions of Vern Miller [the Attorney General of Kansas, CX 737K] . . . [have] nothing to do with our Canons of Ethics, [and] the threat of professional boycott to your client [Medi-Call] I think is significant and most assuredly will occur . . . .
>
> Now listen here you are legal but we are still declaring you unethical . . . . [I]f you continue advertising, I will continue to believe that you are unethical. The fact that you are legal doesn't influence me at all . . . . Now if you want to criticize the system

that brought me up to believe this, criticize it . . . . Your client didn't know the Canons of Ethics and that's that. He needs the book read to him and that's what we're doing. You understand that? (CX 2156 A, B, E, L). [156]

In November 1973, the Area Medical Council wrote to the Secretary of the AMA Judicial Council to obtain an opinion on Medi-Call's advertising (CX 737). The letter enclosed a copy of the Kansas Attorney General's opinion (CX 737I–K). The AMA official responded, in relevant part: "Physicians may not solicit patients according to traditional and accepted ethical standards . . . . One need not, indeed should not, abandon true ethical principles because of some new, legally permitted practice" (CX 736).

The Area Medical Council considered the AMA letter along with advisory letters from several osteopathic associations at its meeting of December 5, 1973, and voted to advise Medi-Call that, despite the legal approval of their operation, the Area Medical Council still considered their advertising practices unethical (CX 2160B). The council sent a letter containing this opinion to Medi-Call (CX 2161).

Medi-Call resumed marketing its house-call service in July 1974, but only through direct-mail promotions (Tr. 1597–98; CX 738). It did not resume radio advertising because of the Area Medical Council's continued opposition (Tr. 1635). The opposition of the medical societies interrupted Medi-Call's promotion of its house-call service for almost a year (Tr. 1635). This long interruption caused Medi-Call to lose momentum and depleted its financial resources (Tr. 1600–01). The action of the societies contributed in part to the financial failure and termination of Medi-Call's physician house call service (Tr. 1600–01, 1635–36).

4. *Publicity in the News Media*

a. General Restrictions on Media Publicity

118. AMA and its constituent and component medical societies have restrained, and acted to restrain, physicians from inducing or permitting unpaid publicity about their practices in the news media. AMA's 1971 *Opinions and Reports* contains a number of restrictions on physician publicity.

Opinion 6 of Section 5 states: "Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned" (CX 462Z5). [157]

Opinion 13 of Section 10 prohibits "self-exploitation" by means of physician publicity and requires physicians to clear certain publicity

with their local medical society in advance (CX 462Z44). The Opinion states, in part: "Photographs of physicians in connection with civic or social affairs, not related to medical news or the care of patients, may be published unless the frequency of such photographs bespeaks self-exploitation. This applies also to magazine articles. Physicians should clear such publicity, whenever possible, with their county society" (CX 462Z44). The 1977 *Opinions and Reports* contains a similar provision (RX 1, p. 35).

Opinion 13 declares that "adherence to the Principles of Medical Ethics" is "expected" of any physician when appearing on TV or radio programs, or in other media of public information, such as newspapers and magazines (CX 462Z44). With respect to physicians' articles in national lay magazines and newspapers, Opinion 5 of Section 10 urges inclusion of a footnote stating "that the article as written had the approval of the county or state, or both, medical societies" (CX 462Z40). Opinion 6 of Section 10 states that, "[i]t is not improper for physicians, *not in active practice,* to write health columns for lay readers" (CX 462Z40) (emphasis added).

Several AMA constituent and component medical societies have issued guidelines interpreting AMA's ethical restrictions on physician publicity. The Los Angeles County Medical Association, seeking to aid the physician in upholding the Principles of Medical Ethics, published a "Press, Radio and Television Code of Cooperation" in 1967, which discouraged personal publicity or advertising (CX 179). Citing a provision of Section 5 of the AMA Judicial Council's 1964 *Opinions and Reports,* the Code cautions physicians that "repeated appearances in the news media or . . . appearances which are obviously planned for the purpose of publicizing the physician will be considered as advertising, which is unethical" (CX 179C). The Code also requires physicians to obtain medical society clearance for all medical appearances except in special circumstances (CX 179C), and prohibits individual physicians from calling press conferences (CX 179E).

In 1975, the Chicago Medical Society adopted guidelines specifying the limited types of information which a physician may include in a news item in a neighborhood newspaper to announce the opening of his practice (CX 2122B; F. 95, p. 120). [158] The guidelines state that telephone numbers are not considered appropriate (CX 2122B). Edwin Holman, Director of the AMA Department of Medical Ethics, participated in the writing and approval of the guidelines (F. 95, p. 120).

In February 1976, the Santa Clara County (California) Medical

Society published guidelines prohibiting promotional statements which are considered self-aggrandizement or solicitation (CX 751C).

The August 1976 compendium of ethics rulings published by the AMA constituent society in Maryland cites the AMA Judicial Council as authority for the ethical policy that only physicians not in active practice should author newspaper columns (RX 308, p. 31).

The Maricopa County Medical Society, an AMA component society in Phoenix, Arizona, which requires its members to abide by the AMA Principles of Medical Ethics (CX 1568C, E), published a "Radio-Press and TV Code" in 1972 (CX 1415B–E, 898). The Code declares, in relevant part:

> A physician shall not be the subject . . . of any form of advertising or publicity nor shall he (or she) knowingly seek or encourage publication, filming, or other presentation of reports through lay channels . . . which shall be of such character as to invite attention to him (or her) of his (or her) professional position, qualifications, achievements, attainments, specialties, appointments, associations, affiliations (hospital, foundation, clinic group or institute) or honors which are of such a character, or in such manner, as would ordinarily result in aggrandizement, or as may reasonably be interpreted as seeking it. To do so, constitutes unprofessional conduct (CX 898D).

The Code contains provisions which discourage the use of physicians' names in media publicity (CX 898D) and label as unprofessional conduct the printing of physicians' addresses or telephone numbers in programs or articles of general public medical information (CX 898F). The Code condemns as unprofessional conduct any regularly appearing radio broadcast, television appearance, or signed column by a physician in active practice, which is not specifically authorized by the Medical Society (CX 898G). In drafting the "Radio-Press and TV Code," the Medical Society was influenced by AMA's 1960 *Opinions and Reports* provisions relating to advertising and solicitation (CX 1919S–U). **[159]**

b. Incidents Involving Physician Publicity

119. In 1967, an AMA component medical society (CX 1979C, E, 475H, K) asked AMA to comment on a physician's article on heart care published in *Seattle* magazine (CX 145A). In reply, AMA sent copies of Opinion 4 of Section 10 of the 1964 *Opinions and Reports* (CX 465Z11, 462Z39, Z40) and the media guidelines which AMA included as Opinion 13 of Section 10 of its 1971 *Opinions and Reports* (CX 462Z42–Z45, 145A). AMA also offered a standard for the local society to apply in determining whether the physician had acted improperly:

> If it finds that the article was instigated by a particular physician for his own self

aggrandizement or finds in its preparation an attempt of a particular physician to aggrandize himself, then perhaps the Media Relations Committee might want to present this matter to the Ethics Committee for further consideration (CX 145A).

A 1971 article published in the *New York Times Magazine* concerning the physician for the Jets football team included a footnote stating that permission to do the article had to be obtained at considerable delay from the Medical Society of the County of New York. The Society's executive director sent a copy of the article to the Secretary of the AMA Judicial Council (CX 177). The AMA official wrote back to commend the county medical society "for the manner in which this feature story was handled" (CX 175, 516E).

The Knoxville Academy of Medicine, an AMA component society (F. 114, p. 150), asked AMA in 1972 whether it would be ethical for a dermatologist to write a column for a local newspaper (CX 184). The Director of the AMA Department of Medical Ethics responded with a copy of the 1971 *Opinions and Reports* and the advice that Opinion 6 of Section 10 (CX 462Z40) suggests that it is inadvisable for physicians in active practice to write health columns for lay readers (CX 183).

In 1973, the Bergen County (New Jersey) Medical Society sent AMA a local chamber of commerce publication containing an article by a former president of the Medical Society, entitled "Preventive Medicine-Its Importance to Business and Industry" (CX 36, 1747). The Medical Society asked whether the article was a "questionable case as far as [**160**] advertising is concerned" (CX 36). In its reply, AMA referred the Medical Society to Section 10 of the 1971 *Opinions and Reports* (CX 462Z38 - Z45) and commented, "[I]f one physician extols his own services, facilities, competence, etc. what is to prevent another physician from doing likewise and then what is the need of a medical society at all?" (CX 1747).

In June 1974, a member of the CSMS Council, the executive body of CSMS (F. 11, p. 9), filed a formal complaint with NHCMA concerning alleged advertising by an NHCMA member physician who practiced acupuncture (CX 701A). The NHCMA Board of Censors considered the charges at a June 24, 1974, meeting attended by the accused physician (CX 701A, B). The Board indicated that a newspaper article based on an interview with the physician on "the medical approach to acupuncture . . . left a feeling like it was advertising" (CX 172A). The Board consulted Opinion 4 of Section 10 in AMA's 1971 *Opinions and Reports* (CX 701B, 462Z39-Z40); it warned the physician never again to discuss this subject with the daily papers (CX 172A) and to disseminate information through recognized medical journals in the future (CX 701A). The Board

decided not to take further action largely because the physician had granted the newspaper and television interviews in question as chairman of the official CSMS Ad Hoc Committee on Acupuncture (CX 172A, 701A, B). After hearing a report from the Peer Review Committee, the NHCMA Board of Governors decided to furnish transcripts of the NHCMA proceedings on the matter to the CSMS Council (CX 173A, B).

Dr. Edward Diethrich

120. In the early 1970's, the Maricopa County (Arizona) Medical Society ("MCMS") denied membership in the society to Dr. Edward Diethrich, a cardiovascular surgeon and director of the Arizona Heart Institute, on grounds of unethical advertising and publicity based on the Society's "Radio-Press and TV Code" and the AMA Principles of Medical ethics. The MCMS, the AMA Judicial Council and other professional medical societies participated in the actions against Dr. Diethrich because of the alleged unethical advertising and publicity. Dr. Diethrich testified in this proceeding that these actions by the MCMS and the AMA had adversely affected the Arizona Heart Institute.

Dr. Edward Diethrich is a board certified cardiovascular surgeon practicing in Phoenix, Arizona (Tr. 1262). He has won a number of awards for his achievements in medical education, research and practice, including two major scientific awards from AMA (Tr. 1264, 1265, 1270–71, 1280–81). He trained under, and later worked closely with, the noted cardiovascular surgeons in Houston, Drs. Michael DeBakey and Denton Cooley (Tr. 1265–67). In addition to performing [161] over 1,000 heart operations a year in Houston, he was an assistant professor of surgery at the Baylor College of Medicine and conducted research (Tr. 1266–70). During this period in which Dr. Diethrich was an active member of AMA, he frequently attended conventions and presented papers and scientific exhibits (Tr. 1274). He testified that he valued his AMA membership for the opportunity it gave him and his associates to present their scientific work to the medical world, for the assistance it provided him in applying for research grants and obtaining patient referrals and for the prestige it accorded him (Tr. 1274–76).

In 1971, Dr. Diethrich and a team of physicians moved to Phoenix and established the Arizona Heart Institute for the study and treatment of cardiovascular problems (Tr. 1281–83). The Institute, which occupies a specially constructed wing of a hospital, brought the latest diagnostic and treatment procedures to Phoenix (Tr. 1283–

91). The Institute also charged fees which were often less than those of competing cardiovascular surgery practices (Tr. 1357-58).

In the spring of 1971, the Arizona Heart Institute held a press conference to publicize its establishment and the programs it would be introducing (Tr. 1294). In May 1971, the President of MCMS wrote Dr. Diethrich that:

> The physicians in this area have traditionally adhered to the code of ethics regarding all publicity and have cleared news releases, public speeches, T.V. appearances and other public contacts through the Society.
>
> I would request that public relations efforts regarding the institute be kept strictly within acceptable ethical bounds so that all physicians in this city will be fairly regarded (CX 1407).

On March 6, 1972, the chairman of the Medical Society's Professional Committee wrote to the director of public relations at the hospital with which the Arizona Heart Institute was associated. He thanked the hospital's public relations staff for attending a meeting with the Professional Committee, and expressed his feelings that the Institute was a superb facility with an unusually qualified director and his hope that the public relations department of the hospital and the Professional Committee would work with one another. He also [162] expressed concern that unusual publicity for any one group of physicians usually creates antagonism in other physicians (CX 1408A). In April 1972, the chairman of the Professional Committee complained about Dr. Diethrich's "self aggrandizing" publicity in a letter to the chief of staff of the hospital with which the Arizona Heart Institute was affiliated (CX 1409). The letter stated that Dr. Diethrich was not a member of the Medical Society so that the Society did not have jurisdiction over his activities, but the letter noted that the chief of staff of the hospital could remind the hospital staff and the hospital board of trustees that Dr. Diethrich's constant publicity has become self-aggrandizing. The letter also referred to possible loss of referrals as a result of continued publicity: "[The publicity] has antagonized many physicians in Phoenix against the Institute. It would be a shame that a facility like the Arizona Heart Institute would find no support among referring physicians and other physicians" (CX 1409).

In June 1972, the Medical Society's Professional Committee invited Dr. Diethrich to a meeting to question him about his recent network television appearances on the Johnny Carson and Dick Cavett Shows (CX 1410; Tr. 1299-1300). Dr. Diethrich did not attend the June meeting. At a meeting of the Society's Board of Censors in September, Dr. Diethrich was told he would have to abide by the

Society's Radio, Press and TV Code. Dr. Diethrich stated that he could not abide by the Society's Code (CX 1413A–B) and still raise enough funding for the continued development of the Institute (Tr. 1303–06). As a result, the Board of Censors voted to table his application for membership in the Medical Society (CX 1413A; Tr. 1306).

Prior to the meeting, the Board chairman told Dr. Diethrich that the Society's opposition to the Institute's publicity was due to some members' feeling that the publicity was "unfair economic competition" (Tr. 1308).

Shortly thereafter, *Life Magazine* published a highly complimentary article on Dr. Diethrich and his Arizona Heart Institute (CX 2010). On October 12, 1972, the MCMS wrote to AMA enclosing a copy of the article and seeking AMA's advice: "The members of our Board of Censors feel that this is an example of blatant self-advertising and is not in accordance with the AMA code of ethics. We would like to have your opinion as to what might be done to curb Dr. Diethrich's endeavors to publicize himself" (CX 1415). The Secretary of the AMA Judicial Council responded by referring the Medical Society to the *Opinions and Reports* relating to solicitation, advertising and publicity, and commenting that "[i]t seems to me you are following the dictates of fair practice . . ." (CX 1416). **[163]**

On October 18, the Medical Society asked Dr. Daniel Cloud, a Phoenix physician who was then a member of the AMA House of Delegates (CX 2014H) and who, since 1974, has been a member of the AMA Board of Trustees (CX 1535A, D), to chair a committee to study the Arizona Heart Institute's publicity and make recommendations "concerning replies" to it (CX 2013). Dr. Cloud met with Edwin Holman, secretary of the AMA Judicial Council, in late October to discuss the issue of Dr. Diethrich's publicity (CX 1417A).

In an October 31, letter to the MCMS referring to the meeting, Mr. Holman stated: "Two ethical concepts, of course, are applicable: solicitation of patients and upholding the dignity and honor of the profession" (CX 1417A). Noting that it might be difficult for the Medical Society to prove sufficient intent to solicit on the part of Dr. Diethrich "to support a charge of unethical conduct," Mr. Holman stated, "as there are several ways to skin a cat there are different ways to handle this problem" (CX 1417A). One suggestion by Mr. Holman was counter publicity and an editorial to be published in the medical society's bulletin, with copies left in hospital waiting rooms for public access (CX 1417B).

In his report to MCMS in November, AMA delegate Cloud noted his meetings with the AMA staff, including two AMA staff attor-

neys, and concluded that the Arizona Heart Institute's publicity "appears to have violated medical ethical concepts with respect to advertising, solicitation of patients, and the boasting of cures and extraordinary success and ability" (CX 1418A). Dr. Cloud recommended that the Medical Society take final action on Dr. Diethrich's application for membership and consider other actions, including the publishing of a general statement "on the malethics of physician advertising" based on "excerpts from the reports of the Judicial Council of the AMA" (CX 1418B–C).

In December 1972, Dr. Diethrich informed MCMS that he would abide by its code of ethics, and the Society's Board of Censors voted to accept him for probationary membership (CX 1421). A month later, a group of Medical Society members, including Dr. Arthur Nelson, a cardiovascular surgeon whose group performed large numbers of the same type of surgical procedures as the Arizona Heart Institute (Tr. 7336, 1293), petitioned the Society's Board of Directors to reverse the Board of Censors' decision to admit Dr. Diethrich to membership (CX 1422). One of the items which Dr. Nelson objected to was a February 1973, newspaper photograph of a Motorola Corporation representative presenting Dr. Diethrich [164] with a check for $5,000 for the Arizona Heart Institute in recognition of its contributions to the advancement of heart surgery (CX 1424B, 1423C; Tr. 7331–32). In March 1973, the Board of Directors reversed the earlier decision admitting Dr. Diethrich and denied his application for membership due to his advertising (CX 1426). Dr. Diethrich has attempted three times since late 1971 to join AMA directly, but his applications were returned to him because he was not a member of the AMA component society in Phoenix (Tr. 1277, 1346–47).

The President of the Allegheny County Medical Society in Pittsburgh wrote to the Secretary of the AMA Judicial Council, in January 1973, to complain about the article in *Life Magazine* as "yet another example of a gross breach of basic medical ethics on a grand scale" (CX 167A). The AMA official responded that he had been told that the medical community in Phoenix, including the local medical society, "is active in its efforts to persuade the individual to cease these practices" (CX 168B). He further commented:

> Your letter seems to me to point out that there will always be someone out of step, either innocently or deliberately. Lawyers are disbarred. Clergymen are unfrocked. Human nature remains. The LIFE article is notorious but it is not being overlooked. What voluntary, permissible actions within organized medicine can be taken, are being taken (CX 168B).

In June 1973, MCMS wrote to the American College of Surgeons ("ACS") for advice as to the ethics of the publicity surrounding Dr.

Diethrich (CX 1429). ACS, of which Dr. Diethrich had been an active fellow (Tr. 1365–67), endorses the AMA Principles of Medical Ethics as standards to govern the conduct of their physician-fellows (CX 1911B). In response to the Medical Society's inquiry, ACS referred the Medical Society to Opinion 6 of Section 5 of AMA's 1971 *Opinions and Reports,* stating that, "solicitation of patients directly or indirectly, by a physician, or by groups of physicians is unethical" (CX 1430A, 462Z5). ACS subsequently brought its own disciplinary proceeding against Dr. Diethrich and put him on three years' probation for solicitation of patients, which included a ban prohibiting Dr. Diethrich from presenting scientific papers or exhibits to the College (Tr. 1371–72). Dr. Diethrich received the same penalty from [165] another specialty society to which he belonged, the Society of Thoracic Surgeons (Tr. 1387–89). That Society's bylaws require its members to adhere to the AMA Principles of Medical Ethics (CX 1981, p. 96).

Since 1973, the Arizona Health Institute has become less visible and more restrictive in bringing its programs before the public (Tr. 1343). It has experienced difficulty in raising funds because of an inability to bring its program to the public (Tr. 1346). The Institute has also been stigmatized in the eyes of potential patients (Tr. 1349), and has suffered a dramatic decrease in the number of patients referred to it (Tr. 1346). These problems are attributable, at least in substantial part, to the actions of AMA, MCMS, ACS and the Society of Thoracic Surgeons against Dr. Diethrich (Tr. 1342–49, 1375–78, 1394).

AMA also correctly points out that the *Life Magazine* article (CX 2010) was in some respects flamboyant (Tr. 7280), and that Dr. Diethrich himself found it distasteful and was disturbed by the overall impression that it left (Tr. 1312, 1433; RX 382). The *Life* article may imply to some that the Institute's facilities and Dr. Diethrich's skills were unique and of extraordinary quality (Tr. 7280–81). More specifically, the article contains the statement that Dr. Diethrich is one of the world's best heart surgeons (CX 2010), a statement which would be difficult to justify (Tr. 7281–82). A group of eminent cardiac surgeons concluded that Dr. Diethrich's competency in certain areas, particularly mitral valve surgery, was below the national standard (Tr. 7282, 7289–90).

The *Life* article (CX 2010) quotes Dr. Diethrich as claiming that his team can identify in advance 90% of all likely heart attack victims. The *Life* article indicates that Dr. Diethrich can prevent most heart attacks in those who have been discovered to be potential victims by doing a coronary bypass and that he performs bypass

operations on patients who are in the midst of a heart attack (CX 2010). The article claims that Dr. Diethrich will perform bypasses on those with hearts already too far gone for most surgeons to touch (Tr. 7298). The article indicates that it took Dr. Diethrich only 90 minutes to do a coronary bypass on one identified patient and 70 minutes to do another such procedure (CX 2010). The *Life* article notes that Dr. Diethrich may do 10 operations per day. These statements, and others in the article, may imply to some that Dr. Diethrich possesses unique, special skills, and that the Arizona Heart Institute has equipment and performs tests and procedures not utilized by others, when such is not the case (Tr. 7291–7310). **[166]**

The *Life* article indicates that, when Dr. Diethrich was 16, an obliging general surgeon let him do one side of a vasectomy. The article states that Dr. Diethrich's technology threatened to make obsolete the methods of practitioners in Phoenix with 40 years' expertise in reading resting EKGs. The article concludes with Dr. Diethrich disparaging a surgeon who would walk into a patient's room the night before an operation and say, "I'm not sure we'll be able to do the job tomorrow. You've got a bad heart, bad arteries, you might have a stroke and the blood pump might break down." These statements might, in fact, constitute a reasonable assessment of the probability of success and the degree of risk involved (Tr. 7315). In short, the article in question (CX 2010) is flamboyant, and could be deceptive and possibly disparaging of other physicians.

In 1974, under the provisions of the Arizona Medical Practice Act (RX 378, 389), the MCMS filed information with the Arizona State Board of Medical Examiners which had led the Society to conclude that the publicity efforts of Dr. Diethrich might constitute advertising in violation of state law (Tr. 1400; RX 387). The State Board admonished Dr. Diethrich for his participation in the publicity practices of the Arizona Heart Institute, which were "looked upon with disfavor" (Tr. 1403; RX 387, 388).

Dr. Diethrich is now a member in good standing of the American College of Surgeons and the Society of Thoracic Surgeons (Tr. 1385–89). Further, some of the decline in patient referrals at the Arizona Heart Institute can be attributed to the admonition of the Board of Medical Examiners (RX 387, 388) and to the stories appearing in the press at that time about malpractice actions pending against Dr. Diethrich (Tr. 1478–79). Dr. Diethrich's nonmembership in MCMS has not affected his ability to obtain malpractice insurance or to hold hospital staff privileges (Tr. 1408). Dr. Diethrich continues to receive referrals from throughout the United States (Tr. 1418–19), and from members of the AMA and the Medical Society (Tr. 1408–09). Dr.

Diethrich has also delivered several medical papers to scientific assemblages and has published a number of articles in respected peer-reviewed medical journals (Tr. 1412–13). He has participated in scientific exhibitions and has had his exhibits reviewed by his peers (Tr. 1413–14); and, he has produced and distributed several movies both to medical and lay audiences (Tr. 1414–16). [167]

Dr. Leon Zucker

121. Dr. Leon Zucker, an ophthalmologist in Waterbury, Connecticut, is an NHCMA and CSMS member who testified on behalf of complaint counsel (Tr. 1709–11).

In April 1976, a newspaper article discussing an operation performed by Dr. Zucker appeared in both the *Waterbury Republican* and the *Waterbury American,* entitled, respectively, "John Leahy sights his future with hope after eye operation" and "He Eyes Chance to See Again After Rare Triple Operation" (Tr. 1716, 1759; CX 692; RNHX 91). The article described the operation, which involved cataract removal, corneal transplant and lens implantation, as "rare" and "unusual" (CX 692). The article was based on the reporter's interviews with the patient and Dr. Zucker (CX 692; Tr. 1718). The reporter had expressed an interest in the eye operation when, as a patient of Dr. Zucker, she had been in his office and Dr. Zucker had mentioned that the operation was a "fairly rare" one (Tr. 1718). Dr. Zucker is a board-certified ophthalmologist in Waterbury, Connecticut, who taught ophthalmology as a clinical instructor at Yale Medical School from 1964 to 1969 (Tr. 1709–12).

Dr. Zucker testified that he participated in the interview that resulted in the article because he thought the public had a right to know that such procedures are possible and that they are being done and can be done (Tr. 1720). At the time Dr. Zucker performed the operation, it was a rare triple operation in the sense that it was not performed very often by physicians in the area (Tr. 1719, 1755–57).

In early May 1976, Dr. Jerome K. Freedman, in his capacity as Vice President of CSMS, wrote to NHCMA to request an investigation of the newspaper article on Dr. Zucker (CX 2006A). Dr. Freedman, a New Haven ophthalmologist, stated that Dr. Zucker's "ophthalmic colleagues are not pleased with the articles which they regard as publicity" (CX 2006A; Tr. 1731). Shortly thereafter, the ophthalmologist-president of the Connecticut Society of Eye Physicians also wrote to NHCMA to complain about the newspaper article and to urge NHCMA "to take whatever action is necessary to discourage continued use of the local press for personal aggrandizement" (CX 2006B–C; Tr. 1732).

The Chairman of the NHCMA Board of Censors, Dr. Samuel Climo, wrote to Dr. Zucker in early June 1976, informing him of the two complaints and requesting his appearance before the Board of Censors at its next meeting (RNHX 92; Tr. 1720). Dr. Zucker believed that a disciplinary proceeding was being instituted against him that could result in expulsion from the society, and that expulsion would be the "death knell" of his professional life in Connecticut because malpractice insurance was obtainable only through NHCMA and CSMS (Tr. 1721-23; CX 1328). [168]

Dr. Zucker met with the NHCMA Board of Censors in July 1976, accompanied by his attorney (Tr. 1723-24; CX 695C). At the meeting, the Board presented the two ophthalmologists' complaint letters and noted that they raised a question of ethical behavior and self-aggrandizement (CX 695C; Tr. 1724). A major concern expressed at the meeting related to a statement in the newspaper articles, in which Dr. Zucker is quoted as saying, "He [the patient] was told he'd never see again, but we made them out to be liars." Some members of the committee stated that they understood the quotation to mean that Dr. Zucker was stating that other physicians who had previously seen or treated the patient were liars. Dr. Zucker testified that he thought the above-noted quotation was susceptible to misunderstanding, and that the phraseology of the statement as reported in the article was inaccurate (Tr. 1719, 1766-67; CX 692; RNHX 91). Another concern expressed at the meeting was that the article's headline was misleading to the public because it stated that the operation performed by Dr. Zucker is "rare" when, in fact, it is more accurately described as fairly rare or uncommon (Tr. 1718, 8483). Dr. Zucker said that he was sorry about the newspaper article (CX 695C). The chairman of the Board of Censors asked Dr. Zucker whether it wouldn't have been less embarrassing if the article had come through hospital sources (Tr. 1724-25). Dr. Zucker agreed to allow the publicity department of his hospital to write and handle future releases (CX 695C, 696, 697E).

Dr. Zucker was notified a few days after the meeting by receipt of a letter, written by the Chairman of the Board of Censors/Peer Review Committee to the NHCMA Executive Director, stating that no action need be taken. Upon receipt of the letter, Dr. Zucker believed that the matter had been concluded (Tr. 1767-68; CX 296). NHCMA's action made Dr. Zucker very circumspect about communicating any information to anyone (Tr. 1725). He was disturbed by the stigma associated with even being charged with unethical behavior and by the resulting impression of at least one of his fellow ophthalmologists in New Haven that he had been censured (CX 136C; Tr. 1745-

46). The NHCMA action also was expensive to Dr. Zucker, causing him to incur attorneys' fees and to spend time away from his practice (Tr. 1746–47).

Dr. Lee Hirsch

122. In March 1975, an article was published in a Springfield, Massachusetts, newspaper describing a local ophthalmologist's performance of eye surgery through an [**169**] accepted cataract removal technique called "phacoemulsification" (CX 161Z69, Z70; RX 281; Tr. 4206, 4252, 830–36, 7813, 7883, 1714–15). At the time the article was published, the ophthalmologist Dr. Lee Hirsch, and his associate, Dr. Krawiec, were the only physicians in western Massachusetts performing eye operations by use of the phacoemulsification procedure (Tr. 892; CX 161H). In response to complaints from other Springfield ophthalmologists who did not perform this surgical procedure (CX 152–53; Tr. 874–75, 892) and action of the local AMA component medical society in Springfield (Tr. 868–74; CX 1838, 1990B, E, 885S, Y, 153), the Massachusetts Medical Society ("MMS") formally censured Dr. Hirsch in early 1977 for the newspaper article and subsequent newspaper publicity (CX 159, 150, 161; RX 277, 278, 280, 281). The MMS ruled that Dr. Hirsch had violated the prohibition on solicitation in the AMA's Principles of Medical Ethics (CX 150A, D, 159). As a result of the medical societies' proceedings against him, Dr. Hirsch incurred substantial legal expenses, lost practice time and patients, was temporarily removed from a hospital's emergency room roster, experienced difficulty in obtaining membership in the American College of Surgeons and suffered much aggravation (Tr. 892–93, 862; CX 161Z80, Z81, 1862). In general, the newspaper articles which appeared described phacoemulsification and very favorably compared phacoemulsification to the more traditional intracapsular technique of cataract removal (RX 277, 278, 280, 281).

Phacoemulsification was developed by Dr. Charles Kelman in 1967 (Tr. 835). In this procedure, the surgeon breaks up the nucleus of the cataract with an ultra-sound needle vibrating 40,000 times per second, and then sucks out the emulsified material (Tr. 835–36). Nevertheless, the intracapsular method is the most widely accepted method of cataract removal (Tr. 833, 7840). In this procedure, the surgeon removes the entire cataract through an incision (Tr. 836–37). Dr. Hirsch took the Kelman course in phacoemulsification in 1974 (Tr. 830–31), and his practice since that time has been limited almost exclusively to the removal of cataracts by phacoemulsification. Since 1974, Dr. Hirsch has performed about 1,450 phacoemulsification operations and about 50 intracapsular extractions (Tr. 838–39). Dr.

Hirsch owns two Cavitron machines, the device which he uses to perform a phacoemulsification procedure (Tr. 839), each of which costs approximately $25,500 (Tr. 939). In late 1974 and early 1975, Dr. Hirsch apparently was seeking publicity of some kind (CX 150E, G, 161 O, 271, 273).

Dr. Hirsch testified in this proceeding as a witness for complaint counsel (Tr. 825, *et seq.*). **[170]**

Shortly after publication of the first article, entitled "Eye Surgery Goes Ultrasonic" (*Springfield Republican,* March 3, 1975) (RX 281), Dr. Hirsch was censured by and expelled from the Greater Springfield Ophthalmological Association for engaging in advertising and personal publicity without Association clearance, conduct which the Association found to be "reprehensible" (Tr. 855, 860; CX 161Z78–79). This Ophthalmological Association is not affiliated with the AMA (Tr. 903).

Two days after publication of the article (RX 281), Dr. Hirsch was asked by the Hampden District Medical Society to appear for a meeting (Tr. 871; CX 1838). At the meeting, which took place on March 13, 1975 (Tr. 873), it was decided to refer the matter to the MMS. The bylaws of the MMS provide that members shall be guided by the AMA's Principles of Medical Ethics (CX 1990E). At MMS, the Committee on Ethics and Discipline advised Dr. Hirsch that it believed the article in question was not in the best interests of the community in that it did not give a fair evaluation of the technique such as would enable a consumer to make an intelligent choice (Tr. 878, 5586, 5589). The Committee took the position that one who publicizes a new technique such as phacoemulsification should make sure that the public understands all aspects of the general situation (Tr. 5590). On the basis of its proceedings, the Committee concluded that the article was misleading (Tr. 5591).

The Committee suggested to Dr. Hirsch that he write to the *Springfield Republican* to try to have an explanation published to give the general public a more accurate description of phacoemulsification, and that he explain to physicians in the District Society what had happened and straighten the problem out at the local level (Tr. 5587; CX 1852). Dr. Hirsch did neither (Tr. 5587–88; CX 1852). The Committee recommended that Dr. Hirsch be censured and be suspended for one year. It advised him of his right to appeal to the Judicial Committee of MMS (Tr. 881, 5588, CX 161Z67). Dr. Hirsch did appeal to the Judicial Committee (Tr. 5588; CX 161Z68) and, after notice and a hearing (RX 375A–G; CX 161A–Z66), the Judicial Committee, on February 22, 1977, censured Dr. Hirsch for unethical conduct but did not suspend him from membership (Tr. 865, 5588; CX

159). The Judicial Committee stated that it censured Dr. Hirsch because the particular publicity at issue was "misleading to the average person" (CX 150D–E), and that Dr. Hirsch had done nothing "to attempt to correct the one-sided slant of the article" (CX 150G–H). The Judicial Committee of MMS, in censuring Dr. Hirsch, cited with approval the *Opinions and Reports* of the Judicial Council of the AMA concerning advertising and solicitation, including the 1976 revision of the *Opinions and Reports* (CX 150A–D, I). [171]

The March 2, 1975, article in question (RX 281) sets forth the purported advantages of the phacoemulsification technique without any discussion of the possible complications of the procedure (Tr. 4212, 4213, 4270) or the contraindications to the procedure (RX 288C). It leaves the distinct impression that phacoemulsification is superior to intracapsular surgery as a procedure for cataract removal (RX 281) when, in fact, such often is not the case (Tr. 7812–17, 7830, 7837; RX 288C, 293). The article emphasizes what the patient can do immediately after surgery (RX 281); however, the real measure of success of an operation is long term results (Tr. 4224, 4229, 7856–57).

In recent years, phacoemulsification procedures for cataract removal have been used less often than they once were (Tr. 7812–13, 7838). It is to be considered an adjunct to, and not a replacement for, older procedures (RX 288C). Dr. Robert C. Troutman, an extremely expert and talented ophthalmologist who testified in this proceeding, stated that only one-half of one percent of the cataract operations currently being performed at Manhattan Eye and Throat Hospital, where Dr. Troutman is surgeon director, are phacoemulsification procedures (Tr. 7812–13). It has been determined recently that complications of phacoemulsification obviated some of the earlier results claimed for the procedure (Tr. 7814). Dr. Troutman prefers the intracapsular procedure for cataract removal, which he described as "a good technique that is applicable on a worldwide basis and has a minimum of complications and particularly late complications" (Tr. 7840). Dr. Troutman is of the opinion that phacoemulsification should not be used on patients who are over 40 years of age (Tr. 7837), and that the procedure is seldom a procedure of choice in cataract removal operations (Tr. 7838).

5. *Yellow Pages Listings*

123. AMA and its constituent and component medical societies have restricted the form and content of physicians' listings in the telephone directory Yellow Pages. The American Telephone and Telegraph Company asked AMA, in 1965, to establish a national

policy governing the listing of physicians in the Yellow Pages (CX 535D). In June 1966, the AMA Judicial Council adopted and distributed to all state and county medical societies a set of "Guidelines for Telephone Directory Listings" by physicians (CX 534C–D, 533K, 673B–I). The AMA House of Delegates approved the Guidelines (CX 663). The AMA Guidelines proscribe the use of display or box advertisements by physicians and physician groups or clinics (CX 673D). They require uniformity of size and face of type (CX 673D). They declare that the name of a physician should not be listed in a telephone directory of a locality where he or she does not have an office, residence or hospital affiliation (CX 673E). They limit a physician to separate listings under no more than two specialties or subspecialties, which must be on the list [172] approved by AMA (CX 637D). The examples of acceptable Yellow Pages listings published in the Guidelines contain only the physician's name, address, phone number, specialty, if-no-answer phone number, residence address and phone number and office hours (CX 673G).

The AMA Judicial Council intended the Guidelines, among other things, to maintain the dignity of the medical profession and assure uniformity of practice from community to community (CX 637C). The Guidelines declare that it is incumbent on the county medical society to implement them for the local medical community (CX 673E), and the local medical societies' standards implementing the Guidelines may vary only to the extent that they do not allow a significant inroad on the general prohibition against solicitation (CX 669A).

In March 1975, AMA advised a professional corporation of psychiatrists who practice in Virginia and North Carolina that, under the Guidelines, the physician is expected to confine his listings to the area in which he maintains his principal practice (CX 663–64).

AMA has distributed the Guidelines and interpretations of them to physicians and member medical societies (CX 663–70, 672–73, 1646–47, 501E), and constituent and component medical societies of AMA have applied the AMA restrictions on telephone directory listings.

In 1969, the Hartford County Medical Association, a component society of respondents CSMS and AMA (CX 991D, 1657A, G, Q), wrote to respondent NHCMA, stating that certain New Haven area physicians were violating the Hartford Society's policy that physicians should not be listed in a telephone book (in this case the Bristol directory) unless they reside, have an office or have a hospital appointment in the area served by the phone book (CX 1822) [this is the ethical policy set forth in the AMA Guidelines for Telephone

Directory Listings (CX 673E)]. The Hartford County Society advised NHCMA that it had asked its members to comply with the requirement with respect to Yellow Pages outside Hartford County, and that it hoped NHCMA would do the same with respect to its member physicians (CX 1822). NHCMA informed the physician in violation of the policy that he should delete his listing from the Bristol phone book (CX 1821). The physician then asked the telephone company to remove his name from the Bristol directory and NHCMA passed this news on to the Hartford County Medical Association (CX 1820). [173]

In April 1975, a telephone company representative asked NHCMA whether NHCMA had any policy regarding telephone directory listings, and specifically inquired about the listings placed by a Dr. Henri Schapira of New Haven. The NHCMA Executive Secretary wrote to Dr. Schapira about the inquiry, and stated that NHCMA policy was that it is ethical for a physician to list himself in telephone directories in areas where he resides, has an office or has hospital privileges, and noted that NHCMA was going to seek advice from the Connecticut Psychiatric Association regarding aspects of Dr. Schapira's listings. The letter states that it is to inform Dr. Schapira of the matter and is a notice of NHCMA's existing policy (CX 677).

In June 1975, NHCMA wrote to AMA's Judicial Council for specific guidelines on these ethical issues, stating that NHCMA had been having problems in the telephone directory listings area (CX 672). In its reply, AMA enclosed a copy of its Guidelines for Telephone Directory Listings and advised NHCMA that "the county medical society . . . must assume a strong leadership role and insist that the guidelines be followed" and that "[i]t is incumbent on the county society to implement these guidelines. . ." (CX 673A). Before this response was received from the AMA, NHCMA's Executive Secretary again wrote to Dr. Schapira, stating that the NHCMA Executive Committee reaffirmed its previously stated policy; the letter set forth an opinion of the Connecticut Psychiatric Society about the contents of psychiatrists' telephone directory listings which concurred with NHCMA's policy. AMA's guidelines and NHCMA's policy are the same (CX 672, 673A–I, 678).

At the time of trial, Dr. Schapira was listed in the Yellow Pages of six telephone directories in areas in and around New Haven. In each of these directories, Dr. Schapira is listed under "Adolescent and Adult Psychiatry Center" as well as under "Schapira Henri J." The listings under Adolescent and Adult Psychiatry Center state "Emotional Sexual & Alcohol Disorders" and "Marital and Family

Therapy." All directories list the two addresses and telephone numbers where Dr. Schapira has offices, New Haven and Wallingford. It can be determined at a glance in all the telephone directories that the doctor's offices are located in New Haven and Wallingford. Dr. Schapira's listings in the 1977 New Haven, Connecticut, telephone directory Yellow Pages, printed after the above-noted correspondence from NHCMA, are identical to his listings in the 1974 New Haven directory that was printed before the above-noted correspondence (RNHX 125A–D, 126A–D, 127A–E, 128A–C, 129A–D, 130A–D, 131A–D). [174]

In February 1977, the Executive Director of the Multnomah County Medical Society in Portland, Oregon, stated in a "Third Warning on Bold Face Listings," that the Society had decided in 1975 that:

> [I]t is "inappropriate and unethical for a physician, clinic, group or professional corporation to use a bold face listing in the Yellow Pages or White Pages of the Portland Telephone Directory." To do so goes beyond acceptable informative advertising, which is permissible, and becomes "solicitation of patients," and presents an advantage to some physicians. (CX 1815A).

This warning appeared in the *Portland Physician* magazine. At about this same time, the Multnomah County Medical Society also sent a form letter to the 30 medical clinics and others who had inserted bold face listings in the 1977 Portland Yellow Pages, specifically calling their attention to the Society's position and requesting compliance with that policy in the future (CX 1815A, B, 1733). The letter states that use of bold face listings borders on solicitation of patients and quotes from the statement of the AMA Judicial Council in its 1971 *Opinions and Reports* that, "No physician member of a clinic may permit the clinic to do that which he may not do. Each physician must observe all the Principles of Medical Ethics" (CX 1733A, 462K).

In May 1975, the Committee on Ethics and Discipline of the Massachusetts Medical Society urged that:

> the names of physicians in telephone directories be uniform as to size and style of type without the use of bold face letters. The display box advertisements for individual physicians, groups of physicians or clinics is not in keeping with the dignity of the profession and should not be used (CX 877B).

These restrictions parallel the AMA Guidelines (CX 673D).

The August 1976 compendium of ethics determinations of the state medical society in Maryland contains detailed limitations on the

form and content of Yellow Pages listings, including the following restrictions which directly parallel the AMA Guidelines: [175]

B. Listings may include the following *ONLY:* Name, address, and phone number, office hours, an 'if no answer' number, physician's or surgeon's home address and telephone number.

C. Listings may be made *ONLY* as follows: 'Practice limited to . . .' (using only those specialties approved by the American Medical Association or as modified and approved by a special liaison group to be named by the Faculty to work with the C&P Telephone Company).

D. Listings must be uniform in size and type face.

E. Display or box advertisements are strictly prohibited. (RX 308, p. 34; CX 673D, E).

In October 1971, the Washington State Medical Association ("WSMA") informed Pacific Northwest Bell Telephone Company that, based on AMA's Principles of Medical Ethics and *Opinions and Reports,* it would be unethical solicitation for physicians to list the word "abortions," or related terminology, in addition to their regular medical specialty in the Yellow Pages (CX 637A). The WSMA asked the telephone company to report to it any physician who requested such a listing (CX 637A). In May 1973, in response to an inquiry from WSMA, the Director of the AMA Department of Medical Ethics sustained the State Association's ethics interpretation, stating: "The Principles of Medical Ethics provide that he [the physician] should not solicit patients. A statement in the Yellow Pages 'Practice Limited to Pregnancy Termination' seems clearly to be solicitation of patients" (CX 640B).

In November 1973, Pacific Northwest Bell wrote to the WSMA to ask whether any of a long list of physicians' services were approved and recognized by the State Association as medical specialties (CX 643). The list included "diseases of skin and skin cancer," "internal medicine and arthritis" and "pediatric and adolescent allergy" (CX 643). In accordance with additional advice from the AMA Department of Medical Ethics (CX 642), WSMA's Board adopted a resolution, in January 1974, that only those specialties approved by AMA or the State Association should be used by physicians in Yellow Pages listings (CX 644, 658F). The list of approved specialties attached to WSMA's letter included none of the physician services mentioned in the telephone company's letter (CX 644B, 643). [176]

In April 1976, the WSMA sent a letter to Pacific Northwest Bell indicating that its January 1974, resolution on physician directory listings was still applicable (CX 658A). The letter stated that the

resolution was based on, and derived from, the Principles of Medical Ethics of the AMA (CX 658A). The letter referred specifically to the ban on solicitation in Section 5 and to Opinion 11 of Section 5, "Solicitation of Patients or Patronage," in AMA's 1971 *Opinions and Reports* (CX 462Z5-Z6), and enclosed copies of these provisions (CX 658).

In a 1976 letter to a Washington State physician, a WSMA official underscored the active regulatory nature of the Association's interest in physicians' Yellow Pages listings: "In the final analysis, we have found the 'management' of Yellow Page telephone directory listings is an ongoing proposition and one that seems to need constant scrutiny and surveillance from year to year as new directories come out" (CX 650).

6. *Business and Consumer Directories*

a. Dissemination of Consumer Information by State and Local Medical Societies

AMA contends that ethical considerations have not prevented services from being made available to consumers and, in support of this contention, AMA presented several witnesses to testify about the preparation and distribution of consumer directories.

Hennepin County Health Coalition

124. LuVerne M. Pearman, Executive Director of the Hennepin County Health Coalition ("Coalition"), a non-profit organization in Minneapolis composed of diverse interest groups in the health care field, testified in this proceeding (Tr. 5259, 5261-62, 5268). The Coalition was created in 1974 to improve primary health care in the county (Tr. 5260). Fifty percent of its funding comes from the county government, with the remaining funding coming from private donors, including hospitals and the Hennepin County Medical Society (Tr. 5261). Among the projects undertaken by the Coalition was the preparation of a directory of primary care physicians in Hennepin County (Tr. 5259, 5267; RX 267). Published in 1974 (Tr. 5269), this directory was prepared from responses to questionnaires sent to all area primary care physicians (Tr. 5284). A representative of the Hennepin County Medical Society helped review drafts of the questionnaire (Tr. 5273-75). The directory had a response rate from physicians of approximately 80 percent (Tr. 5285). [177]

The directory included information on the nature of each physician's practice, reimbursement mechanisms used, continuing medical education programs undertaken, teaching appointments held,

hours of service, waiting periods for routine visits, house calls, location and accessibility of office, special services offered, procedures done in office, credit practices, prescription practices and a variety of other information (RX 267; Tr. 5277–79). Information on fees was published in aggregate form giving fee ranges existing in the community (Tr. 5280–82). Eight thousand copies of the directory were ultimately distributed to public libraries, referral areas and hospital waiting rooms (Tr. 5289).

The Hennepin County Medical Society did not oppose the development, preparation or dissemination of the directory, nor did it declare physician participation in the project to be unethical (Tr. 5271, 5276, 5283). Ms. Pearman testified that the Medical Society was "positive and supportive," both behind the scenes and publicly (Tr. 5272, 5283). It provided $5,000 annually for three years to help fund the Coalition (Tr. 5263, 5283–84) — between five and six percent of its total operating budget. At the time the directory was published, there was no physician advertising in the community and the only directory of physicians available covered a small area of the county (Tr. 5291–93, 5300).

Whatcom County Medical Society

125. Kenneth L. Culver, Assistant Executive Secretary for the Whatcom County Medical Society (covering the northwestern corner of Washington State), testified in this proceeding (Tr. 5819, *et seq.*). Among the projects undertaken by the Medical Society under Mr. Culver's supervision was the preparation of a directory of physicians (Tr. 5821). In June 1974, several member physicians had received questionnaires from a local college (Tr. 5826; RX 402). At that time, the Medical Society sent a bulletin to its members asking them not to complete the questionnaire (Tr. 5827, 5830–31; RX 404). A special board meeting of the Society was then convened to discuss the subject of a physician directory (Tr. 5833). The Medical Society authorized its staff to contact the school, Fairhaven College, in order to coordinate a joint publication effort (Tr. 5832–33), and, subsequently, met with students from the college on several occasions to draft a questionnaire (Tr. 5837; RX 403A, 405). The questionnaires were sent to the members of the Whatcom [178] County Medical Society along with a Society bulletin requesting prompt completion and return. More than 90 percent of those physicians solicited responded with completed questionnaires (Tr. 5888). Fairhaven College students compiled the data, and Medical Society personnel reproduced the booklet (Tr. 5862, 5888). The directory (RX 407) was published in June 1975 (Tr. 5864). Information in the directory

included facts about acceptance of walk-in and new patients, office location and accessibility to public transportation, after-hours coverage, languages spoken, prescription of generic drugs, availability of information on preventive medicine, prescription of contraceptives and minimum fees for office visits (RX 407). Of the 500 copies of the directory printed, half were given to the Medical Society and half to the College for their own distribution (Tr. 5864–65). The Medical Society distributed its 250 directories to its members, public agencies and the general public at no charge (Tr. 5865; RX 408).

There are 120 physicians in Whatcom County who belong to the local medical society; less than six physicians do not belong to the society (Tr. 5886). Although the Medical Society stated to its members that the directory would be kept up-to-date through future editions (RX 405A; Tr. 5890–91), the Society withdrew its support when the college proposed, and ultimately prepared, an updated directory (Tr. 5893–95). At the time the directory was published, there was no physician advertising in Whatcom County (Tr. 5886–87).

Pima County Medical Society

126. The Professional Guild of Arizona ("Guild") is a registered labor union of physicians created in 1974 to deal with the hours, wages and working conditions of practitioners of contract medicine (Tr. 7554). It enforces health care contracts and collects unpaid benefits from insurance companies or government agencies through group action claim review (Tr. 5757–58). The local medical association in Tucson is the Pima County Medical Society. In 1977, the Guild published a directory of physicians for the Tucson area (Tr. 5758; RX 526). The president of the Guild, Dr. William A. Davis, testified about the preparation of the directory (Tr. 5758, *et seq.*).

The Guild first prepared a questionnaire which was designed to elicit information to help a new resident choose a physician. The questionnaire was sent to every [179] physician and osteopath in Tucson, and the responses were reviewed for accuracy (Tr. 5762). The Guild did not consult with the Pima County Medical Society, the Arizona Medical Society or the AMA regarding its decision to publish the directory (Tr. 5763–64). However, after the questionnaire was distributed, the Guild contacted the Pima County Medical Society about the ethics of the directory project. The Society expressed the opinion that the project was ethical and stated no objection (Tr. 5765; RX 527). The Medical Society suggested to the Guild that one question on medical specialties be altered to restrict areas to those supported by a recognized board (Tr. 5765; RX 528).

The Guild agreed and modified the directory accordingly (Tr. 5765; RX 529).

The Pima County Medical Society had no direct role in the publication and distribution of the directory (Tr. 5789). Its secretarial staff was instructed to advise the numerous callers to the Society (Tr. 5786) that the directory was going to be published, it was not unethical and participation was a matter of individual choice (Tr. 5766, 5790; RX 527). The directory, which is divided into sections by geographical region and specialty (Tr. 5768–70), includes information on each physician's specialty, patients treated, medical school and other training, board certification, hospital affiliations, language spoken, office location and hours, accessibility by bus and fees for office visits and certain special procedures (Tr. 5770–72; RX 526). Fifty-five percent of the area physicians responded to the questionnaire and were listed in the directory (Tr. 5772–73). Four thousand copies of the directory were published, and more than 2,000 were distributed through drugstores and physicians' offices (Tr. 4773–74).

The Lane County Medical Society

127. Bruce S. Strimling, M.D., a pediatrician practicing in Eugene, Oregon, is a member of the Lane County Medical Society, the Oregon Medical Association, the AMA and other professional societies (Tr. 5400–01). In 1974 and 1975, Dr. Strimling was Chairman of the Public Health and Low Income Care Committee of Lane County Medical Society (Tr. 5403–04). As part of its goal of promoting maximum access to health care (Tr. 5405, 5407–16), the Committee developed a consumer directory of physicians in Lane County, Oregon (Tr. 5409). The idea for a directory was prompted by articles in *American Medical News* (RX 462) and a local newspaper concerning a directory of physicians in Prince Georges County, Maryland (Tr. 5410–13). Dr. Strimling testified in this proceeding as a witness for AMA (Tr. 5400, *et seq.*). **[180]**

The directory concept was presented to the Medical Society membership as a means of acquainting consumers with the available facilities in the community, including information about the Society's referral system, emergency care in the area and how to use it (RX 463B). The project was first discussed at a general meeting of the Society (Tr. 5415–16; RX 463); the directory project was approved at a subsequent meeting (Tr. 5420). The Medical Society initially sought a consumer organization that would be willing to assist in management of the project and to publish it in conjunction with the Medical Society (Tr. 5428–29). When no offers were forthcoming, the Medical Society began preparation of the directory in conjunction with other

interested organizations including CARES, an agency of the County Health Department (Tr. 5434).

The committee first accumulated information about prior directory projects to aid in drafting an appropriate questionnaire (Tr. 5420–23; RX 464, 466, 369, 475, 476). Due to concern that a directory might violate state law or medical ethics (Tr. 5426–27; RX 465), the committee wrote for guidance to the State Board of Medical Examiners (Tr. 5435; RX 468; CX 2125), the Oregon Medical Association (Tr. 5437–38; RX 470) and the AMA (Tr. 5441). The State Board of Medical Examiners concluded that publication of such a directory was a proper function of the society but requested the opportunity to review it prior to publication (Tr. 5436–37; RX 472). The ethics committee of the Oregon Medical Association found no ethical problems relating to the medical society, but also requested the opportunity to review the directory prior to publication (Tr. 5436, 5437; RX 472). The AMA referred the Medical Society to the *American Medical Directory* as to the types of information and specialty designations that should be used in community directories (Tr. 5441; RX 473).

A questionnaire was ultimately developed by all interested parties (Tr. 5450–52, 5460; RX 482H–J, 488). At the suggestion of various Society members, a question about areas of special interest was deleted (Tr. 5457, 5459, 5487–88; RX 478; CX 2129). The final questionnaire (CX 2132) listed 35 specific questions, but did not request fee information. "Almost all" physicians in the area are members of the local society (Tr. 5470). Of the 290 members of the Society, 244 elected to participate in the directory (Tr. 5471; RX 489). The information on the returned questionnaires was summarized by CARES (Tr. 5464–65), and 1,000 copies of the directory were published at county expense (Tr. 5468–69). The directory (RX 489), published in January 1976 (Tr. 5467), includes [181] information about a physician's specialty, type of practice, medical school, internship, residencies, fellowships or other training, board eligibility or certification, hospital staff appointments, personnel and facilities, special services provided, languages spoken, office location and hours, after-hours coverage, acceptance of new patients, treatment of welfare patients, wait for appointments, time for an office visit, payment arrangements and handling of complaints; however, it provides no fee information (RX 489). The directory also includes an introduction that gives the background of the directory as well as physician participation, information on medical education and credentials, advice on how to find a physician, a list of medical

resources in Lane County and a short note explaining the doctor-patient relationship (RX 489).

The Clear Creek Valley Medical Society

128. The Clear Creek Valley Medical Society is a local society covering the northwestern metropolitan areas of Denver (Tr. 7528–29). In April 1975, the Society organized its Consumer Directory Publication Committee (Tr. 7530), chaired by Dr. Joel M. Kaplin, who testified about the directory effort (Tr. 7526 *et seq.*). The Committee was formed because the members of the Society believed that a consumer oriented directory of medical care would be both beneficial to the public and a good public relations effort for the physicians (Tr. 7530; CX 2303A).

The first step taken by the Committee was to contact the local and state medical societies and the AMA to determine if medical ethics or state law would be violated by the publication of a directory (Tr. 7531). The Committee also contacted the Consumer Research Council in Washington, D.C., a Ralph Nader organization, for guidance and for a sample questionnaire (Tr. 7532). This questionnaire was modified and sent to all area physicians and osteopaths (Tr. 7536). The questionnaire included 22 specific inquiries concerning the physician's practice, education, appointments and affiliations (RX 656X). The Medical Society deleted questions relating to acceptance of Medicaid or Medicare patients (Tr. 7532–33). Requests for fee information were also omitted (Tr. 7533). In order to achieve a good response rate, the Society called physicians who did not initially respond to the questionnaire (Tr. 7537). The overall response rate was 76 percent of Medical Society members and 45 percent of nonmembers (Tr. 7551–52). [182]

In March 1976, the Judicial Council of the Colorado Medical Society approved publication of the directory. The state medical society also recommended that information on fees and on acceptance of Medicaid and Medicare patients be excluded (Tr. 7550; CX 2304). The local society was aware that physician directories were not contrary to AMA ethical principles from articles published in the *American Medical News,* an AMA newspaper (CX 2301, 2300).

The directory was published in March 1977 (Tr. 7551). Broken down by specialty, it includes information about a physician's area of practice, education, teaching positions, affiliations with hospitals and medical societies, location of offices, waiting time for appointments, hours, office personnel, special services provided, languages spoken and payment and billing practices (RX 656). Also included is a section on public programs offered by the Medical Society, a section

on private health insurance companies to give the public an idea of what to look for in obtaining health insurance and a section on how to use the directory (Tr. 7540–41; RX 656). Five thousand copies of the directory were published at a cost of $11,000 (Tr. 7551, 7554–55). Despite excellent media coverage (Tr. 7552, 7554) and an adequate distribution network, fewer than 2,000 copies of the directory were sold (Tr. 7552–53).

The Allegheny County Medical Society

129. The Free Clinic of Pittsburgh is an organization funded from private foundation and government grants. It provides care to indigent persons (Tr. 5913–14). At the end of 1974, the Free Clinic invited the Allegheny County Medical Society to participate in the publication of a consumer directory of physicians in Pittsburgh (Tr. 5916). The Allegheny County Medical Society has approximately 2,450 members of the 3,100 licensed physicians in Allegheny County. Of these 2,450, 80 percent are members of the AMA (Tr. 5912). The Medical Society concurred with the Free Clinic that there was a community need for such a physician directory, and agreed to cooperate and contribute to the format and content of the directory (Tr. 5958–59; CX 2179). H. David Moore, Jr., Executive Director of the Medical Society, testified about the preparation of the directory (Tr. 5910, *et seq.*). [183]

In the summer of 1975, officers of the Free Clinic and the Medical Society met to discuss the idea of a directory and to develop a questionnaire (Tr. 5916, 5919–20). Draft questionnaires (RX 675; CX 2180) were supplied by the Free Clinic, and certain modifications were made (Tr. 5916, 5919–20). The Medical Society suggested deletion of certain questions (Tr. 5921–24); some of the suggestions of the Medical Society were followed and some were not (Tr. 5921–24). It was the Medical Society's initial position that there would be "no mention" of specific fees (CX 2303B). There was a continuing controversy between the Free Clinic and the Medical Society over publication of fee information (Tr. 5975). The questionnaire was mailed to all licensed physicians providing primary care within the city of Pittsburgh, including both members and nonmembers of the Medical Society (Tr. 5737, 5739).

The questionnaire was distributed in July 1975 (Tr. 5939). Approximately 60 percent of the physicians surveyed responded (Tr. 5940). The information received from responding physicians was compiled; printing costs were divided between the two groups (Tr. 5941; RX 671). The directory (RX 666) was published in February 1977 (Tr. 5942). It is prefaced by a letter to the reader, signed by officers of the

Medical Society and the Free Clinic, identifying the organizations involved and describing the scope of the directory. This material is followed by a table of contents and a list of groups contributing to the directory. These groups helped the Free Clinic pay for its portion of publication costs (Tr. 5947). An introduction explaining the purpose and form of the directory appears next, along with information on how to use the directory, what to look for in a medical check-up and a position on physician-patient communications. These sections were all reviewed and approved by the Medical Society before they were included in the directory (Tr. 5947–48).

The body of the directory is divided into five sections: family practitioners, general practitioners, gynecologists, internists and pediatricians. Individual listings include information on a physician's location, type of practice, age, years in practice, specialty, treatment of new patients and walk-ins, house calls, age limits on patients, after hours coverage, affiliation with specific hospitals, office hours, acceptance of Medicare or Medicaid patients, billing practices, prescription of contraceptives, itemization of bills, average waiting time for appointments and tests performed at the office (RX 666). Some individual [184] listings also include fee information (RX 666). Physicians could choose to provide specific fees, a range of fees or indicate from whom this information might be secured (Tr. 5950). An appendix to the directory includes the letter and questionnaire mailed to physicians, a family guide to immunizations, a table of fees providing the average fees and fee ranges for each of six specialties and 16 specific procedures and an index of physicians listed by zip code (RX 666).

Five thousand copies of the directory were published and were divided equally between the two organizations for distribution (Tr. 5952, 5954–95). The cost to the Medical Society of its participation in the directory project amounted to approximately $13,000, including printing costs and staff time (Tr. 5958).

New Haven Medical Directory

130. In 1975, Dr. Hans Neumann, the Medical Director of the New Haven Health Department, decided that it would be useful for the city health department and various social agencies to have a directory of physicians that could be used to refer patients for primary care (Tr. 8595–97, 8622). Dr. Neumann testified about the preparation and publication of the directory (Tr. 8590, *et. seq.*).

The city health department staff discussed the idea of a directory and decided that it should be limited to primary care physicians. They concluded, in the interest of time and the desire for a large

response rate to the questionnaires, to include in the directory only essential information about physicians and their practices. Due to financial constraints and the fact that the original purpose of the directory was as a patient referral aid, the health department staff planned to publish only about 50 copies of the directory and distribute them to senior citizen centers, housing projects, the visiting Nurse Association and other social agencies (Tr. 8598–8602).

The city health department staff prepared a questionnaire to send to physicians requesting information as to the physician's name, address, telephone number, section of city, type of practice, office hours, hospital affiliation, acceptance of Medicare assignment, acceptance of Medicaid patients, acceptance of new patients for primary care and basic fees for a first visit and a follow-up visit. The staff included on the questionnaire a statement that, while it may seem awkward to state a standard fee, such information would be useful, and noted that fees vary according to circumstances. The staff added this statement to the questionnaire to indicate recognition of the fact that fees depend on the treatment required (Tr. 8603–08; RNHX 143). [185]

Thereafter, Dr. Neumann initiated communication with the New Haven Medical Association ("city association"), an independent city medical association (a different organization than NHCMA, and not affiliated with the respondents herein). The city association agreed to cosponsor the project (Tr. 8594, 8608–09, 8613).

Dr. Neumann wrote a cover letter to accompany the questionnaire; in July 1976, both the letter and questionnaire were sent to physicians in New Haven who were listed in the telephone directory as practicing internal medicine, general practice or pediatrics. Dr. Neumann included in the cover letter a reference to the AMA's newly issued guidelines on physician directories. This reference was included independently by Dr. Neumann (Tr. 8609–12; RNHX 144). Dr. Neumann's staff sent out 100 to 150 questionnaires and received approximately 80 to 100 responses. None of the physicians receiving the questionnaire asked Dr. Neumann whether it was ethical to participate in the directory (Tr. 8609, 8614–17).

In late 1976, the directory was compiled, typed and photocopied. Approximately 50 copies of the "Primary Medical Care Directory" were printed and distributed without charge to the various social agencies in New Haven that would be likely to refer patients to primary care physicians. The 1976 directory includes an explanatory foreword written by Dr. Neumann and his staff. The directory is divided into four sections—family practice, internal medicine, pediatricians and health care centers. The listings include all the

information requested in the questionnaire, including basic fee (Tr. 8617-20; RNHX 109).

In the fall of 1977, Dr. Neumann and the city of New Haven Mayor's Committee on the Elderly decided to publish a new edition of the directory. Thereafter, the city health department staff contacted the city medical association which again agreed to cosponsor the project. Health department staff used the same form questionnaire that had been used for the earlier directory. The staff drafted a cover letter, similar to the one used in 1976, which was sent along with the questionnaire to physicians whose names had not appeared in the first directory. The staff sent a letter noting that a revision was occurring to physicians whose names had been included in the first directory. Followup letters were sent if physicians did not respond to the first letter (Tr. 8622-27; RNHX 146, 147, 148).

Dr. Neumann's staff sent out approximately 100 to 120 questionnaires and received about a 90 percent response rate. None of the physicians objected that participation in the [186] directory would be unethical. At the time of Dr. Neumann's testimony at trial, the directory had been compiled and typed, and was ready for photocopying and distribution to social agencies. The revised directory had the same format and information as the 1976 edition (Tr. 8627-29; RNHX 149A-Z15). There were no objections to the publication or distribution of the directories from any medical societies (Tr. 8622, 8629).

b. Medical Society Opposition to Business and Consumer Directories

131. AMA and its members societies have limited the publication of information on physicians in business and consumer directories. Opinion 18 of Section 5 of the 1971 *Opinions and Reports* declares that, "[m]ost, if not all, listings of physicians by specialty in directories published by commercial concerns, are but subtle ways of avoiding the pronouncement of the Principles of Medical Ethics concerning solicitation of patients" (CX 462Z9). Opinion 18 of Section 5 of the 1971 *Opinions and Reports* also states that if a physician permits the use of his name in a commercial directory that does not include on like terms the names of all licensed physicians in the directory area, he "has the burden of proving that his action is in keeping with the Principles" (CX 462Z9).

The 1971 *Opinions and Reports* recommends that local medical societies enforce an ethical policy that "the listing of physicians in directories of participating members [in bank credit card programs] is contrary to the ethics of the medical profession" (CX 462Z22 [Sec.

7, Op. 13]). In an August 1976 compilation of ethics interpretations, the state medical society in Maryland endorsed this AMA Judicial Council ethical standard and recommended its implementation and application by county medical societies (RX 308, p. 61).

In 1966, the King County (Washington) Medical Society sought the advice of the AMA Department of Medical Ethics on the ethical propriety of listing physicians in a directory of services and businesses participating in a bank credit card plan (CX 99). AMA's reply, which cited provisions of its *Opinions and Reports* (CX 100), assisted the county society in resolving the issue (CX 101A) and the society ruled that "any physician who allowed the use of his name in such a directory would be in violation of the Code of Ethics" (CX 101A). [187]

Payne Avenue Business Directory

132. D. Patrick McCullough, an attorney in St. Paul, Minnesota, who testified in this proceeding, is a member of the Board of Directors of the Payne Avenue Business Association, a group of business and professional people located on Payne Avenue in St. Paul (Tr. 359–60). In 1972, the Association's Board of Directors discussed the possibility of promoting its annual "Harvest Festival" by placing various paid advertisements in a community newsletter. The newsletter was to include a listing of Payne Avenue area businesses and services, including physicians (CX 34B). The list was to contain only the name, address, telephone number and business or profession of each of the association's members (CX 34B), and was to serve as an alternative to the phone book for consumers interested in obtaining services specifically in the Payne Avenue neighborhood (Tr. 367). The business association hoped that distribution of the list would help maintain the viability of the aging Payne Avenue area as an in-town shopping district (Tr. 367–68, 360–61).

Attorney McCullough, working on the project, contacted the Minnesota State Medical Society concerning "possible ethical considerations" about the proposed list (CX 34B). The state society then sought the opinion of the AMA Department of Medical Ethics (CX 34A). The Director of the AMA Department of Medical Ethics replied that, under the applicable Judicial Council ruling, the list would be unethical if it included only those physicians who were members of the business association and was not open "to all physicians on like terms" (CX 33). Even if all the doctors in the neighborhood were to be included, the AMA letter questioned whether the list would be "in keeping with the ideals of the medical profession" (CX 33). The letter stated that "the wishes of all the physicians in Ramsey County

should be taken into consideration" (CX 33). Inclusion, in the directory, of all the physicians in the county would have defeated the purpose of the plan, which was to serve the Payne Avenue neighborhood in particular (Tr. 381–82). As a result of the AMA letter, the proposed directory of businesses and services was dropped (Tr. 378, 380–82).

Prince George's County, Maryland, Directory

133. In the summer of 1973, Public Citizen's Health Research Group of Washington, D.C. [a Ralph Nader-affiliated organization, Tr. 2126], undertook the compilation of a directory of physicians in Prince George's County, Maryland (Tr. 2126, 2136). Approximately 80 percent of the practicing [188] physicians in Prince George's County belong to the Prince George's County Medical Society. All members of the local society belong to the state society, the Medical and Chirurgical Faculty of the State of Maryland (Tr. 7405–06), and 95 percent of all physicians practicing in Maryland are members of the state society (CX 679C).

In Maryland, advertising by physicians is illegal, except as provided by the regulations of the Board of Medical Examiners (Tr. 7412–13; RX 400B). The Maryland state medical society elects all eight members of the Board of Medical Examiners which has the authority to adopt regulations governing advertising by physicians in Maryland. All members of the Board must be physicians practicing in Maryland (CX 2047A, B, D). The regulations provide that a physician may advertise only by use of a personal professional card, a removal notice, an announcement concerning his practice or identification signs, all of a specified size and restricted to certain information (RX 308, p. 3, 309, p. 3, 689, p. 3).

The Health Research Group did not notify the county medical society or the state medical society of its plan to compile a directory prior to initiating its survey of physicians (Tr. 2203–04, 7467, 7479). In mid-July, the consumer group undertook its own questionnaire survey of Prince George's County physicians after its preliminary search for information on physicians practicing in the county had produced only the names, addresses, telephone numbers, specialty certifications, local medical society memberships and some information on physicians' educations (Tr. 2128–29, 2132–38, 2141; CX 679D–H, 2032). The questionnaire, developed without consulting with the medical societies (Tr. 2203, 7407; CX 2032), included questions on specialty, type of practice, teaching or staff appointments, medical education, Board certification, hospitals used, office hours, after-hours coverage, support personnel, average waiting time for appoint-

ments, acceptance of new and walk-in patients, treatment of Medicaid and Medicare patients, time for examination, languages spoken, house calls, fee and billing information, tests available, prescription of birth control and various specific drugs, immunizations and handling of complaints (CX 2032). Physicians were then contacted in a telephone survey (Tr. 2138). Where no response was given by the physician to a particular question, a space was provided labeled, "would not answer." If the physician declined to participate at all, the questioner was directed to inform him or her that the [189] survey was a consumer effort and that "refusal to cooperate" would be published in the directory (CX 2032; Tr. 2218–19). Many physicians phoned the local medical society for information about the survey and the organization sponsoring it, and were disturbed by the Group's threats to list physicians as uncooperative (Tr. 7406–11).

Since the Health Research Group had not contacted the local society in advance, the society had no knowledge about the project or the Group. Moreover, the local society was concerned that questions relating to fees and other specific medical practices were being asked that might be prohibited and constitute unethical advertising by physicians (Tr. 7411–12). Because of the local society's concerns about the proposed directory, it circulated a warning note to its member physicians (CX 680).

The Health Research Group contacted the local society after the first week of the telephone survey (Tr. 2148), informing them of the identity of the organization and the nature of the survey (Tr. 7423). In a letter to the Health Research Group, the society enclosed the relevant ethical and legal regulations and referred the Group to the Board of Medical Examiners or the Commission on Medical Discipline for consultation (CX 681). A copy of the questionnaire was subsequently sent to the society (CX 682). Upon reviewing the questionnaire, the society had further concerns with the questions asked (Tr. 7430–31). The questionnaire was sent to each physician with a cover letter which demanded that the questionnaire be completed, verified and returned within a week, or else the original response would be deemed correct and published in that form. Physicians were again told that if any questions remained incomplete, the directory would note that the physician "would not answer" (CX 683).

The local society thereupon circulated another message to its members (CX 684), which stated that the legal and ethical considerations raised by the questionnaire had not been resolved. Member physicians were advised that if they declined to participate in the directory, they should do so by stating "the information returned for

review is incomplete and inaccurate and that the physician does not consent to publication" (Tr. 7442–43; CX 684).

At the suggestion of the local society, the consumer group contacted the state medical society (Tr. 2148, 2150). The state medical society advised the consumer group by [**190**] letter that: "Other than to indicate his [a physician's] identity in such directory and specialty, if any, which he has and perhaps indicate his office hours, any other publications pertaining to the physician would constitute advertising" (CX 2035A). The state society, an AMA constituent organization (CX 2050J, Z22) that has adopted AMA's Principles of Medical Ethics as its ethical standards (RX 308, p. iii), also stated that a physician who answered any of the other questions in the questionnaire would be acting unethically (CX 2032, 2035). The letter specifically disapproved of a physician publicizing either his fees, that he is available to walk-in or non-English speaking patients or that he makes house calls (CX 2035A).

Many physicians declined to participate in the Health Research Group's directory project (Tr. 2036–43; CX 679N, O, 2031B). The questionnaires which were returned were compiled and the directory was published in January 1974 (Tr. 2166–67). About half of the doctors who had cooperated in the consumer group's initial telephone survey declined to complete the written questionnaire they were sent (Tr. 2158), and only 25 percent of the physicians in the county agreed to inclusion of their names in the directory (CX 2031B, 679 O; Tr. 2166). Only 500 copies of the directory were published by the Health Research Group (Tr. 2233–35).

The directory as published (RX 294) contains not only the responses to the questionnaires but a lengthy introduction. The introduction contains assertions about the alleged prevalence of unnecessary prescriptions and surgical procedures and the widespread physical or mental incompetence of physicians (Tr. 2240–43; RX 294H, S). The introduction also states that the state and local medical societies engaged in a systematic "intimidation of doctors" (RX 294W), and attempted to block publication apparently because the directory would reveal differences between doctors (RX 294J). It also states that "medical society resistance is to be expected in any consumer sponsored survey" (RX 294X). Emphasis was placed on the lack of cooperation of nonresponding physicians, and the names of those physicians were placed in a special list (Tr. 2250–51). The introduction also suggests that better medicine is practiced in group practices than by sole practitioners (RX 294A, A–1, A–2).

On the day of the directory's publication, the Health Research Group filed suit in federal court against the local and state medical

societies, the Commission on Medical [191] Discipline and their officers. The lawsuit challenged the constitutionality of the Maryland advertising statute (Tr. 2167). The federal district court stayed proceedings to allow the parties to engage in settlement negotiations (Tr. 2262; CX 679K) and, subsequently, invoked the abstention doctrine until such time as the Maryland Commission on Medical Discipline had ruled as to whether publication of the directory was prohibited under Maryland law (Tr. 2176, 7487). At the time of the hearing in this case, the decision to abstain was on appeal to the Fourth Circuit Court of Appeals (Tr. 2176).

Health Research Group also filed a request for a declaratory ruling with the Maryland Commission on Medical Discipline pursuant to Article 41, Section 250 of Maryland law (RX 401). The Commission ruled that the directory constituted "advertising" within the meaning of the Maryland statute and was, therefore, illegal (CX 2031). It noted that consumer directories, as such, are not necessarily advertising, although "particular directories, because of the method of compilation, the interpretive gloss, or other factors, may violate Maryland law" (CX 2031P). The Commission held that a physician who participated in the Health Research Group directory would violate Maryland law, but declined to prosecute any participating physicians on the grounds that they were probably unaware of the introduction and commentary and would likely not have participated had they been aware of the endorsement and ratings suggested by those sections (CX 2031E–F).

134. In June 1974, the AMA Judicial Council issued an opinion on consumer directories of physicians stating it would not be unprofessional for a physician to be listed in a directory which is intended to list all physicians in the community on a uniform and nondiscriminatory basis and did not include any "self-aggrandizing" statement or qualitative judgment about physicians (CX 509A–B, N). In December 1974, the AMA House of Delegates adopted the Judicial Council report, with only minor word changes as follows:

> It is not unethical for a physician to authorize the listing of his name and practice in a directory for professional or lay use which is intended to list all physicians in the community on a uniform and non-discriminatory basis. The listing shall not include any self-aggrandizing statement or [192] qualitative judgment regarding the physician's skills or competence. The *American Medical Directory* provides an example of the kind of information that may be properly listed in national as well as community directories for health service personnel. Likewise, specialties or specialty practices used in the *American Medical Directory* should set the pattern for specialty designations (RX 5).

This statement was in effect as of November 1977 (Tr. 3998).

The *American Medical Directory* lists only each physician's name, address, year of birth and licensure, specialty, board certifications, type of practice, educational background and AMA membership status (RX 11, 12, 13, 14).

In 1975, the Illinois State Medical Society was considering issuance of guidelines permitting descriptions in consumer directories of a physician's education, hospital, and medical school affiliations, type of practice, office hours, house call policy, acceptance of Medicare assignments policy, second language spoken, billing practices and in-office allied health personnel (CX 718A, F–I). AMA advised the state medical society that "any such detailed directory . . . could not help but be self-aggrandizing for certain physicians, contrary to AMA principles," and informed the state medical society that the ethics "difficulty" of a directory is "compounded" by widespread distribution (CX 717A–B). AMA noted that the Judicial Council's opinion on consumer directories (RX 5) "is more negative than positive," and that "AMA is *not* on record as positively favoring directories" (CX 717A–B) (emphasis in original).

Catawba County, North Carolina, Directory

135. In the fall of 1974, a sociology class at Lenoir Rhyne College decided to prepare a directory of physicians in Catawba County, North Carolina (Tr. 2366). The course instructor, Professor Daniel C. Bruch, who testified in this proceeding, assigned one student to contact the president of the Catawba County Medical Society ("CCMS") to determine whether the society would endorse the project. Another student was asked to write to the AMA to determine its position on the question of physician directories (Tr. 2371; CX 1835). Sometime in late September 1974, several students met with J. Thomas Foster, M.D., president of CCMS. Dr. Foster also testified in this proceeding. The students sought Dr. Foster's reaction to the preparation of a consumer directory of [193] physicians in Catawba County, North Carolina. Dr. Foster stated that, in his opinion, the general idea of a physician's directory was a good one (Tr. 2372–73, 7363). Shortly thereafter, the class sent a questionnaire to each of the physicians practicing in Catawba County (CX 698A–G; Tr. 2374, 7364). The questionnaire requested such information as the physician's name, address, specialty, fee-for-service or prepaid group practice status, number and type of support personnel in office, medical education and post-graduate training, board certification, hospital and teaching appointments, standard fees for phone consultations and office visits, billing procedures, willingness to make house calls, average waiting room time, acceptance of the Medicare

reimbursements schedule as payment in full and willingness to show patients their medical records on request (CX 698).

At the October 11, 1974, meeting of the CCMS, the subject of the directory was again discussed (Tr. 7364; RX 884A–B). The members expressed concern with several aspects of the questionnaire, such as whether the directory would be periodically updated (Tr. 7365) and whether the question regarding fees might prove to be misleading to consumers (Tr. 7366). Finally, some members felt that the question concerning a physician's prescribing of generic drugs might be misleading to consumers (Tr. 7367–68). The society discussed the AMA's position on the question of physician directories and decided that it would be all right for member physicians to respond "the way the Judicial Committee [sic] of the AMA states that it could be done, or otherwise, it would be unethical and considered to be advertising" (RX 884B).

Sometime during the next week, the Executive Committee of CCMS met with Professor Bruch's class to discuss the question of the physician's directory. When the society representatives raised their concerns about the updating of the directory and the possibility of misleading information, the students were unfriendly (Tr. 2407, 7373). The college class was told that the "self-aggrandizing" clause in the AMA Judicial Council opinion applied "when you list fees" (Tr. 2383, 2410). The CCMS official also stated:

> [S]omebody who reads the directory may choose a physician on the basis of fees, and get the cheapest doctor for example, and therefore it might become a point of competition between physicians to stress the fees and to work out a fee schedule that would be more advantageous than somebody else's (Tr. 2383–84). [194]

On November 11, 1974, the class received a letter from the AMA (CX 1834A–B) in response to their request for the AMA's position on the subject of physician directories (CX 1835). The letter noted that the AMA Judicial Council had adopted a report stating in part:

> It is not unprofessional for a physician to authorize the listing of his name and practice in a directory for professional or lay use. Which [sic] is intended to list all physicians in the community on a uniform and nondiscriminatory basis; providing that the listing shall not include any self-aggrandizing statement or qualitative judgment regarding the physician's skill or competence (CX 1834A. *See also* RX 5).

There is no evidence of any other communication with AMA. By letter of November 14, Dr. Foster informed Professor Bruch of the society's decision. The letter stated, in part: "the Catawba County Medical Society declines to ask its members to answer the questionnaire on the basis that the answers could be considered to be construed as unprofessional self-aggrandizement. The answers that

might be considered ethical would be of no value in a Consumers' Directory" (CX 890). Following the society's action, the college class received only one additional completed questionnaire from a physician, the family pediatrician of the professor directing the project (Tr. 2396). Overall, the class received completed questionnaires from only approximately one-fourth of the physicians surveyed (Tr. 2397).

7. *Direct Contact with Institutions and Physicians*

Dr. Harry G. Browne

136. In mid-1973, Jerry K. Crowell, the administrator of the Lewis County Hospital in Hohenwald, Tennessee, asked Dr. Harry Browne to conduct a pre-survey of the hospital's laboratory and pathology services to determine what upgrading would be needed to bring the services into compliance with the standards of the Joint Commission on Accreditation of Hospitals ("JCAH") (Tr. 281–82, 292–93). Dr. Browne testified in this proceeding (Tr. 1905, *et seq.*) as did Mr. Crowell (Tr. 281, *et seq.*) Dr. Browne is a board certified pathologist in Nashville, and holds a clinical assistant professorship of pathology at Vanderbilt University (Tr. 1905–07). He practices in association with a large pathology group and laboratory company which provides services to hospitals, physicians and others throughout Tennessee and western Kentucky (Tr. 1908–10, 1944). [195]

Dr. Browne is in active competition with Dr. Jack Freeman and other pathologists for the pathology and laboratory business of hospitals in western Tennessee (CX 5A–B, 1B; Tr. 1928, 1930). Dr. Freeman has serviced Lewis County Hospital since 1971 (Tr. 291–92, 296). Dr. Browne visited Lewis County Hospital in the early fall of 1973 to conduct a pre-survey (Tr. 292–93). The hospital had asked Dr. Browne to make a proposal of the services which his pathology group and laboratory company could provide the hospital to give it better coverage than it was getting from Dr. Freeman and to bring it into compliance with the JCAH requirements (Tr. 293–94, 304–05). In October, Dr. Browne submitted a written proposal to the hospital (CX 4). Several months later, Dr. Browne sent Mr. Crowell a more detailed proposal which compared his proposed services and fees with those of Dr. Freeman (CX 1866). Prior to submitting his written proposal, Dr. Browne and his staff had been in direct contact with the hospital personnel, partly in the hope of obtaining their pathology and laboratory business (Tr. 1911–13; CX 4A).

Before acting on Dr. Browne's proposal, the hospital administrator gave Dr. Freeman a copy of it (Tr. 305–06). Dr. Freeman submitted a counter-proposal to the hospital which was almost identical to Dr.

Browne's offer (Tr. 306). The hospital thereafter decided to renew Dr. Freeman's contract, and Dr. Freeman immediately began providing the hospital with significantly improved services (Tr. 306-07, 312-14; CX 1864-65). Prior to Dr. Browne's proposal, Dr. Freeman had never discussed with the hospital administrator possible improvements in his services to the hospital (Tr. 313); furthermore, until Dr. Browne made his pre-survey, Mr. Crowell was unaware that improvements could be made in the hospital's laboratory and pathology services (Tr. 314).

In early 1974, Dr. Freeman sent a copy of Dr. Browne's proposal (CX 4) to the Chairman of the Ethics Committee of the Nashville Academy of Medicine (CX 3, 12), the local AMA component society (CX 1825B, E). Dr. Freeman objected that Dr. Browne's proposal was unethical (CX 3), and indicated that he would also start soliciting business if Dr. Browne's conduct were considered proper (CX 3). The Nashville Academy wrote to the Director of the AMA Department of Medical Ethics for advice (CX 12). The AMA official responded that solicitation of patients or patronage was forbidden, and that Opinions 6, 9, 11 and 20 of Section 5 of the 1971 *Opinions and Reports* (CX 462Z5-Z6, Z9) governed the matter (CX 11). The Nashville Academy then informed Dr. Browne that it had received a [**196**] complaint about his proposal to Lewis County Hospital (CX 7). The Academy stated that it had obtained an ethics opinion from AMA and recommended that Dr. Browne read the *Opinions and Reports* provisions cited by AMA (CX 7, 11). The Academy also stated that it had referred the matter to the Tennessee Medical Association's ("TMA") Judicial Council for its further review (CX 7).

Sometime in late June or early July 1974, the chairman of the TMA Judicial Council requested that Dr. Browne furnish the details surrounding his association with the Lewis County Hospital (Tr. 1922). Dr. Browne complied by sending a detailed description of the situation (CX 1A-C). The TMA Judicial Council then wrote to AMA for additional advice (CX 10). The state society specifically asked whether it was ethical for a physician to solicit, not patients, but referrals from another doctor or from the medical staff of a hospital (CX 10A). It stated that some physicians in the area viewed Dr. Browne's activities as "overly aggressive competition" (CX 10B). It also noted that the complaining pathologist merely wished "the same privileges of solicitation . . . as the other man" (CX 10B). In response, AMA noted that the Principles of Medical Ethics proscribe solicitation of patients or patronage, and stated:

> If a pathologist asks a hospital for the opportunity of providing pathological services and laboratory services, I would think this is solicitation. It is solicitation of

patronage—of business. . . . I do not believe it is acceptable, usual or customary for any physician to solicit referrals or to solicit or offer *consultative* services to fellow physicians . . . . (CX 9)(emphasis in original).

The TMA then wrote to Dr. Browne, informing him that its Judicial Council considered his method of offering services to hospitals to be in conflict with the Principles of Medical Ethics, as interpreted by the AMA Judicial Council (CX 8C). The state society official's letter urged Dr. Browne to exercise greater care in bringing his conduct into line with AMA's and the state society's ethics interpretations (CX 8C). Dr. Browne agreed to abide by the advice and recommendations in every way (CX 2), and has since abided by them (Tr. 1929). **[197]**

Upon receiving the medical association advice, Dr. Browne resolved to modify his behavior so that it would not be considered distasteful (Tr. 1925). He became less personally involved in presenting proposals for the provision of the services of his pathology group and laboratory, particularly in offering services to Dr. Freeman's clients (Tr. 1925, 1928). Specifically, Dr. Browne instructed his laboratory company's marketing representative, in his discussions with potential clients, not to volunteer the names or fees of Dr. Browne and his pathology associates or to offer their services (Tr. 1927-28). He required hospitals to request proposals in writing as well as to request Dr. Browne's help, instead of Dr. Browne seeking proposals (Tr. 1925-27). He became less aggressive in marketing out of concern for his reputation, stating: "If I was to be criticized by my fellow physicians for being aggressive, it would denigrate my reputation and I did not want that to happen to make my position less effective as a physician and more humiliating as a human being" (Tr. 1927).

Other Incidents Involving Direct Contacts with Potential Users of Medical Services

137. A pathologist in San Antonio, Texas, wrote to the Board of Censors of the Bexar County Medical Society in early 1972 to request an ethics investigation of the solicitation activities of a clinical laboratory and its two associated pathologists (CX 2062D). The inquiring pathologist stated that the laboratory and its two pathologists had already obtained as clients a hospital and several physicians whom he had been serving (CX 2062D). The executive director of the Medical Society referred the pathologist's complaint to the Society's attorney for an opinion as to the legality and ethics of the alleged solicitation (CX 2062A). The attorney replied that, because the Medical Practice Act did not prohibit solicitation by physicians

unless it was misleading to the public, the laboratory's solicitations really raised questions of ethics (CX 2063).

The Medical Society's Board of Censors then called the two accused pathologists to its April 1972 meeting (CX 2064A). The Board decided to inform the pathologists that they were in violation of the AMA ethics provision on solicitation of patients by groups and that they should immediately stop soliciting physicians' business through the laboratory's use of their names (CX 2064A). Shortly thereafter, the chairman of the Board of Censors sent a letter to the two pathologists quoting Opinion 8 of [198] Section 5 of AMA's 1971 *Opinions and Reports,* entitled "Solicitation of Patients by Groups" (CX 2065A, 462Z5). A few days after their meeting with the Board of Censors, and again following their receipt of the Board Chairman's letter, the pathologists wrote to the director of the laboratory with which they were associated and requested that their names not be used in contacts with hospitals or other prospective customers (CX 2066A–B).

The Santa Clara County (California) Medical Society has severely restricted the direct solicitation efforts of an industrial medical clinic headed by Dr. Joseph LaDou. The Medical Society has based its actions, which it took in response to complaints from competing medical clinics, on provisions of AMA's 1971 *Opinions and Reports* (F. 98, pp. 124–29).

In August 1976, the state medical society in Maryland published an ethics interpretation prohibiting physicians from the active advertising or direct solicitation of new contracts for delivery of industrial health care services (RX 308, p. 33).

In 1972, a San Francisco physician sent a letter to a local insurance company describing his office facilities and offering to perform physical examinations on its behalf. AMA, which reviewed the letter at the request of an insurance company employee, enclosed a copy of the Principles of Medical Ethics and declared that the conduct of the physician constituted solicitation in violation of Section 5 of the AMA Principles of Medical Ethics. The AMA also recommended that a copy of the physician's letter be sent to the local medical society (F. 96, pp. 122–23).

AMA has condemned as unethical solicitation of patients a number of physicians' form letters and other communications to fellow physicians seeking referrals (*See, e.g.,* F. 110, p. 145; 112, pp. 146–27).

8. *Open Houses*

138. Opinion 13 of Section 5 in AMA's 1971 *Opinions and Reports*

states that if a physician holds an "open house" with the intent of directly or indirectly soliciting patients, he is acting contrary to the Principles of Medical Ethics. The opinion makes it incumbent on physicians to discuss their plans for open houses with their component medical societies before implementing them (CX 462Z7). [199]

In 1973, the Columbia County (Pennsylvania) Medical Society requested advice from the Pennsylvania Medical Society about several physicians who had advertised and held an "open house." The Pennsylvania Medical Society sent AMA a copy of the newspaper advertisement for the open house (CX 95B–G) and asked for AMA's ethics advice (CX 95A). In response, AMA referred the Pennsylvania Medical Society to Section 5 of the AMA Principles and advised that, since the open house had already been held, the medical society was to obtain an apology from the physicians involved (CX 94).

In August 1976, the state medical society in Maryland published an interpretation, citing the AMA Judicial Council as authority, which declared unethical the holding of an open house for the purpose of solicitation of professional patronage (RX 308, p. 31).

In 1974, the Maricopa County Medical Society in Phoenix adopted guidelines for HMO marketing activities which state that an open house for prospects at the management level and for physicians is allowable, but that it is not allowable on a patient level except for invited specific groups of people that are in the decision-making process (CX 898I).

In 1975 and 1976, other AMA member medical societies have adopted ethical standards authorizing physician attendance at open houses held by HMOs only where the guests are personally invited (CX 2121B, 2122B, 751D).

9. *Other Methods of Soliciting Patients*

139. Opinion 27 of Section 5 of AMA's 1971 *Opinions and Reports* prohibits physicians from mailing out reprints of articles they have written where their intent is to solicit patients directly or indirectly (CX 462Z11). In its advice to medical societies, AMA has applied this restriction to the mailing of reprints to other physicians as well (CX 117–19, 140–43).

Opinion 14 of Section 7 in AMA's 1971 *Opinions and Reports* states that it is unethical for physicians to use their participation in bank credit card programs to solicit patients and, in particular, to list themselves in any bank credit card directory of participating members. Physicians are also prohibited from displaying outside

their offices plaques or signs indicating their participation in such credit card plans (CX 462Z22-23). In August 1976, the state medical society in Maryland published a similar ethical rule, citing the AMA Judicial Council as authority (RX 308, p. 61). [200]

E. Advertising by Fringe Medical Practitioners

1. *Health Quackery*

140. James Harvey Young, Professor of History and Chairman of the History Department at Emory University, teaches courses in American social and intellectual history and conducts two colloquial, one on the history of American medicine, the other on the history of American advertising (Tr. 6605-07). Professor Young's major research has been an analysis of health quackery in America. Quackery can be defined as the use of misleading communications to persuade consumers to use products, drugs or devices to improve their health (Tr. 6608-09). Professor Young has lectured on this subject at numerous medical schools and historical association meetings, participated in an international conference on health quackery, received grants or fellowships to study health quackery from various organizations and served on various national bodies related to this field, including the National Food and Drug Advisory Council and the Consumer Task Force of the White House Conference on Food, Nutrition and Health. Professor Young was chairman of the History of Life Science Study Section of the National Institutes of Health, a body which judges applications of scholars who wish to conduct research in the history of medicine or life sciences. Professor Young has written three books and about 50 articles on medical advertising (Tr. 6610-11).

Professor Young, an expert on the history of medical and health advertising in the United States, testified about false and misleading medical advertising in America as far back as the colonial period. He described many fraudulent methods of promoting medicines, devices and medical services which have been utilized over a 200 year period in the United States (Tr. 6627-35). According to Professor Young, passage of various regulatory legislation has not eliminated the continued threat of medical quackery; quacks merely have become more sophisticated (Tr. 6637-39). Quackery has historically included false and misleading medical advertising by physicians (Tr. 6642-49).

Professor Young testified that the misleading advertising of medical products and services remains a serious problem for several reasons. The ignorance of consumers is a major cause of the problem, since most laymen do not have sufficient medical expertise to

recognize the deceptive nature of some medical advertising. Fear also plays a significant role in quackery, particularly with regard to an individual with a disease which medical science cannot cure or control. Individuals who are [201] stricken with a painful, life-threatening disease often do not act rationally regarding health matters. Finally, quacks rely on the fact that many ailments cure themselves. The individual then adopts the quack remedy, and often is "cured," not by accepting the remedy, but through natural causes. Yet, the patient will believe the remedy worked, will rely on it in the future and will refuse accepted medical treatment (Tr. 6652–54). Misleading advertising may thereby operate to disparage orthodox medical treatments and cause an unfavorable separation between reputable health care professionals and the public (Tr. 6650–51). A major social cost of medical quackery is the suffering and death of people who have rejected orthodox treatment methods in favor of quack remedies (Tr. 6649–50).

Professor Young believes that an increase in the amount of medical advertising is likely to result in an increase in the level of quackery and deception (Tr. 6655). Moreover, he testified that a removal of ethical guidelines which have been adopted by medical societies is likely to result in increased consumer deception. While neither ethical guidelines nor governmental regulations are likely to inhibit the unethical practitioner, some physicians who do not now engage in questionable advertising would probably do so were it not for the existence of standards set by medical societies. Professor Young stated that, without such guidelines, misleading advertising by physicians is likely to enhance quackery (Tr. 6656–58).

2. *Cosmetic Surgery Advertising in California*

141. Advertising by physicians has been most prevalent among plastic surgeons in California. AMA introduced extensive evidence of the experiences of physicians' organizations, individual physicians and consumers with advertising by cosmetic surgeons in California (Tr. 6888–7354). AMA contends that California provides a kind of laboratory in which the nature and effects of widespread physician advertising can be studied (RAF, p. 330).

Advertising by cosmetic surgeons in California began two to three years ago in the form of small, infrequent notices in the classified ads (Tr. 7050). In the past two years, the advertisements have become larger and more frequent (Tr. 7050–51). The record contains numerous examples of recent advertisements by plastic surgeons in California (Tr. 6964; RX 268, 269, 680, 682–85, 781, 783–87, 797, 800, 801). Some advertisements contain false promises about the physical

results of surgery (Tr. 6933), inaccurate statements about the surgical procedure (Tr. 6975; RX 269), [202] false claims about the innovative character of an operation (Tr. 6988, 6990; RX 682, 785, 786) or false claims about the physician or his or her staff (Tr. 6986–88, 7108; RX 682, 785, 786, 804, exhibit 2). Some advertisements include "before and after" photographs, with the "after" picture posed in a more favorable angle and lighting (RX 268, 680, 682–83, 786, 800, 916–17; Tr. 6972, 6988–89). Showing the results of one patient's experience, or giving one person's testimonial, may imply to some people that anyone can and should have the same operation with similar results, an assertion that can be misleading (RX 682, 800; Tr. 6933–34, 6970–72, 6986, 7104–05).

Some advertisements utilize truthful information in a manner that may mislead potential patients as to the qualifications of the advertising physician. An example is one physician who included his membership in the AMA as part of his qualifications; membership in the AMA is not a function of professional skill (Tr. 6972–73, 6980; RX 268, 787, 783, 679, 680). More subtle is a claim by a physician asserting his qualification as a "Board certified cosmetic surgeon" (RX 268, 679, 680). In fact, there is no American Board of Cosmetic Surgery and, if cosmetic physicians are certified, they are certified in other specialties which may have nothing at all to do with cosmetic surgery (Tr. 6933, 6973, 6990). Other advertised credentials, perhaps impressive to lay persons but medically meaningless, include authorship of articles published in obscure medical journals (Tr. 6974, 6979; RX 268, 680B), invention or modification of surgical instruments (Tr. 6979–89; RX 787, 783) and false statements about "special residency training and expertise" (Tr. 6980; RX 787). The names of the advertising surgical groups themselves, such as the Academy of Cosmetic Surgery Medical Group (Tr. 6994; RX 684, 801) or Bay Area Woman's Medical Educational Services (RX 797; Tr. 6992–93), could imply that there is a learned organization or nonprofit social institution involved when such is not a fact.

Some advertisements emphasize the modernity of the facilities, and invite visits by patients who wish to make comparisons (RX 269, 787, 785, 683). Potential patients may not have the expertise to judge its adequacy or medical necessity, and may be misled by superficial appearances (Tr. 6981–82). The invitations also may be designed to lure people into the office where "hard-sell" techniques are adopted (Tr. 6981–82), and to divert attention from the qualifications of the surgeon (Tr. 6982). Some advertisements emphasize the reasonableness of the fees and the easy financing which is made available (RX 269, 787, 786, 684, 784, 685). Pictures of attractive models used in

some [203] advertisements, have little relevance to the cosmetic surgery (Tr. 6984, 6990; RX 680, 682, 684, 690, 800-01). The bikini-clad figures may deceptively suggest that plastic surgery can reshape and rejuvenate the whole body (Tr. 6993-94, 6994-95; RX 684, 690, 784, 797, 801). These psychologically-appealing advertisements may minimize the seriousness of surgical operations (Tr. 6976-77; RX 269). Rarely, if ever, is fee information included in the advertising (RX 804, p. 7). Further, the easy financing which is featured may turn out to be quite expensive (Tr. 6977). Notably absent from such advertising is information about the risks involved in the operation, the expense of the surgery, the potential of permanent disfigurement and, sometimes, even the name of the operating surgeon (Tr. 6976-78, 6984-85, 6995, 7109; RX 680, 684, 685, 784, 781, 801, 804, exhibit 2).

Advertisements for cosmetic surgery appear in reputable publications, such as the *Los Angeles Times* (RX 279, 268, 800, 680, 684), and are widespread, appearing daily in newspapers in San Diego, Santa Ana and Los Angeles (Tr. 6997). Yellow Pages listings in the August 1977, edition of the City of Los Angeles telephone directory contain numerous advertisements for cosmetic surgeons. For example, there are a number of advertisements for E. B. Frankel, M.D., who is associated with the following organizations, all using the same location and telephone number: Acne Derm Medical Group, Affiliated Dermatologists' Medical Group and Cosmetic Surgery Center Medical Group; Dr. Frankel also sponsored a listing under his own name (RX 907A-G). Two advertisements appear for the Bosley Medical Group, including one which prominently states, "End Baldness Permanently With Your Own Living Hair" (RX 907B, C). The Yellow Pages also contains an advertisement for the Acupuncture Institute of Stanley Durbin (RX 907C).

3. *Consumer Witnesses in California Who Experienced Cosmetic Surgery*

142. Respondent AMA called consumer witnesses who testified about their experiences with cosmetic surgery in California, either for breast augmentation (Tr. 6995, 6767, 6795, 6824, 6889) or a "tummy tuck" (Tr. 6855). All of the witnesses responded to advertising by cosmetic surgeons which they had observed in the newspapers or on radio and television (Tr. 6696, 6769, 6795, 6825, 6889). Each of the witnesses was also subjected to high pressure sales techniques after responding to the advertisement (Tr. 6699, 6702, 6770-73, 6800-05, 6828-29, 6858-59, 6892-94). Five of the witnesses suffered severe injury to their health and serious emotional difficulties as a consequence of the surgery. The daughter of the remaining witness

died as the apparent result of the surgery performed by the advertising physician. [204]

The advertisement seen by the first witness appeared in the *Los Angeles Times* in August 1976 (Tr. 6697), and was sponsored by the so-called Women's Advisory Council (RX 877). The second witness saw an advertisement in the *San Diego Evening Tribune* in late 1976 (Tr. 6767–68); the sponsoring organization was identified as the Academy of Cosmetic Surgery; and a telephone number also appeared (Tr. 6767–68). The third witness saw advertisements in newspapers and on television and radio sponsored by "Women Who Help Women" (Tr. 6795). The fourth witness also saw and heard newspaper, radio and television ads sponsored by "Women Who Help Women" in July 1974 (Tr. 6825–26). The daughter of the fifth witness saw an advertisement in the *San Jose Mercury* in November 1976 (Tr. 6855–56). The witness's daughter contacted the advertising surgeon to arrange for a "tummy tuck," although she had previously been advised by several non-advertising physicians that the surgery was contraindicated in view of her obesity, diabetes and general physical condition (Tr. 6857). The sixth witness responded to an ad from the *Los Angeles Times* sponsored by "Women Who Help Women" (Tr. 6890).

All of the witnesses testified as to the medical treatment they received and the results of their cosmetic surgery (Tr. 6689–6919). Without going into the elaborate detail present in the witnesses' testimony, it is concluded from that testimony and from pictures of the results of the surgery that the care was unprofessional in every respect. One patient died and the others were permanently disfigured, even after reconstructive surgery performed by other surgeons. The five witnesses who survived the surgery were under medical care for weeks and months, and the total costs of the surgery were substantial.

4. *Advertising by Bariatric Physicians*

143. Bariatric medicine deals with people who have weight problems (Tr. 7137). The purpose of bariatric treatment is not merely to promote a change in weight, but also to help the patient live a longer, healthier and more useful life (Tr. 7145). A decrease in weight may also cure or control such serious physical problems as high blood pressure, hypertension, diabetes and heart disease (Tr. 7145–46). There are about 560 members of the American Society of Bariatric Physicians (Tr. 7140). This organization, which is not related to the American Medical Association, strives to encourage a high level of bariatric medical care through continuing medical

education programs, seminars and scientific publications (Tr. 7140–41). Approximately 60 members of the Society are certified by the American Board of Bariatrics (Tr. 7139). [205]

When a prospective patient presents himself to a reputable bariatric physician, the first stage of treatment normally involves both an in-depth interview and an extensive physical examination (Tr. 7142). A patient's desire to lose weight may be symptomatic of deeper psychological problems which cannot be treated by the bariatric physician. A reputable bariatric physician will not ignore a patient's psychological problems in order to treat only their physical consequences, but will endeavor to promote the patient's mental health as well (Tr. 7147–48). Sound bariatric treatment often involves not only diet and exercise, but consultation with a psychologist who can aid in behavior modification (Tr. 7143–44). Possible problems which a bariatric physician encounters include patients who suffer from diabetes, high blood pressure, glaucoma, cirrhosis, intestinal problems or kidney or liver dysfunctions, all of which require specialized forms of bariatric treatment (Tr. 7152–53). Recidivism in obesity is common, and weight control requires a well-rounded diet program, good exercise program and a change in eating habits and mental attitude (Tr. 7155). The key to bariatric treatment is loss of fat and a reduction in caloric intake (Tr. 7159–60).

Advertising of weight control programs is widespread both in California and across the United States. A large part of this advertising is sponsored by physicians (Tr. 7166; RX 806–09, 811–16). The copy of a bariatric advertisement may be meaningless but eye-catching, such as "Serious About Losing Weight?" (Tr. 7182; RX 812), or "Come in Fat. . .Walk out Thin" (Tr. 7188; RX 809). Other advertisements are more misleading, suggesting that the consumer can lose a certain amount of weight in a specified limited time period without strenuous exercise, side effects or hunger, and claiming that the system is safe for the "entire family" (Tr. 7177–80; RX 806, 807, 809). Bariatric advertisements frequently feature pictures or drawings of attractive men and women. In fact, even patients who manage to lose large amounts of weight will not look like they did before the weight gain because skin has stretched and wrinkled. Few, if any patients, will resemble the attractive bodies pictured in the advertisements (Tr. 7178–79, 7182–83; RX 813). Some advertisements claim they have a special or unique method of weight control (Tr. 7180, 7187; RX 811, 812, 814). In fact, no one clinic or physician has a unique "key" to weight loss; dieting and exercise is the only effective method of bariatric treatment (Tr. 7180–81). Bariatric advertisers often make unsubstantiated claims about the number of

individuals they have successfully [206] treated (Tr. 7183-84; RX 813, 814, 816), and support their claims with patient testimonials (Tr. 7188-89; RX 808). These advertisements contain no information on the number of individuals who failed to lose weight (Tr. 7184).

The weight clinics to which consumers are drawn by these bariatric advertisements often provide inadequate care at a high cost. The patient may be required to pay a certain amount of money immediately or sign a contract, and repeated collection attempts may be employed if he or she defaults (Tr. 7168-69). High pressure sales tactics are also used (Tr. 7170). Some physicians advertise a large number of offices in various locations, although they could not possibly service all of them and although patients are likely to be unable to contact their physician when they need to (Tr. 7185-86; RX 808, 816).

5. *Evaluation of Advertising by Fringe Medical Practitioners*

144. Most of the physicians engaged in the advertising of cosmetic surgery and weight loss programs are fringe practitioners (Tr. 9337, 6655). Moreover, since most of these advertising physicians are not members of state and local medical societies, they are not subject to their disciplinary jurisdiction (CX 2593, 2420, 2576-77, 2579-81; Tr. 6785, 9337; RX 679, 682, 683, 693, 797, 801); thus, AMA and its local medical societies cannot control the advertising of these doctors through their ethical restrictions (Tr. 9512-13, 9339-41). In any event, most of the fringe practitioners involved in the advertising incidents about which AMA has produced evidence are being actively proceeded against by state licensing officials and, in some cases, by local district attorneys in criminal prosecutions (CX 2206-07, 2210-17, 2222-25, 2582-84).

Quacks and borderline practitioners in the medical field have practiced for many years in California (Tr. 7025, 6757-58; RX 804, p. 6); witnesses were unaware of such advertising by doctors in states other than California (Tr. 6920-7026, 7031-7123, 9529). Most physicians are competent (Tr. 9526, 9335, 9367), and the number of physicians who would make false claims is small (Tr. 9333). Medical educational standards, both for qualifications and character, are stringent, and the physicians being turned out today are of exceptionally and uniformly high quality (Tr. 9335).

The essence of the problems raised by AMA's testimony with respect to cosmetic surgeons is not with the advertising but, rather, with the negligent, inept, insensitive and almost ruthless medical care given the patients (*See* RAF, pp. 339-60). [207]

XI. ETHICAL RESTRICTIONS ON PHYSICIANS' CONTRACTUAL ARRANGEMENTS

A. Contract Practice of Medicine

145. Section 6 of the Principles of Medical Ethics states: "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgement and skill or tend to cause a deterioration of the quality of medical care" (CX 462Z12; RX 1, p. 5). AMA has defined "contract practice" as follows:

> Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita (CX 462Z12).

B. The Restrictions and their Background

146. The 1971 AMA Judicial Council's *Opinions and Reports* provide that an organization's contract with a physician to deliver medical services is "unfair or unethical" under any of the following conditions:

(a) When the compensation received is inadequate based on the usual fees paid for the same kind of service and class of people in the same community.

(b) When the compensation is so low as to make it impossible for competent service to be rendered.

(c) When there is underbidding by physicians in order to secure the contract.

(d) When a reasonable degree of free choice of physicians is denied those cared for in a community where other competent physicians are readily available. [208]

(e) When there is solicitation of patients directly or indirectly[5] (CX 462Z12-13).

AMA has also published this five-part ethical guideline in its 1974 *Report on Physician-Hospital Relations* which was in effect as of the issuance of the complaint herein.

AMA's 1971 ethical standards also proscribe the following contractual relationships:

(a) Opinion 5 of Section 6 of the 1971 Judicial Council's *Opinions and Reports* states: "A physician should not dispose of his profession-

[5] "[B]y 'solicitation' is meant to seek professional patronage by oral, written or printed communications either directly or by an agent" (CX 462Z13).

al attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee" (CX 462Z13).

(b) Opinion 8 of Section 6 declares that "[t]he action of a physician in accepting a salaried position offered by the hospital" to provide professional medical care in the emergency room "is not consonant with the policy of the AMA" (CX 462Z14, 959Z62).

(c) Opinion 4 of Section 6 states:

> In increasing numbers, physicians are disposing of their professional attachments to lay organizations under terms which permit a direct profit from the fees or salary paid for their services to accrue to the lay bodies employing them. . . . Certain hospitals are forbidding their staffs of physicians to charge fees for their professional services to 'house cases' but are themselves collecting such fees and absorbing them in hospital income. Some universities, by employing full time hospital staffs and opening their doors to the general public, charging such fees for the professional care of the patients, as to net the university no small profit, are in direct and unethical competition with the profession at large . . . . (CX 462Z13). [209]

(d) AMA's 1974 *Report on Physician-Hospital Relations* states:

> [A] physician should not bargain or enter into a contract whereby any hospital, corporation or lay body by whatever name called or however organized may offer for sale or sell for a fee the physician's professional services . . . . The physician and the medical staff, as principals, should not approve any contract whose terms or conditions are inconsistent with the 'Principles of Medical Ethics' and established policy of the American Medical Association.
>
> Throughout many years, it has clearly been AMA's position that no lay organization should profit from fees received for physicians' services (CX 959Z2).

This ethical restriction closely resembles Opinions 4, 5 and 8 of AMA's 1971 *Opinions and Reports* (CX 462Z13–15).

147. The actions of AMA's House of Delegates and Judicial Council over the years reveal the anticompetitive motivations behind AMA's ethical restrictions on contract practice. The AMA's House of Delegates adopted a resolution, in 1869, recommending "that all contract physicians, as well as those guilty of bidding for practice at less rates than those established by a majority of regular graduates of the same locality, be classed as irregular practitioners" (CX 1435Q). The AMA House of Delegates rescinded the 1869 resolution eight years later. In 1872, the House referred to the state societies a similar recommendation from its Committee on Ethics:

> [T]hat members of the profession hired by the month or year for definite, stipulated wages, by individuals, families, railroad or manufacturing corporation, or any other money-making institution whatever, for ordinary medical and surgical practice

(always excepting benevolent and eleemosynary institutions and medical officers of the Army and Navy), are to be classed as irregular practitioners (CX 1435Q). [210]

In the 1890's, the AMA House of Delegates adopted a report declaring that contract practice had "gone too far" and that "[t]oo much of the spirit of trade has found its way into the profession, and its further encroachment should be resisted—not encouraged" (CX 1435Q, R).

In 1926, the House of Delegates adopted a resolution recommending that "the whole matter of contract practice be investigated under the direction of the Judicial Council" (CX 1435R). In response, the AMA Judicial Council reported to the House of Delegates, in 1927, that "[t]here is no doubt that the [contract] practice is growing in frequency and becoming widespread. In fact, it is entering into so many phases of the practice of medicine as to be a distinct menace to the stability of our organization" (CX 953B). The Judicial Council proposed, and the House of Delegates then approved, language identical to the provisions of Opinion 3 of Section 6 of the Judicial Council's 1971 *Opinions and Reports* as a "formula . . . to pronounce as ethical or unethical, a given contract for medical services" (CX 1435R–S, 953B–C, E, F).

In 1927, the Committee on the Costs of Medical Care, a commission of leaders in medicine, public health and the social sciences funded by the Carnegie Corporation, the Rockefeller Foundation and other private philanthropies, began an extensive five-year study of the country's health care system (CX 2085). In its report, published in 1932, the Committee recommended the expansion of prepaid health care, involving an increase in the amount of contract practice (CX 2085M, V–Y, Z57). Nine physician members of the Committee on the Costs of Medical Care, including the Secretary of AMA, the then Chairman of the AMA Judicial Council and the 1927 Chairman of the Judicial Council (CX 2085R, Z27, 952B, 953B), published a minority report opposing the Committee's recommendations on group prepaid medical practice (CX 2085Q–Z25). Citing provisions of the Opinion 3 language adopted by the AMA House of Delegates in 1927, the minority disapproved the Committee's proposals for expanded group contract practice, stating that "[a]ny method of furnishing medical care which degrades the medical profession through unfair competition or inadequate compensation . . . must be condemned" (CX 2085W–Y). The minority also criticized the group practice contracts recommended by the Committee on the ground that "[w]herever they are established there is solicitation of patients, [211] destructive competition among professional groups . . . and demoralization of the profession" (CX 2085Z6), and that

"able physicians outside of the groups are being pushed to the wall" (CX 2085Z7).

In 1933, the AMA House of Delegates voted to endorse the minority report of the Committee on the Costs of Medical Care as "expressive, in principle, of the collective opinion of the medical profession" (CX 1435Z42). That same year, the AMA House of Delegates amended the Principles of Medical Ethics to incorporate the Opinion 3 language on contract practice (CX 952B, E, 1435S).

In 1934, the AMA House of Delegates further amended the Principles of Medical Ethics to provide further that:

> It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy (CX 1435S–T).

Absent the second sentence, this provision parallels Opinions 5 and 8 of Section 6 in AMA's 1971 *Opinions and Reports* (CX 462Z13–14) and the restriction on contract practice published in AMA's 1974 *Report on Physician-Hospital Relations* (CX 959Z2).

C. Application of the Restrictions

148. AMA and its member societies have utilized the above described ethical restrictions on contract practice (F. 146, pp. 207–09) to proscribe contracts under which hospitals, group prepaid health plans and other lay organizations employ physicians to care for patients, especially where the physicians are employed for a fixed salary. In a number of instances, AMA and its member societies have counseled physicians to refrain from actions contrary to the contract practice ethical restrictions. [212]

In 1936, the Medical Society of Milwaukee County (Wisconsin) expelled several physicians for associating with a prepaid group health plan proposed for the employees of the International Harvester Company (CX 580A–B). On appeal, the State Medical Society of Wisconsin and the AMA Judicial Council affirmed the physicians' expulsion (CX 580C–D). The AMA Judicial Council held that the physicians' relationship with the group plan constituted unethical contract practice and involved unethical solicitation of patients and advertising (CX 580C, E).

Shortly thereafter, the Medical Society of the District of Columbia expelled one physician affiliated with the Group Health Association,

a prepaid group health plan, and succeeded in pressuring another to resign from the plan. The Medical Society charged the physicians with violating the same AMA ethical provisions on contract practice that were subsequently incorporated in Opinion 3 of Section 6 of the 1971 *Opinions and Reports* (*AMA* v. *United States,* 130 F.2d 233, 238–40 n. 23 (D.C. Cir. 1942), *aff'd* 317 U.S. 519 (1943)). In furtherance of the AMA policy of opposing group prepaid medical practice, the Medical Society also threatened disciplinary action against any physician who consulted with, or any hospital which granted staff privileges to, a Group Health physician (*United States* v. *AMA,* 110 F.2d 703, (D.C. Cir. 1940), *cert. denied,* 310 U.S. 644 (1940)). Both respondent AMA and the Medical Society of the District of Columbia were convicted of conspiracy to restrain and obstruct the development of the group health plan, in violation of the Sherman Act. In affirming the convictions, the D.C. Circuit Court stated: "The concern of [AMA and the local medical society] with the effect of Group Health on the economic status of the medical profession, and upon competition in financing and making available medical and hospital services, is abundantly illustrated by articles and statements of officers and members thereof" (*AMA* v. *United States,* 130 F.2d 233, 239 (D.C. Cir. 1942)). The Supreme Court affirmed the convictions in 1943 (*AMA* v. *United States,* 317 U.S. 519 (1943)). The Administrative Law Judge takes official notice of these decisions.

In 1965, AMA responded to an inquiry from the California Medical Association asking whether a physician could ethically compete with other physicians, through competitive bidding, to obtain an employment contract to perform physical examinations (CX 1158A, 539A). In its [213] response, AMA relied on the first three paragraphs of Opinion 3 of Section 6 of the *Opinions and Reports* governing contract practice (F. 146, pp. 2–7–08), including the provision barring "underbidding by physicians" (CX 1158A–C). The AMA letter stated:

> The guidelines as to what would be proper bidding could be indirectly resolved from points 1 and 2 [the first and second subparagraphs of the third paragraph of Opinion 3 of Section 6 of the 1964 *Opinions and Reports* (CX 465V) and later in the 1971 *Opinions and Reports* (CX 462Z12–13)]. That is, when the bid is below what is the usual fee paid for the same kind of medical service in the locality and when the remuneration is so low as to make it impossible to render competent service [it is unethical]. . . .
>
> . . . [As to] whether or not an affirmative response to such a general invitation to bid for use of the physician's professional services would [it] be within keeping of the dignity of the medical profession? Secondly, a doctor, would know by the type of request tendered to him that he probably is going to be competing against many of his associates for a specific contract or employment. Wouldn't this be a competitive force of so great a magnitude that it would cause a deterioration of the quality of medical service rendered? . . .

Thirdly, wouldn't such a request, if answered, make an inroad into the concept of professionalism in that it reduces the profession to a business? (CX 1158C-D).

In the mid 1960's, corporate plantations in Hawaii were contracting with physicians, on salaried and other fixed compensation bases, to provide medical care for their workers and retirees (CX 852A, 850C). When the plantations' retirees began obtaining coverage under the [214] newly instituted Medicare program, the plantations decided to seek Medicare reimbursement for the services rendered by their contract physicians, while continuing to pay the physicians on a salaried basis (CX 852A-B). The plantations also planned to pay the Medicare deductible for those retirees who continued to obtain their care from the plantations' contract physicians (CX 852A-B). The Honolulu County Medical Society's executive secretary, and later the Hawaii Medical Association's attorneys, wrote to AMA in 1967 asking whether the proposed contractual arrangements were ethical (CX 852, 850). The Hawaii Medical Association's attorney stated: "If the Judicial Council deems it unethical, the doctors will pull out of the contract" (CX 848, 850A). The Secretary of the AMA Judicial Council responded to the Honolulu County Medical Society, enclosing contract practice provisions of the Judicial Council's *Opinions and Reports,* and stating:

[T]his matter is a classic example of contract practice . . . . To the extent that the company seeks to derive benefit for itself from the labors of the physician . . . [i]t would be in derogation of basic ethical principles of medicine. . . . [T]he proposal of the plantation does not appear to be in keeping with traditional AMA policy. Were the plantation to accept an assignment of the physician's benefit, the plantation would be selling the services of the physician and would be exploiting him. There would be no assurance that the income of the physician from the plantation would relate in any way to the amount of services he furnished the individual patient . . . . Perhaps the time has come when an educational program is needed to eliminate as far as possible this older form of contract practice, substituting a fee-for-service system . . . . (CX 851).

The Honolulu County Medical Society adopted, as "clear and unequivocal," AMA's position on the plantations' contractual proposal and declared unethical any arrangement violating the policies set forth in the AMA letter (CX 846). The [215] Secretary of the AMA Judicial Council then wrote to the county society, praising it for "using the *Opinions and Reports* of the Judicial Council [to take] a stand" (CX 845). The AMA letter, which quoted a portion of an earlier AMA Judicial Council report, stated:

The Judicial Council believes that the remedy for the evils associated with contract practice resides in the county societies, and that these societies should use their

influence and power . . . to prevent underbidding for these contracts below what would give a fair reward for medical services rendered . . . .

It seems to me that the Honolulu County Medical Society is observing the spirit of ethical principles . . . . (CX 845A–B).

In January 1966, the AMA Department of Medical Ethics wrote to a Utah radiologist that "an agreement under which the hospital employs the radiologist and sells his services . . . is always considered unethical since professional services are being purveyed to the direct benefit of a lay group; namely, the hospital" (CX 807C, 537A).

In February 1966, the AMA Department of Medical Ethics advised a West Virginia physician that it is unethical to contract to provide coverage for a hospital's "walk-in" patients on a fixed salary basis, even when the physician's services are billed separately (CX 813A–B). AMA sent the physician the 1966 *Opinions and Reports* and directed his attention to, among other provisions, Opinion 8 of Section 6 (CX 813A), which proscribed salaried emergency room practice (CX 463V, W).

In May 1966, the Kentucky Medical Association, an AMA constitutent society whose members must subscribe to the AMA Principles of Medical Ethics (CX 1827H, I, J), threatened three physicians with disciplinary action (CX 1823) for permitting a "lay organization to purvey their services to the public and not restricting their method of compensation as nearly as possible to the time-honored 'fee-for-service' concept" (CX 1823A). The state society's Board of Trustees stated that occupancy of offices in hospitals by "a privileged few" physicians "is a form of solicitation which is inimical to high professional standards" (CX 1823A). **[216]**

In June 1966, the AMA House of Delegates "approved for circulation" a model physician-hospital contract for the staffing of hospital emergency rooms (CX 954A–E). It provides:

11. *Professional fees:* The charges for professional services rendered by the Partnership [of physicians] shall be established, billed and collected by the Partnership in the same manner as are the fees of other physicians engaged in the independent practice of medicine. It is intended that the Partnership's schedule of fees shall conform generally with those customarily charged in the locality and nearby localities for comparable services (CX 954C).

The model contract also provides that the physicians "shall organize and operate the Emergency Department or Section and engage in medical practice therein in accordance with the ethical and professional standards of the American Medical Association . . ." (CX 954D). As recently as June 1974, the Secretary of the AMA Judicial

Council sent a copy of the model contract to a hospital which had requested guidance in staffing an emergency room (CX 868, 869A–D).

In 1967, the House of Delegates of the state medical society in Maryland voted to disapprove the closed-panel practice of medicine as an abridgement of "freedom of choice" (RX 308, p. 29). It relied on a similar policy adopted by the AMA House of Delegates in 1959 (RX 308, p. 29). Previously, the AMA Judicial Council had declared that "free choice of physician . . . expressly requires that any qualified licensed physician residing in the area in which the plan operates be allowed to participate" (CX 1435Z57). The Maryland medical society published its "freedom of choice" resolution in its August 1976 compendium of interpretations of the AMA Principles (RX 308, pp. iii, 29).

In April 1968, a New York physician wrote to AMA to ask whether his part-time employment as a salaried physician at a hospital would violate the AMA Principles of Medical Ethics. AMA replied that the opinions of its Judicial Council do not approve of hospitals employing physicians (CX 1753A). [217]

In July 1968, the Secretary of the AMA Judicial Council wrote to a Virginia physician that it is not ethical "for a physician to have a contractual relationship with a hospital in which professional fees for his services are collected by the hospital and he receives a salary not related to those fees" (CX 831).

Also in 1968, the Chairman of the Judicial Council of the Florida Medical Association wrote to the AMA Judicial Council inquiring about the ethical principles that apply to physicians employed on a salary basis by a hospital or medical school (CX 528A, B), AMA learned that the state association, whose own ethical principles are the AMA's Principles of Medical Ethics (CX 2543K), had adopted a statement providing:

> A salary may be paid to a physician for time spent in administration and supervisory capacity but not for patient care.
>
> It is not unethical for a physician to accept a salary for supervisory, or educational and administrative activities or his presence; but it shall be unrelated to how many patients he sees or how much money he collects from the patients for services rendered them; and fees for treatment of patients shall continue to be billed in the physician's name and disposed of by the physician rendering the service (CX 528A).

The AMA Judicial Council carefully considered this statement and unanimously decided that the Florida Medical Association's own ethical policy statement on salaried hospital practice would serve as an acceptable response to the state association's inquiry to AMA (CX 528B).

In December 1969, the Secretary of the AMA Judicial Council

responded to a physician's inquiry by sending a letter to an AMA field representative (CX 812, 459D). The letter stated: "If the salaried physician is being paid by the hospital for medical care given patients the hospital is practicing medicine through a licensed employee . . . . [This activity] is contrary to AMA policy. See opinion 4 and 5 on page 32, Opinions and Reports of the Judicial Council [CX 463V]" (CX 812A). [218]

In October 1972, the State Medical Society of Wisconsin, a constituent society of AMA whose members are governed by the AMA's Principles of Medical Ethics (CX 1906A, G), wrote to the Secretary of AMA's Judicial Council regarding the ethics of a prepaid group health plan's distribution to the public of a list of its staff physicians (CX 1198). In response, the Judicial Council Secretary cited Opinion 3 of Section 6 of the 1971 *Opinions and Reports* as the most applicable opinion of the Judicial Council (CX 1199). Opinion 3 includes a ban on contract practice "[w]hen there is solicitation of patients directly or indirectly" (CX 462Z13).

In 1973, the Washington State Medical Association, an AMA constituent society that requires its members to subscribe to AMA's Principles of Medical Ethics (CX 475H, I, K, O), asked the AMA Judicial Council for ethics advice on a contract plan proposed by Manpower, the large temporary help service. Manpower wanted to hire physicians to cover hospital emergency rooms and adult health clinics and to conduct physical examinations, and pay them based on an established schedule. It had requested the state association's assistance in locating physicians who might be interested (CX 822A-C). The Secretary of the AMA Judicial Council wrote back noting that, under the proposal, Manpower "would hire a physician and tell him where and when to work, determine his salary, and determine its charge for its service in providing him to its subscribers" (CX 823). The AMA letter said the plan "would exploit the physician" and violate "ethical principles" (CX 823B). The AMA official called the state association's attention in particular to Section 6 of the Principles of Medical Ethics and to the opinions found in the 1971 *Opinions and Reports* following that section (CX 823B). The state association then wrote to Manpower, informing it of AMA's judgment that the contract practice plan would violate ethical principles and declining to provide assistance to Manpower (CX 824).

A hospital in Indianapolis paid an internist a fixed stipend to direct an arthritis treatment clinic which collected fees from patients for the services it rendered (CX 799). In 1974, a member of the medical staff of the hospital wrote to the AMA Judicial Council to ask whether the arthritis clinic was "in violation of ethics and

policies of the AMA" (CX 799). In its response, the AMA Judicial Council questioned the propriety of the clinic selling its contract physician's services for a fee, stating that "[t]he policy of the American Medical Association is that the physician should set his own fees and bill his own patients" (CX 798). [219]

In 1974, a physician's attorney asked AMA whether the physician's contemplated employment with a medical clinic licensed by the Chicago Board of Health would be legal and ethical (CX 815). The physician planned to assign the fees he collected from his patients to the clinic, in return for compensation on an hourly basis (CX 815). The Secretary of the AMA Judicial Council responded that the practice was of questionable legality based on cited court cases. He advised that "[f]rom an ethical point of view I would say that it is contrary to the long established policy of the AMA," and enclosed an opinion reflecting that policy (CX 814).

Sometime after issuance of the complaint in this proceeding, the Texas Medical Association sent a letter to the Texas Hospital Association, with copies to the chiefs of staff of Texas hospitals and to the presidents of every county medical society in Texas, stating that "the only acceptable method for [hospital-based] physicians to fulfill their ethical and legal obligations" is for the individual physicians to bill their patients directly or through hospital accounting departments on a fee-for-service basis (CX 859A, B). The letter referred to the Principles of Medical Ethics (CX 859A), which govern the state society's members (CX 1899U, Z5). The letter also paraphrased the first paragraph of Opinion 5 of Section 6 of the *Opinions and Reports,* which states that physicians should not permit the sale of their services by a hospital or lay organization for a fee (CX 462Z13). The letter asked the Texas Hospital Association to cooperate "in circulating this policy to administrators of hospital facilities in Texas in order that physicians seeking to comply with these ethical guidelines may be able to negotiate, and if necessary renegotiate, acceptable contracts for provision of these medical services" (CX 859A). The letter also stated that Texas law prohibited the corporate practice of medicine. An attachment to the letter, containing Texas Medical Association ethical policies issued in November 1975 and May 1976, stated that physicians who practice under circumstances other than separate, direct billing of patients for particular services rendered "may be subject to charges of unethical conduct and previous policy allows no latitude in deciding the ethics of the matter" (CX 859C, D, A). [220]

Florida Health Care Plan

149. In 1968, the Florida Medical Association ("FMA"), adopted a statement, later approved by the AMA Judicial Council, declaring it unethical for a physician to be paid a salary for patient care (CX 528A).

Throughout the 1970's the FMA and the Volusia County Medical Society ("VCMS"), both AMA member societies (CX 2543A, 1961B), have impeded the development of an HMO by restricting its marketing activities and declaring its physician employment contracts to be unethical. In their actions, the societies have relied on AMA ethical standards and other AMA statements.

In 1971, Dr. E. D. Davis, who testified in this proceeding, and others began organizing the Florida Health Care Plan ("FHCP"), an HMO in Daytona Beach, Florida, which has since gained federal certification and begun operations (Tr. 9146–47, 9155–56, 9158). Its staff includes contract physicians who are paid a fixed salary to care for patients (Tr. 9196–97). In late 1971, the VCMS voted unanimously to oppose and disapprove the plan (CX 2575D, E).

In 1972, the FMA published an ethics opinion stating:

> [A]ny physician contemplating providing medical service in an HMO setting should always be aware of Section 6 of the Principles of Medical Ethics and particularly those ethics covering conditions of medical practice, contract practice, purveyal of medical service to direct profit of lay group, practice of medicine by lay corporations, and lay corporations [Opinions 1, 2, 3, 4, 11 and 12, respectively, of Section 6 of the 1971 AMA *Opinions and Reports* (CX 462Z12–13, Z15)] (CX 2572E).

Also in 1972, the state society issued *Criteria for Ethical Contracts Between Physicians and Hospitals* ("Criteria") (CX 825). The Criteria begin with an almost verbatim rendition of the final paragraph of Opinion 5 of Section 6 of AMA's 1971 *Opinions and Reports* (CX 462Z14). The Criteria also declare that ethical contracts must not include a maximum or ceiling on the contract physician's income (CX 825).

In 1973, at the request of FMA, AMA's Department of Field Service supplied VCMS with "anti-HMO's" information "[which] will give you and your physicians all of the necessary information and 'ammunition' to rebut HMO activities in your area" (CX 2101). [221]

In May 1977, two of FHCP's physicians applied for malpractice insurance coverage (CX 2558, 2566) from an insurance carrier established and controlled by FMA (CX 2540C, D, 2539C). The only other source of malpractice insurance in Florida was a program run

by the State of Florida. The rates for this plan were substantially higher than the FMA carrier's rates (Tr. 9198-99, 9202, 9210).

The state society's insurance carrier obtained copies of the FHCP physicians' employment contracts and forwarded them to the FMA's Judicial Council for review (CX 2562, 2565, 2544). The Judicial Council declared the employment contracts unethical (CX 2563-65, 2544). In June 1977, the insurance carrier rejected the physicians' applications for coverage (Tr. 9201-02), stating in letters to the physicians:

> The Judicial Council has disapproved this contract due to the ceiling on the physicians income or the flat salary which you receive from Florida Health Care Plan, Inc. It is the feeling of the Council that this cap or ceiling is not consistent with the ethical principles of the Florida Medical Association. The Council feels that the income of a physician should be based on his production and the ceiling can result in the exploitation of the contract physician (CX 2565, 2544).

FMA's ethical principles consist of AMA's Principles of Medical Ethics, as interpreted by the opinions of the AMA Judicial Council (CX 2543K).

The physicians employed by the FHCP have had to obtain their malpractice insurance from the high cost plan administered by the State of Florida (Tr. 9198, 9210-11). Consequently, FHCP must pay insurance premiums four times higher than the premiums charged by the medical society carrier (Tr. 9210-11).

D. The Connecticut Respondents

150. The AMA House of Delegates has adopted a resolution declaring that no state or local society which has not adopted AMA's Code of Ethics shall be entitled to [222] representation in AMA (CX 1435Z15-16). CSMS has adopted the AMA's Principles of Medical Ethics to govern the conduct of its members (CX 991D, L-M; CX 1404I-J). NHCMA has also adopted the AMA's Principles of Medical Ethics (CX 1404I). NHCMA's bylaws declare that members can be expelled for violating AMA's Principles of Medical Ethics, "as reflected in the [AMA] Judicial Council" (CX 1404I).

CSMS adopted a resolution in 1962 condemning as "corporate practice of medicine" hospitals' receipt of fees from government health programs and other third-party payers for services which the hospitals' staff physicians were providing to certain beneficiaries (CX 1344A, Z9-Z11). The resolution declared that such beneficiaries "shall have the status of private patients of privately practicing physicians" and that "no fees paid by any third party agency for services rendered by such physicians shall be paid directly or

indirectly to any hospital . . ." (CX 1344Z9, Z11). This resolution is similar to Opinion 5 of Section 6 of AMA's *Opinions and Reports* (CX 462Z13). Copies of the resolution were distributed to general community hospitals throughout Connecticut (CX 1344Z10).

The original draft resolution stated that "the practice of payment to hospitals of fees for services to patients is detrimental to the private practice of medicine and should cease" (CX 1344C–D). In the debate on the resolution, one CSMS delegate stated: "The big thing that we are most concerned about is the fact that certain pressures may be brought upon private physicians in the institutions to which these patients are admitted so that the fee will be paid to the hospital for professional services rendered by physicians" (CX 1344G). Another delegate received applause when he stated that "it is the principle behind this thing . . . that third party payments should not get into the hands of people other than the doctors" (CX 1344Z2). Another CSMS delegate also was applauded when he stated: "[W]e want to stop the hospitals from putting their hands out for that particular type of payment . . . . Now, if we get strong on this motion, perhaps in the future we can go to the help of these poor anesthesiologists and radiologists" (CX 1344Z1). Three years later, in 1965, the CSMS House of Delegates adopted resolutions from its Sections on Radiology and Pathology, supporting "the principle that all hospital patients be billed separately for the professional services of doctors of medicine" (CX 1343E, H, A, B–C). The House declared that "[t]his principle is in accordance with the positions adopted by the American Medical Association . . ." (CX 1343E). In some of its advisory letters to physicians regarding contractual arrangements, AMA has linked the [223] separate billing requirement to the ethical proscription regarding salaried medical practice (CX 820, 830, 831, 806C, G, 813A–B, 798, 799).

From 1972 to 1974, NHCMA complained about HMO written solicitations of patronage in letters to CSMS (CX 964), the Connecticut Commissioner of Insurance (CX 962, 963) and the Commissioner of the Connecticut Department of Consumer Protection (CX 965). In its letter to the insurance commissioner, NHCMA questioned the propriety of a "closed panel health service plan without free choice of physician" which was "supplying medical service . . . in direct competition with the rank and file of taxpaying practitioners" (CX 962).

In 1974, NHCMA wrote to the Secretary of HEW to criticize an HMO's application for a federal grant (CX 966). In a December 1976, newspaper interview, the president of NHCMA associated HMOs

with socialized medicine and otherwise disparaged them (CX 2440, 2441).

Earlier, in a September 1971, letter written by one NHCMA official to another, NHCMA questioned whether, in light of its advertising and publicity, a New Haven HMO was "in violation of AMA principles of medical ethics and principle [sic] of *economics*" (CX 960) (emphasis in original). However, NHCMA took no action because a Connecticut statute permitted the HMO's promotional activities (CX 961).

E. Physicians' Arrangements with Nonphysicians

151. The AMA Principles of Medical Ethics and 1971 *Opinions and Reports* prohibit partnerships between physicians and nonphysician health professionals (CX 1189A, 462Z15, Z16, 1154, 1153). AMA's 1971 *Opinions and Reports* permit physicians to join in the formation of professional associations or corporations for the delivery of health care only if ownership of the organization remains solely in the hands of licensed physicians (CX 462Z15, Z16).

In 1970, AMA advised a county medical society that it would not be ethical for a psychiatrist-member of the county society to form a partnership with a psychologist (CX 1189, 52A).

In 1975, AMA sent an advisory letter to Dr. Paul D. Saville, a West Virginia rheumatologist, who testified in this proceeding (Tr. 2705), informing him that it would be neither ethically nor legally acceptable to form a business partnership or income-sharing arrangement with a [224] physician's assistant for the purpose of delivering health care (CX 1196). After receiving the AMA advice, Dr. Saville and the physician's assistant, Helen Kramer, formed an income-sharing arrangement; however, fearing physician hostility, they have kept the arrangement secret from everyone except their spouses (Tr. 2727–30). Physician's assistant Kramer, who also testified in this proceeding, brought administrative and patient-relations skills to the private practice of Dr. Saville, who lacked such skills (Tr. 2758–59, 2717). The result was a maximal effective practice which enabled the physician always to see new patients who came to his office and to treat a large group of people at minimal cost to them (Tr. 2717–19). Explaining the benefits of the income-sharing arrangement, Dr. Saville testified:

[W]e both contribute something, and it is to our mutual advantage that we both do well.

And the better we do, the harder Helen works, the harder I work, the more income

there is, and the more load on Helen's back. It is a better incentive to share in the profits rather than be fixed salary, in my opinion (Tr. 2720-21. *See also* Tr. 2762).

In 1975, the Texas Medical Association advised an orthopedic surgeon that, under AMA's *Opinions and Reports,* it would be unethical for the physician to enter into an income-sharing arrangement with a physical therapist working in his office because the physical therapist would be getting a direct financial interest in the productivity and fees earned by the physician (CX 1150, 1151A-B).

In 1974, Dr. Kenneth Pitts, a psychiatrist residing in Hillsboro Hills, Michigan, first considered the possibility of establishing a psychiatric out-patient center in surburban Detroit. He discussed the matter over a period of months with Dr. Marvin Hyman, a clinical psychologist with whom Dr. Pitts had worked in the past. Dr. Hyman shared Dr. Pitts' enthusiasm for the project and the two men set out to establish a new out-patient center (Tr. 3166-68). Dr. Pitts and Dr. Hyman each invested an initial sum of $10,000 and, in late 1974, the Orchard Hills Psychiatric Center was organized under Michigan law as a professional corporation (Tr. 3167-70; CX 2102). Each of the men received 50 percent of the corporate shares (Tr. 3171). Dr. Pitts is medical director of the Center and Dr. Hyman serves as its [225] administrative director (Tr. 3164, 3170). All medical decisions at the Center are made by staff psychiatrists. Psychologists and social workers do not have authority to prescribe drugs, hospitalize patients or sign patient termination forms (Tr. 3173).

When the Center was created, Dr. Pitts considered establishing the practice on his own and hiring Dr. Hyman as an employee. Dr. Hyman, because of "professional or personal pride," wanted to be an equal "partner" in the practice (Tr. 3174). The doctors decided that the formation of a professional corporation would be the best alternative—it would offer the potential for a profit-sharing and pension plan, and would allow Drs. Pitts and Hyman to have an equal position in terms of profit and control (Tr. 3174).

In April 1975, Dr. Pitts, who testified in this proceeding, wrote to the Michigan State Medical Society concerning the ethical propriety of forming a mixed professional corporation with a psychologist and a social worker (CX 1183B). The Medical Society deferred its decision until it had obtained the opinion of the AMA Judicial Council (CX 1184). The AMA Judicial Council told the Medical Society that Opinions 14 and 15 in Section 6 of AMA's *Opinions and Reports* prohibit a psychiatrist from owning jointly with a psychologist a professional corporation for the delivery of mental health services, notwithstanding the legality of the arrangement under state law (CX 1185, 1183, 2102N). In October 1975, the Medical Society conveyed

the AMA ethics interpretation, which had confirmed its own opinion, to Dr. Pitts, and stated that the prohibition would apply to partnerships of otolaryngologists-audiologists, pathologists-medical technologists, ophthalmologists-opticians, radiologists-physicists, family physicians and paramedical personnel or physician assistants (CX 1186). In May 1976, the Medical Society's Judicial Council reaffirmed that physician-nonphysician partnerships are unethical (CX 1729).

The Medical Society's October 1975, letter led Dr. Pitts to incorporate the AMA ethics opinions in the standards for out-patient psychiatric clinics which he subsequently drafted for the Michigan Psychiatric Society (Tr. 3189–90; CX 2054C). These standards for out-patient psychiatric clinics, published in April 1977, quote Opinions 13 and 15 of Section 6 of AMA's 1971 *Opinions and Reports* (CX 462Z15, Z16), and state that any out-patient psychiatric clinic organized as a professional corporation must be solely owned by physicians (CX 2054A, C). The Michigan Psychiatric Society [226] promulgated these standards to its members, advising them that it would enforce the standards through peer review and ethics committee activities (Tr. 3191; CX 2054C).

Dr. Pitts had already formed his mixed corporation when he was told it was unethical (Tr. 3182–83). It made possible his association with other professionals and created opportunities for teaching and professional development (Tr. 3174–75). The psychologist, Dr. Hyman, brought a special skill in psychological testing and many other special talents to the joint endeavor (Tr. 3175). Dr. Pitts did not dissolve the corporation because he did not believe the corporate arrangement compromised medical practice; he also thought that it would have been "a very complicated thing to dissolve the corporation at that time" and that Dr. Hyman might have grounds for a lawsuit (Tr. 3185). Dr. Pitts was embarrassed by the situation, but apparently suffered no monetary losses, possibly because information about his situation was not generally known (Tr. 3185–88).

Association with nonphysician health personnel such as psychologists, physician's assistants and physicial therapists, can help physicians spend their time where it is most needed and can increase their productivity (CX 959Z24, 197Z27, U.).

XII. ABANDONMENT OR DISCONTINUANCE

152. The Principles of Medical Ethics of the American Medical Association (RX 1) consist of a preamble and 10 short paragraphs setting out basic principles or standards by which a physician may determine the propriety of his or her conduct in relationships with

patients, colleagues, allied health personnel and the public (Tr. 3940–44, 4289; RX 1). The 10 basic sections of the Principles were approved by the AMA's House of Delegates in 1957 (Tr. 3940, 4289; RX 1).

The *Opinions and Reports* of the Judicial Council are a collection of opinions and statements of the Council on a variety of subjects which have come before it (CX 462; RX 1). Some of these opinions and statements involve interpretations of the Principles of Medical Ethics; the opinions, statements and interpretations are modified from time to time to meet changing conditions of medical practice (RX 1, p. 1; Tr. 4290). The Judicial Council's interpretations of the Principles of Medical Ethics are contained in a booklet, entitled *Judicial Council Opinions and Reports* (Tr. 3982; CX 462; RX 1). The *Opinions and Reports* are distributed to anyone requesting a copy (Tr. 3982). The Judicial Council opinions and statements circulated by AMA [227] prior to the issuance of the complaint in this proceeding were the 1971 *Opinions and Reports,* which were published in booklet form and distributed commencing in 1972 (CX 462). Subsequent to issuance of the complaint, the Judicial Council, in 1976, issued revised opinions and statements which were published in booklet form in 1977 (RX 1). The Principles of Medical Ethics remained unchanged (RX 1, pp. 4–5). Some of the activities of AMA officials and the Judicial Council which preceded publication of the 1977 *Opinions and Reports* are described in the following paragraphs.

In September 1975, the Secretary of the Judicial Council wrote to a state medical society: "It was not felt that a major revision of the profession's position on advertising was necessary or advisable, but that an updating of the Judicial Council's previous opinions and reports on advertising might be helpful in the near future" (CX 627A–B). He further stated that any updating would uphold, in general, "reasonable restrictions" on advertising (CX 627B). The proposal for a new "updated" edition of the 1971 *Opinions and Reports* was formally sanctioned at a meeting of the Judicial Council in November 1975 (Tr. 4336; RX 621). Thereafter, on April 9, 1976, four months after the complaint in this proceeding was issued, the Judicial Council issued a revised statement on physician advertising and solicitation (CX 502A, H–K). The content and format of a new edition of *Opinions and Reports* was approved by the Judicial Council on June 26, 1976 (CX 501F). This revised statement was included in a revised edition of the *Opinions and Reports* which was published by the Judicial Council in March 1977, well over a year after the complaint herein was issued (RX 1, pp. 30–31; Tr. 4335). The

AMA Judicial Council issued the revised statement on advertising and solicitation and the 1977 edition of *Opinions and Reports* largely because "changing legal considerations," represented by the Supreme Court decision in *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773 (1975) (Tr. 4337), and administrative agencies' consideration of physician advertising and solicitation (CX 502A, E–H) had, in the view of the Judicial Council, rendered some provisions in the earlier [1971] edition of *Opinions and Reports* "legally inappropriate" (Tr. 4338, 4335; CX 503I).

For a number of months following issuance of the complaint in this proceeding, AMA continued to distribute excerpts from the 1971 *Opinions and Reports,* as well as its "Guidelines on Telephone Directory Listings" and the 1974 *Report on Physician-Hospital Relations* (CX 1790A, 1788, 501D–E). Through at least the beginning of the trial [228] in this proceeding, AMA component and constituent medical societies have continued to restrict physician advertising, solicitation and contract practice based on the 1971 *Opinions and Reports* (Tr. 2076–78, 2085–86; RX 1, p. 31, p. 61, F. 95, p. 121; 98, pp. 124–29; 109, p. 144; 114, pp. 150–52; 118, p. 158; 123, pp. 174, 176; 138, p. 199; 139, p. 199; 148, p. 219; 149, pp. 220–21; 151, pp. 224–26). There is no evidence that any of these societies rescinded any existing ethical rulings, or revised existing ethics guidelines or codes on advertising, solicitation and contract practice since 1975, because of changing legal considerations or because of the revised statement of the Judicial Council. For instance, the former president of the Maricopa County Medical Society, a physician who had served as chairman of both the Society's Professional Committee and its Board of Censors (Tr. 7208–09), stated his belief that, as of the date of his testimony in January 1978, physician members would not be allowed to advertise factual nonmisleading information, such as the opening or closing of an office in newspapers under the Code of Ethics of the Maricopa County Medical Society (Tr. 7254). This statement supports the belief that the 1971 *Opinions and Reports* continue to affect the application of ethical principles to physicians' advertising, solicitation and contract practice, as evidenced by their pervading influence on the ethical guidelines promulgated and enforced by local medical societies. A further example of continuing reliance being placed on the 1971 *Opinions and Reports* involves the Michigan Psychiatric Society, which adopted parts of the 1971 *Opinions and Reports.* Although the psychiatric society is not affiliated with AMA, the chairman of the committee who drafted the society's 1977 guidelines relied on the AMA ethical interpretations of 1971 (Tr. 3189–90; CX 2054C; F. 151, pp. 225–26).

153. The 1976 revised statement of the Judicial Council expressly "reaffirms the long-standing policy of the Judicial Council on advertising and solicitation by physicians" (RX 1, p. 30). The revised statement does not rescind or amend the long-time absolute ban on solicitation in the AMA Principles of Medical Ethics; "[The Principles] proscribe the solicitation of patients" (RX 1, p. 30). Dr. Robert S. Stone, who is Dean of the University of Oregon Medical School, a former Director of the National Institute of Health and a member of AMA's House of Delegates as well, was called by AMA to testify in this proceeding "exclusively about the AMA's position on advertising and solicitation by physicians" (Tr. 9683, 9686, 9688, 9711). He testified that it would still be appropriate for a local medical society to reprimand a physician or clinic for truthfully advertising its services because "that is soliciting business" — "The issue is not the truth of the contents [of the advertisement]" (Tr. 9716–18). [229]

While the revised Judicial Council statement permits the physician to provide certain information which the public is entitled to know, such as names of physicians, their types of practice, office location, office hours and "other useful information that will enable people to make a more informed choice of physician," the statement continues the use of catch-words such as "accepted" local media, "dignified" announcements, "reputable" directories, "solicitation" and "self-laudatory" statements (RX 1, p. 30), words which AMA and its local societies have long used to proscribe physician advertising (CX 462Z5 [Sec. 5, Op. 6], Z6 [Sec. 5, Op. 11], Z7 [Sec. 5, Op. 13], Z39 [Sec. 10, Op. 3], Z44 [Sec. 10, Op. 13], 545D, 514B, 512C, 94, 768B, 117). Examples of acceptable media for making information available to the public are stated to be office signs, professional cards, dignified announcements, telephone directory listings and reputable directories. No mention is made of newspapers, periodicals, radio or television (RX 1, p. 30).

Physician publicity and announcements which constituted "infractions of good taste" were disapproved under the 1971 *Opinions and Reports* (CX 462Z5 [Sec. 5, Op. 6], Z7 [Sec. 5, Op. 14]; Tr. 741; F. 99, pp. 130–31). Dr. Robert B. Hunter, the Chairman of AMA's Board of Trustees, called as a witness by AMA, testified that AMA officials have made public utterances that it is AMA's position that physician advertising must not be only factual, but also "tasteful," and that most state and local medical societies also have that policy (Tr. 9660–61. *See also* Tr. 4870–72). Dr. Stephen C. Biering, Dean of the School of Medicine, University of Indiana, called as a witness by AMA regarding its position on physician advertising and solicitation (Respondent American Medical Association's List of Witnesses For

Its Surrebuttal Case, dated April 21, 1978, p. 3), testified that it is appropriate for a medical society to reprimand or expel a member who has advertised in the newspaper in a truthful fashion but in "bad taste" (Tr. 9533–34).

The 1977 *Opinions and Reports* declares that "local, state, specialty medical associations. . .may have ethical restrictions on advertising, solicitation of patients, or other professional conduct of physicians that exceed the Principles of Medical Ethics" (RX 1, p. 30). AMA has made all such supplementary ethical principles binding upon the respective medical societies' members, provided that the principles are not inconsistent or in conflict with AMA's constitution and bylaws (CX 1435Z20). AMA [230] also has declared that when a physician disregards "local custom," as determined by the local society, he has acted unethically and may be subject to disciplinary action (CX 462Z9–10, Z7, I–J, 1349; RX 1, p. 9).

The 1977 *Opinions and Reports* continues to prohibit health plans from placing in their advertisements the names and qualifications of particular physicians, unless the plan's entire physician roster is included (RX 1, p. 31. *See also* CX 951).

The 1977 *Opinions and Reports* continues to prohibit physician publicity in the media if it "bespeaks self-exploitation," and encourages physicians to pre-clear publicity with their local medical society (RX 1, p. 35. *See also* CX 462Z44). AMA's 1974 ethics restriction on physician directories, which prohibits inclusion of "self-aggrandizing" statements (CX 509A–B, N; RX 5), is still in effect (Tr. 3998).

The 1977 *Opinions and Reports* does not enumerate physician prices or fees among the items of information that it says can be advertised; it mentions prices only in discussing the information that may be included in a "reputable" directory (RX 1, p. 30).

The 1977 *Opinions and Reports* continues to provide that physician conduct may be deemed unethical and subject to medical society disciplinary action when it does not conform to the "customs and usages of the medical profession" and may reflect upon the "dignity of and respect for the medical profession" (RX 1, p. 9; CX 462I–J [Preamble, Op. 4]).

AMA has not specifically rescinded the 1971 *Opinions and Reports* or the 1974 *Report on Physician-Hospital Relations* (CX 959, 461Z156). AMA has not specifically rescinded the "Guidelines on Telephone Directory Listings" (CX 673B–I), which were adopted and approved by the AMA House of Delegates (CX 663, 673A). In June 1977, the AMA House of Delegates adopted a resolution commending the Judicial Council for "updating" the *Opinions and Reports* (RX 4, p. 52); however, the resolution did not rescind the House's earlier

adoption of provisions in the 1971 *Opinions and Reports* and of other AMA restrictions on advertising and solicitation (CX 463), and remained silent on the relationship of the 1977 *Opinions and Reports* to those earlier provisions and restrictions (RX 4, p. 52). While the 1977 *Opinions and Reports* does state that the [231] Judicial Council has "suspended the distribution of the previous edition of Opinions and Reports" (RX 1, p. 1), it does not state that the 1971 or other preexisting AMA ethical restrictions on advertising and solicitation have been rescinded or superseded (RX 1, p. 1). There is no evidence that AMA has advised or requested component and constituent societies to revise or update their own codes or guidelines.

Furthermore, AMA's conduct in respect to the formal and informal promulgation, distribution and enforcement of the Principles of Medical Ethics, established by the record as existing prior to 1975, continued after 1975 as well. Since this conclusory finding is somewhat ambiguous as to which ethical standards were enforced subsequent to 1975, some further elaboration is necessary. Accordingly, it is further found that the correspondence in the files of AMA in the possession of Susan Roberts, prepared, dispatched or received from January 1, 1975 to October 11, 1976 (the date the subpoena duces tecum was served on AMA), relating or referring to any alleged breach of any ethical standard of medical practice by any physician, would have revealed instances of AMA's and of component and constituent medical societies', reliance upon the 1971 *Opinions and Reports* of the Judicial Council in the enforcement of the Principles of Medical Ethics, or reliance upon ethical interpretations consistent with positions stated in the 1971 *Opinions and Reports* (Order Ruling on Complaint Counsel's Motion for Adverse Rulings and Other Relief Due to Noncompliance with Subpoena Duces Tecum by Respondent the American Medical Association, dated February 24, 1977, p. 10). The Administrative Law Judge makes this finding based upon Rule 3.38 of the Commission's Rules of Practice providing for sanctions for disobeying the Administrative Law Judge's order (Order Ruling on Motion of Respondent American Medical Association to Quash Subpoena Duces Tecum, dated November 12, 1976; Order Ruling on Complaint Counsel's Motion for Adverse Rulings by Respondent the American Medical Association, dated February 24, 1977). This finding is consistent with other documentary evidence received in the record (*e.g.,* CX 627, 501, 502, 1790, 1788). Accordingly, this is an appropriate adverse finding. [232]

CONCLUSIONS

I. FACTUAL SUMMARY

The complaint issued in this proceeding challenges the ethics restrictions of respondents AMA, CSMS and NHCMA as violative of Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45. These ethics restrictions do not deal with the medical or therapeutic aspects of a physician's practice; at issue are predominantly restrictions on economic activities. The record evidence presents a substantial body of formal and informal actions, initiated, instigated and directly or indirectly influenced by each of the respondents, that have the effect of enhancing the economic positions of the members of each of the respective medical societies. Moreover, this result has not come about through mere chance or coincidence but, rather, through the concerted efforts of each of the respondents and the numerous other constituent (state) and component (local) medical societies located throughout the United States. The end result of their energies has been the placement of a formidable impediment to competition in the delivery of health care services by physicians in this country. That barrier has served to deprive consumers of the free flow of information about the availability of health care services, to deter the offering of innovative forms of health care and to stifle the rise of almost every type of health care delivery that could potentially pose a threat to the income of fee-for-service physicians in private practice. The costs to the public in terms of less expensive or even, perhaps, more improved forms of medical services are great.

The main body of evidence against respondent AMA consists of the Principles of Medical Ethics, official interpretations of the Principles, which AMA has adopted and disseminated, and letter after letter from AMA officials to medical societies and individual physicians explaining the Principles, applying the Principles to specific conduct and urging compliance with the Principles by the constituent and component societies. This body of evidence, consisting principally of documents from the files of AMA and constituent and component societies located throughout the United States, shows the sweeping nature of the challenged restraints, including a total ban on solicitation of patronage, severe restriction of most forms of advertising and unfair interference with physicians' contracts with third parties.

AMA has invited concerted action by its constituent and component medical societies to enforce the challenged restrictions. All of AMA's member societies have accepted [233] this role within the

AMA ethics framework. They have adopted AMA's Principles of Medical Ethics as their own, their members have abided by them and they have formally and informally enforced the Principles. The Connecticut respondents have adopted AMA's ethical principles and, like AMA's other member societies, have engaged in enforcement of the challenged restrictions.

This proceeding has placed several issues in precise focus. At the outset, there is the jurisdictional question, arising out of Section 4 of the Act, as to whether each of the respondents is a "company . . . or association . . . organized to carry on business for its own profit or that of its members", 15 U.S.C. 44. Another aspect of the multi-faceted question of whether respondents are subject to the Commission's jurisdiction arises out of the "in or affecting commerce" requirement of Section 5(a)(1) of the Act, 15 U.S.C. 45. To come within Commission jurisdiction, respondents' acts and practices must be shown to have the requisite interstate commerce nexus.

The record evidence presents a far-ranging and impressive accumulation of the activities of AMA, CSMS and NHCMA from which to focus on the jurisdictional issues. A substantial amount of each respondents' activities are devoted to the betterment of the health care delivery system in the United States through contributions to science, education and the public health. However, a substantial amount of each respondents' activities also inures to the pecuniary advantage of individual physicians. In fact, some of respondents' activities which are clearly beneficial to the general public also operate to directly or indirectly confer economic benefit upon the physician members of the respondent medical societies. Thus, the record evidence establishes that each of the respondents carries on business for the profit of its members. The record also establishes that respondents' acts and practices are in or affecting commerce. Consequently, each of the respondent medical societies is subject to Commission jurisdiction. This jurisdictional issue is discussed hereafter (*See* pp. 236–54, *infra*).

Having resolved the jurisdictional questions against respondents, the substantive issues of respondents' acts and practices must be considered. Complaint counsel contend that respondents and other medical societies have acted to place restraints on physicians' solicitation and advertising activities. Complaint counsel argues that these restraints [234] constitute unfair methods of competition in violation of Section 5. Complaint counsel also contend that respondents and others have acted anticompetitively with respect to physicians' contractual arrangements, also in violation of Section 5.

Essentially, the record evidence demonstrates that the restraints

placed upon physician competition by AMA and state and local medical societies have operated to restrict the dissemination of information about the price, type and availability of medical services, including information concerning industrial medical clinics, preventive medical services and prepaid group practice plans (*i.e.,* HMOs). The methods that can be used to seek patronage, were it not for the adamant opposition of medical societies, have been denied to physicians as have the benefits to the public that would come with increased competition in the health care sector. AMA and its constituent and component medical societies have restricted physicians' use of announcements, form letters and brochures, newspaper advertising, radio and television advertising, publicity in the news media, Yellow Pages listings, business and consumer directories, direct contact with institutions and physicians, open houses and other methods of soliciting patients. Moreover, ethics limitations have hampered the ability of physicians to engage in contractual arrangements for the provision of medical services.

The effects of respondents' ethical restrictions on physicians, and respondents' purported justification for the restrictions, are discussed later in this decision (*See* pp. 254–79, *infra*).

Having laid out a substantial body of evidence detailing the anticompetitive restraints placed upon physicians by the respondent medical societies and other medical societies not named as parties to this proceeding, Commission counsel assert that the existence of a conspiracy to restrain competition among physicians is thereby established. Taken together, the organization of each of the respondents, their interrelationships and the mutuality manifest throughout their application and enforcement of ethics proscriptions attest to the logical conclusion that the respondents and others have acted in concert to restrain competition among physicians.

Each of the respondents is a nonprofit corporation, comprised primarily of physicians engaged in the private practice, fee-for-service delivery of medical care (F. 1, p. 5; 9, p. 8; 12, p. 9). Respondent AMA is a national organization, with its basic make-up that of a federacy of [235] its state medical societies, which are termed constituent societies. The constituent societies, in turn charter local medical societies, which are termed component societies. In most instances, a physician must be a member of a component society to be a member of a constituent society, and a member of a constituent society to be a member of AMA. A

substantial majority of all physicians retain membership in the AMA and in their constituent and component medical societies.[6]

Not only is there a virtually singular identity of membership in the AMA and state and local medical societies, but there are also other indicia of interconnections. Often, dues are centrally collected by the constituent society for the AMA and the component society. There is a true hierarchy in the manner in which physicians are elected to serve as officials of each of the respective medical societies. For instance, members of component societies elect the officials who govern the constituent societies; they, in turn, elect the governing officials of the AMA (*See* F. 6-8, pp. 7-8; 10-11, pp. 8-9; 13, p. 10).

Of even greater significance is the deference paid by the state and local societies to the AMA. This unbending support of the national organization is attested to by the degree to which the constitutions and bylaws of AMA's constituent and component societies provide that AMA's Principles of Medical Ethics shall govern the conduct of their members.[7] The extent to which local and state societies look to AMA for advice and guidance on ethical matters and the quite numerous occasions on which they follow and implement that advice do more than suggest the interrelationships between the national and the state and local societies. Indeed, the abundance of record evidence establishes an interlocking relationship both organizationally and practically with regard to the formal and informal enforcement of ethics policies. This evidence establishes the existence of a conspiracy between AMA and its constituent and component societies (*See* pp. 279-90, *infra*).

There is also little merit to AMA's contention that it abandoned or discontinued any anticompetitive acts or practices by the issuance and publication of its 1977 *Opinions and Reports* (RX 1). There is no policy statement by AMA to the effect that the 1971 or any other preexisting AMA ethical restrictions have been rescinded [236] or superseded; nor is there any evidence that AMA's constituent and component medical societies have revised or otherwise departed from the ethics strictures of their own codes and guidelines. There is only an unbroken continuum of ethical pronouncements, and enforcement of those pronouncements, that will perpetuate the anticompetitive effects amply established in the record absent a remedial order (see discussion on Abandonment or Discontinuance, pp. 290-92, *infra,* and on Remedy, pp. 293-98, *infra*).

[6] F. 3-4, p. 6; 9, p. 8; 12, p. 9. However, a physician need not be a member of a particular medical society in order to be licensed to practice medicine. F. 2, p. 5; 9, p. 8.

[7] See Appendix A, pp. 306-09.

II. JURISDICTION

A. Nonprofit Exemption

In Section 5(a)(2) of the Federal Trade Commission Act, Congress limits the jurisdiction of the Commission to "persons, partnerships, or corporations", 15 U.S.C. 45(a)(2). Section 4 of the Act defines the word "corporation," for purposes of Section 5(a)(2), to include:

> any company, trust . . . or association, incorporated or unincorporated, which is organized to carry on business for its own profit or that of its members, and has shares of capital or capital stock or certificates of interest, and any company, trust . . . or association, incorporated or unincorporated without shares of capital or capital stock or certificates of interest . . . which is organized to carry on business for its own profit or that of its members.[8]

Respondents take the position that they are professional societies committed to the advancement of science, education and the public health, and are not organized for their own pecuniary benefit or that of their members (AMA Conclusions of Law, p. 6).[9]

Respondents are organized as nonprofit corporations; no part of their funds has ever been distributed to their members, the largest single source of funds are dues from [237] their members and each respondent is exempt from the federal income tax. Respondents argue that, under the rationale of the decision in *Community Blood Bank of the Kansas City Area* v. *FTC,* 405 F.2d 1011 (8th Cir. 1969), they are exempt from Federal Trade Commission jurisdiction. It is clear, however, that in reviewing a jurisdictional challenge under Section 4 of the Federal Trade Commission Act, the form of incorporation is not controlling. *Id.* at 1018–19. The crucial consideration is whether each of these respondents is carrying on business "for its own profit or that of its members", 15 U.S.C. 44. This determination must be made on an *ad hoc* basis depending on the facts of each case. *Id.* at 1018.

While this is a case of first impression involving professional associations claiming the nonprofit exemption under Section 4, there are, nevertheless, some guidelines that are helpful in resolving the controlling issue. In *Community Blood Bank,* the court recognized that Congress did not intend to provide a blanket exclusion for all nonprofit corporations, for it was aware that corporations ostensibly organized not-for-profit, such as trade associations, were merely

[8] 15 U.S.C. 44.

[9] Respondent AMA, on March 24, 1976, filed a Motion for Summary Decision Dismissing the Complaint for Lack of Jurisdiction on the basis that AMA is a nonprofit corporation not subject to the jurisdiction of the Commission. Respondents CSMS and NHCMA filed similar motions on April 26, 1976. These motions were subsequently denied as were requests for interlocutory appeals.

vehicles through which a pecuniary profit could be realized. *Id.* at 1017. The court also accepted, as settled law, the principle that the Commission does have jurisdiction over nonprofit organizations engaged in activities that produce a pecuniary profit. *Id.* at 1019.[10]

In *Community Blood Bank,* the court examined the activities of the respondents and found that those activities did not inure to the financial benefit of anyone and at all times were directed towards promoting a community-sponsored program in the public interest. *Id.* at 1020–22. These facts convinced the court that the organization was in law and in fact charitable, and that the Commission lacked jurisdiction over the nonprofit corporation because it was actively engaged in business only for charitable purposes. *Id.* at 1019, 1021. [238]

In *Ohio Christian College,* the Commission pierced the corporate veil of a nonprofit corporation to assert jurisdiction over the corporation where it provided the individual respondents with much of their subsistence and shelter. *Ohio Christian College,* 80 F.T.C. 815, 847 (1972). In a recent decision, the Commission asserted jurisdiction over a nonprofit corporation "existing in substantial part for the pecuniary benefit of the egg industry." *National Commission on Egg Nutrition,* 89 F.T.C. 89, 177 (1976), *aff'd,* 570 F.2d 157 (7th Cir. 1977), *cert. denied,* 47 U.S.L.W. 3218 (October 2, 1978). In determining that the National Commission on Egg Nutrition was subject to Commission jurisdiction, the Commission looked at the record as a whole. This required analysis of a large number of possible indicia of commercial purpose, such as origin, character of membership, source of funding, relationships with profit oriented groups, nature of publications and stated purpose. *Id.* at 177, 178.

The facts determinative of jurisdiction in the present proceeding do not fit into the exact pattern of any previously decided matter. It is therefore incumbent that the entire record be examined to determine if respondents' activities are entirely charitable or if their activities are infected with a commercial purpose. In *National Commission on Egg Nutrition,* a decision rendered several years subsequent to the *Community Blood Bank* decision, the Commission stated that the respondent existed in "substantial part" for the pecuniary benefit of the egg industry. At another point in its decision, the Commission stated that the respondent "exists in principal part" for the benefit of the egg industry. The Commission

[10] The court cited a number of court cases where the Commission has successfully exercised jurisdiction over trade associations, specifically, *FTC* v. *Cement Institute,* 333 U.S. 683 (1948); *Fashion Originators Guild* v. *FTC,* 312 U.S. 457 (1941); *Millinery Creators Guild, Inc.* v. *FTC,* 312 U.S. 469 (1941); *Pacific States Paper Trade Ass'n.* v. *FTC,* 273 U.S. 52 (1927); *California Lumbermen's Council* v. *FTC,* 115 F.2d 178 (9th Cir. 1940), *cert. denied,* 312 U.S. 709 (1941); *Chamber of Commerce* v. *FTC,* 13 F.2d 673 (8th Cir. 1926).

also stated that an organization which engages primarily in noncommercial activity and incidentally performs a function valuable to commercial interests might not be subject to its jurisdiction. Further, the Commission indicated that the presence of only one possible indicia of commercial purpose might be an insufficient basis for asserting jurisdiction. *National Commission on Egg Nutrition,* 89 F.T.C. at 177–79. The conclusion to be drawn from this imprecise language would seem to be that the Commission will assert jurisdiction over nonprofit organizations whose activities engender a pecuniary benefit to its members if that activity is a substantial part of the total activities of the organization, rather than merely incidental to some noncommercial activity.

Respondent AMA contends that the test of whether a corporation is organized for profit within the meaning of Section 4 is whether it *pays* dividends or other pecuniary [239] benefits to its members (AMA Conclusions of Law, pp. 16, 19). The Commission has previously held otherwise: "Profit, for the purpose of Section 4 of the Federal Trade Commission Act, is not limited to dividends, gains or direct reward." *Ohio Christian College,* 80 F.T.C. at 848.[11] The benefits to the egg industry generated by the respondent in the *National Commission on Egg Nutrition* were advertisements creating a favorable business atmosphere promoting the consumption of eggs. *National Commission on Egg Nutrition,* 89 F.T.C. at 178. No direct benefits were paid to the egg industry. The Commission asserted jurisdiction over the respondent and the courts have upheld that determination. Thus, AMA's contention that dividends or other benefits must be paid is rejected. If respondents directly or indirectly promote the pecuniary and economic interests of their members, the statutory test is satisfied.[12]

The respondents contend that for an organization to be subject to the jurisdiction of the Commission, profit-seeking must be the reason that it was organized and must play a dominant role in its activities (AMA Conclusions of Law, p. 20). While admitting that some parts of their budgets are devoted to activities that confer economic advantages upon their members, respondents argue that such activities are incidental or subordinate to the scientific, educational and public

[11] The Commission quoted, with approval, the definition of profit as stated by the Ohio Supreme Court: "Profit does not necessarily mean a direct return by way of dividends, interest, capital account or salaries. A savings of expense which would otherwise be incurred is also a profit to the person benefitted." *Russell* v. *Sweeny,* 153 Ohio St. 66, 68, 91 N.E. 2d 13, 16 (1950).

[12] The Seventh Circuit Court of Appeals, in a separate proceeding involving a request by the Commission for a preliminary injunction, ruled that even though the respondent in National Commission on Egg Nutrition did not earn or distribute profits to its members, it was within the Commission's jurisdiction because it pursued "profit indirectly" by seeking to improve the business environment for them. *FTC* v. *National Commission on Egg Nutrition,* 517 F.2d 485, 488 (7th Cir. 1975), *cert. denied,* 426 U.S. 919 (1976).

health activities in which they are primarily engaged (AMA Conclusions of Law, p. 25; CSMS Conclusions of Law, pp. 11–12, 14; NHCMA Conclusions of Law, pp. 4–6). [240]

There is no such dominant purpose standard elucidated in any previous case. If respondents are engaged solely in scientific, educational and public health matters which might incidentally have some economic benefit for their members, they might well be exempt from Commission jurisdiction under Section 4. That is not the situation in this case, however. An analysis of the whole record in this proceeding reveals that respondents are engaged to a substantial degree in activities which directly and indirectly protect and enhance the economic well being of their members.

It is not disputed that AMA devotes a substantial part of its time and resources to the advancement of medical science, education and the public health. AMA plays an active role and devotes significant amounts of time and resources to the organizations which set standards for and accredit medical schools, internship and residency programs and continuing medical education courses for physicians and allied health services (F. 16(a)–(d), pp. 12–15). Such programs and courses are open to members and non-members of AMA.

The AMA also devotes a sizeable portion of time and resources to scientific activities. It publishes one of the most influential medical journals in the world, *Journal of the American Medical Association ("JAMA")*. It also publishes nine highly regarded specialty journals, such as the *Archives of Dermatology.*[13] (F. 17(h), pp. 23–25). The AMA publishes a variety of important scientific works including AMA Drug Evaluations, for example (F. 17, pp. 16–25). It sponsors a number of conferences and publications in various medical areas, *e.g.*, nutrition (F. 17(f), pp. 19–20). Its publications and conferences are not restricted to AMA members.[14]

In the field of public health, the AMA engages in a wide variety of activities, such as testifying on many legislative bills and administrative regulations, conducting programs to upgrade the quality of health care in jails, assisting United States medical efforts in South Vietnam and later the Vietnamese physicians who fled South Vietnam to this country [241] and instituting a program to reduce the amount of violence on television (F. 16(f), pp. 15–16; 17(c), pp. 17–18; 17(e)–(g), pp. 18–23; 18, pp. 25–29). AMA distributes hundreds of pamphlets and posters on health care matters to the general public (F. 17(c)–(d), pp. 17–18; 17(f), p. 20; 17(g), pp. 21–23). It also responds

[13] The journals are basically self-supporting, since revenues from advertising and subscriptions roughly equals costs of publication and dissemination of the journals (F. 17(h), p. 25; 53, p. 70).

[14] AMA members receive *JAMA* and one specialty journal free as a membership benefit. The non-member subscription price for *JAMA* is $30 per year, and $18 per year for each specialty journal (F. 17(h), pp. 24, 25).

to calls and letters from the public asking general medical questions (F. 17(c), p. 17; 19, p. 32). It gathers and publishes data on physicians and health care; such data is utilized not only by AMA, but also by scholars and governmental units (F. 16(e), p. 15; 17(d), p. 18; 17(g); 19, pp. 29–32).

The Connecticut respondents engaged in activities that are somewhat similar to the activities of AMA, although on a much smaller scale since their memberships are smaller than AMA's membership. CSMS conducts an annual Scientific Assembly on subjects relating to science and medicine. It has a committee on continuing medical education concerned with investigating and evaluating alternatives in continuing medical education programs and in sponsoring continuing medical education programs. Those programs are available to members and nonmembers alike (F. 55, pp. 73–77).

CSMS publishes a monthly journal, *Connecticut Medicine,* which contains articles of educational value, as well as articles of general intellectual interest and information on the society's activities. The journal is furnished free to CSMS members (F. 56, p. 77).

CSMS offers pamphlets on health related matters to the public free of charge, answers requests from members of the public seeking information about locating a physician, sends delegates to organizations concerned with health care and communicates with legislative bodies concerned with issues of health care (F. 57, pp. 78–80). CSMS has published a Relative Value Scale for use by Connecticut physicians in ascertaining fees (F. 60, p. 83). CSMS annually gives an $8,000 grant to Connecticut medical schools to be used as a loan fund for needy students (F. 61, p. 84).

NHCMA has standing committees, some of which are concerned with matters of public health (F. 74, pp. 92–93). NHCMA publishes *Issues and Insight* on a quarterly basis for distribution to its membership. It sends representatives and advisors to various community-oriented health organizations, such as the Cancer Society and the American Heart Association (F. 76–77, p. 95).

While it can be argued that the above described activities of respondents have, at most, indirect or incidental economic benefits to members, a closer examination of many of [242] respondents' activities reveals a clear, direct economic purpose and effect. These activities which have a pecuniary benefit to members have been set forth in detail in the findings of fact herein (*See* F. 23–50, pp. 38–61; 62–73, pp. 84–92; 79–84, pp. 96–101). These activities combined with other characteristics of respondents, leave no doubt that while respondents do engage in educational, scientific and public health

activities, a significant part of their time and resources are devoted to obtaining, protecting and furthering the economic interests of their members.

AMA's membership is limited to physicians, interns and medical students. In 1977, 63.8 percent of AMA's total revenues came from membership dues, with the bulk of the remainder coming from advertising and subscriptions revenue. Most of AMA members are engaged in the profit motivated private practice of medicine, with over 75 percent of office based practitioners and over 80 percent of board certified physicians in this country being members of AMA. AMA has told its membership that it operates to protect and foster their interests and that one of its primary purposes is to serve its membership (F. 3, p. 6; 23, pp. 38–40).

In communications with its members, AMA has detailed some of its most important activities which have a direct economic benefit for physicians. For example, AMA told its membership that it had made substantial progress towards solving the medical liability insurance crisis, won an important legislative battle to prevent Federal control of residencies, fought for and won exemption for current medical students from paying back Federal grants to medical schools and supported a pay increase for V.A. physicians (CX 1522).

AMA told its membership that because of activities undertaken by AMA certain things did not happen to physicians: precertification of hospital admissions; a national health insurance plan which physicians cannot live with; price controls on physicians' fees; sweeping HMO grants; national relicensure of physicians; unrealistic restrictions on physician discretion in prescribing drugs; mandatory government service for all medical school graduates; and, premature HEW establishment of consumer-run program review teams for Medicare and Medicaid. AMA has stated to its [243] membership that other things did happen for physicians because of AMA: modification of the Keogh law; development of a universal health insurance claim form; American Hospital Association acceptance of the concept that the medical staff should be represented on hospital boards; and, model state legislation to safeguard medical information (CX 245D).

AMA has told its members that certain key benefits of membership are insurance programs at a lower cost than is available anywhere else, a membership retirement fund, physician placement service, leading scientific publications, authoritative legal information and guidelines on every aspect of medical practice, professional management information and guides "to increase the productivity

and profitability of medical practice," the resources of the nation's greatest medical library and comprehensive scientific programming at conventions (CX 245D).

Although these membership representations may be somewhat exaggerated as sales materials, there is no reason to doubt that AMA contributed substantially to all the listed accomplishments. In fact, other record evidence supports AMA's representations.

AMA contends that its program of governmental "interface" serves to encourage government to initiate and maintain programs which will best serve the public health, that there is no substantial economic motivation underlying the program and that it is not designed to enhance the economic welfare of physicians (RAF, p. 53).[15] This contention is rejected. While there are public interest aspects to some of AMA's positions on legislation and administrative regulations, it is concluded that AMA's governmental lobbying activities are directed primarily at the interests of its membership - the physicians.[16] [244]

AMA has stated that the most important AMA membership benefit is having AMA as an effective and influential national spokesman to represent the medical profession's views, interests and rights (CX 259Z13).[17] Professor Paul Feldstein, an acknowledged expert in the field of medical economics, believes that political representation of physicians is AMA's most important activity for its membership (CX 2586F). AMA itself has categorized some of its legislative activities as being in behalf of consumers; it acknowledges that other activities are for physicians (CX 246).

AMA lobbying activities which have had substantial economic impact on physicians include the removal of price controls on physicians' fees (F. 25, p. 43); assurance that physicians receive their usual, customary, and reasonable fees under the Medicare program F. 26, pp. 43–44); opposition to national health insurance programs that do not meet AMA's physician reimbursement standards[18] (F. 27, p. 44); opposition to federal funding of HMOs and opposition to liberalization of existing HMO legislation (F. 28, p. 45; 102, p. 134);

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[15] AMA contends that its opposition to federal price controls on physicians' fees arose out of a concern that controls would lead to "a decline in the quality of medical care" (AMA's Reply to Proposed Findings of Fact of Counsel Supporting the Complaint, p. 19). Can one logically conclude that this is the sole motivation of AMA's effort?

[16] Indirect service to the public may result from some of AMA's legislative activities. In most instances, however, it is the physician who directly benefits. AMA has stated: "Activities in the area of quality assurance and promoting the effective delivery of care ultimately benefit the public, but the benefits generally accrue to the public through the physician" (CX 1042Z7).

[17] As part of its effort to achieve this goal, AMA has 10 lobbyists registered with the federal government (Tr. 9886).

[18] In 1950, the AMA spent over $2.5 million in a campaign it mounted against President Truman's national health insurance proposal (F. 27, p. 44; 45, p. 56).

support for passage of the Keogh Act (F. 29, p. 45); work to solve the malpractice insurance crisis facing physicians (F. 24, p. 41; 30, p. 46; 43, p. 54); support for pay increases for physicians in the Armed Forces and the Veterans Administration (F. 38, p. 49); and opposition to legislation requiring relicensure, retraining recertification or continuing medical education of physicians (F. 31, p. 46). In support of its efforts to influence legislation, AMA organized, and now supports and controls, a political organization, American Medical Political Action Committee, which engages in political education activities and provides financial support for political candidates (F. 22, pp. 35–37; 39, p. 50).

There are other AMA activities which provide a direct economic benefit to AMA members. AMA is very active in dealings with third-party payers, having been instrumental [245] in the creation and development of the Blue Shield insurance plans. AMA acts to assure that physicians are reimbursed on an adequate basis by insurance plans, including Medicare. AMA intervenes directly with insurance carriers when disputes are deemed to have national significance. AMA provides support for foundations for medical care which are physician-controlled health care organizations created to counteract the economic impact of HMOs. AMA has attempted to intervene with the Department of Defense in its military dependents medical program to assure that physicians fees are adequate. To assist physicians in billing and collecting from third-party payers, AMA has developed and distributed a uniform claim form and has developed two publications to aid physicians in billing for medical services, *Current Medical Information and Terminology* and *Current Procedural Terminology* (F. 40, pp. 50–52).

AMA has represented physicians' interests when dealing with hospital administrations such as by calling for separate billing by hospital and physician (F. 41, pp. 52–53); has instituted court actions to challenge governmental controls on physicians' fees (F. 42, pp. 53–54); created and funded, at an investment of $2 million, American Medical Assurance Company to help solve the malpractice insurance crisis (F. 43, p. 54); spent approximately $3 million on public relations activities to help boost the public image of physicians (F. 45, pp. 55–56); and provides members with negotiations training, (F. 46, p. 56), practice management assistance (F. 47, p. 57), legal advice (F. 48, p. 58) and scientific journals and a medical newspaper (F. 49, pp. 58–59). AMA also sponsors insurance programs for its members and has established an investment retirement fund (F. 20, p. 34; 49, pp. 58–59).

Lastly, AMA's ethical restrictions on advertising, solicitation and

contract practice insulate physicians from competition and have a substantial economic benefit to AMA members. The economic effects of these restrictions are discussed in a separate section of this decision at pages 254–79, *infra.*

The evidence unquestionably establishes that AMA has engaged in the listed activities and that they do have a substantial pecuniary benefit for AMA members. AMA has, [246] in fact, represented to its members that these are important benefits to the membership; there is no evidentiary basis in this record on which to doubt these statements. Being a membership organization supported by membership dues, it is neither illogical nor derogatory of the organization to conclude that AMA provides substantial economic benefits for its members.[19]

The federal income tax exemption accorded AMA supports the conclusion reached herein. AMA is exempt from payment of federal income tax pursuant to Section 501(c) (6) of the 1954 Internal Revenue Code. Internal Revenue Regulations describe a Section 501(c)(6) organization as a business league, which is an association of persons having some common business interest, the purpose of which is to promote such common interest and not to engage in a regular business of a kind ordinarily carried on for profit. In contrast, the American Medical Association Education and Research Foundation, a subsidiary of AMA, is exempt from federal income tax pursuant to Section 501 (c)(3), which section exempts from federal income tax those organizations organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary or educational purposes (F. 21, p. 35; 50, pp. 60–61).

AMA devotes a substantial portion of its income to the activities which have an economic benefit for its members. While precise percentages of AMA's income devoted to these activities cannot be ascertained, Professor Paul Feldstein estimated that between 35 percent and 43 percent of membership dues income was spent for these purposes (F. 53, p. 70). [247]

In a report to members made in December 1976 (CX 1055), the AMA explained where its dues dollar goes:[20]

[19] In 1946, the Supreme Court of Illinois, in *American Medical Association* v. *Board of Review of Department of Labor,* 392 Ill. 614, 65 N.E. 2d 350 (1946), had to determine whether or not AMA was entitled to exemption from an Illinois state tax. This issue involved a determination of whether AMA's activities were solely scientific, educational or charitable. The court stated: "It is conceded that appellant [AMA] devotes a substantial portion of its efforts and of its income towards protecting and furthering economic benefits to the individual members of the association." 65 N.E. at 354.

[20] In this publication distributed to all members, informing them of the many benefits that come with AMA membership, benefits that assure economic advantages to physicians, AMA stated in bold-faced type, in reference to the group rates available to members in the various insurance and retirement programs offered by AMA: "In many cases, a physician member can save more than the equivalent of his annual AMA dues" (CX 1055R).

1. Assisting the Physician and His Practice	17.7%
2. Strengthening Organized Medicine	13.8
3. Representing the Profession	10.0
4. Serving the Public	8.0
5. Upgrading Care Through Educational Standards	12.3
6. Disseminating Scientific Information	38.2

The total of the first three categories equals 41.5 percent of dues revenue. The 41.5 percentage would appear to directly benefit the physician; it does not include anything from "disseminating scientific information," which would include the distribution of *JAMA* and specialty journals free to members.

Respondent AMA asked several of the physician witnesses who testified in this proceeding whether they felt they received an economic benefit from AMA membership; several said that they did not think so, and that they had dropped their membership in AMA because the dues were getting larger and it was no longer worth the price (Tr. 1153, 2665, 4203). This fact, however, reveals little about the nature of the organization of AMA and the purposes of its various programs. Whether an institution has failed in its profit-making endeavors or is perceived as having failed is irrelevant. The witnesses' abandonment of membership reveals, if anything, that members expected something personal in return for the monies given respondent AMA, and when the expected return was not forthcoming, they stopped giving — hardly the typical attitude of the charitable contributor. [248]

The Connecticut respondents engage in substantial activities which have a pecuniary benefit for their members. In the first instance, one must be a member of a local and state society before being eligible to become an AMA member (F. 4, p. 6). The pecuniary benefits which AMA provides its members are key benefits which are available to CSMS and NHCMA members upon joining AMA through their local and state societies. In 1975, 81.6 percent of the physicians registered in Connecticut were members of CSMS; over 50 percent of CSMS members were also members of AMA (F. 9, p. 8).

Approximately 71 percent of all physicians registered in New Haven County are members of NHCMA; over 90 percent of NHCMA members are also members of CSMS, and approximately 40 percent are also members of AMA (Tr. 8439). Membership in NHCMA provides an opportunity for a physician to become a member of CSMS and receive the pecuniary benefits offered by that society.

CSMS as an organization represents the professional interests of physicians in Connecticut in a manner that would be impossible for individual physicians to act on their own behalf. A guiding principle of CSMS is that physicians should always have the right to charge their usual, customary and reasonable fees (F. 62, pp. 84–85). CSMS has published a *Relative Value Guide* and strongly recommended that physicians use it to determine usual, customary and reasonable fees. Third-party payers in Connecticut also use the *Guide* to determine physician fees (F. 63, pp. 85–86). CSMS has opposed policies of insurance carriers and governmental agencies to prevent physician fees from being reduced or becoming substandard. CSMS opposed a contract adopted by the Connecticut Blue Shield Plan because payments to physicians were lower than the usual and customary fees being received by CSMS members. CSMS strenuously opposed a payment policy adopted by Aetna Life and Casualty Company that paid fees only up to a level determined by Aetna (F. 64, pp. 86–87).

CSMS has urged its component societies to form foundations for medical care to protect the interests of practicing physicians. CSMS issued an interest-free loan, repayable when feasible (RCX 68, p. 17), in an amount of $4,999, to the New Haven County Foundation for Medical Care (F. 65, pp. 87–88).

CSMS has lobbied for legislation having significant economic benefits for physicians. CSMS opposed price controls on physicians' fees. CSMS pressed for repeal of the Connecticut law requiring physicians to pay a $150 [249] annual registration fee. CSMS has lobbied for adoption of malpractice insurance legislation that would forestall premium increases as well as make it more difficult for plaintiffs to prevail in malpractice litigation and reduce the size of possible malpractice liability awards against physicians. CSMS has supported increases in and faster payment of physicians' claims under Medicaid, and has opposed the charging of fees by the State Health Laboratory and legislation expanding the practice of podiatrists and chiropractors (F. 66, pp. 88–89).

In support of its legislative activity, CSMS has organized and financially supported Connecticut Medical Political Action Commit-

tee to serve as the political "arm" and "tool" of the medical profession in Connecticut (F. 58, pp. 80–82; 67, p. 89).

CSMS operates a physician placement service, gives estate planning and settlement advice, operates a public relations program and sponsors a variety of group insurance programs at a savings to CSMS members, the most significant of which is the malpractice insurance policy available to CSMS members at a substantial savings (F. 68–70, pp. 90–91). CSMS also publishes a monthly journal, *Connecticut Medicine,* made available to members free of charge (F. 56, p. 77; 71, p. 91).

CSMS's principal source of funds is membership dues (F. 72, p. 91). It is exempt from federal income tax under Section 501(c) (6) of the 1954 Internal Revenue Code (F. 73, p. 92. *See also* F. 50, pp. 60–61).

NHCMA also defends and supports the maintenance of usual, customary and reasonable physicians fees, and is an advocate for better working conditions for its local physicians (F. 79, p. 96). NHCMA has engaged in lobbying activities on behalf of physicians, protesting federal controls on physicians' fees, opposing the special treatment given HMOs and the annual $150 registration fee for physicians practicing in Connecticut. NHCMA maintained an active legislative program to resolve the malpractice insurance crisis. NHCMA urged CSMS to press the Connecticut Welfare Department to bring the Medicaid program fees up to the usual, customary and reasonable level. NHCMA protested to the Connecticut Commissioner of Insurance about the marketing efforts of an HMO operating "in direct competition" with private practitioners, and it urged the Department of HEW to deny extension of grant money to an HMO (F. 82, pp. 99–100). [250]

The New Haven County Foundation for Medical Care was organized by NHCMA to promote the economic interests of its members and has loaned the Foundation $4,999 on an interest-free basis. The Foundation is an organization of fee-for-service practitioners which is controlled by NHCMA with fees based on the usual, customary and reasonable concept (F. 80, pp. 96–98).

NHCMA operates an active Board of Censors and Third Party Payments Committee, which together comprise the Peer Review Committee. The Peer Review Committee assists NHCMA members in their disputes with third-party payers and patients about fee-related matters. The Committee has relied upon the CSMS *Relative Value Guide* and a conversion factor geared to the usual, customary and reasonable fee concept in their resolution of fee disputes (F. 81, pp. 98–99).

NHCMA also operates a public relations program, sponsors

insurance programs for members and intervenes with local hospitals on behalf of physicians to assist them in obtaining hospital privileges (F. 83, p. 101).

NHCMA's principal source of funds is membership dues, and it is exempt from federal income tax under Section 501 (c)(6) of the 1954 Internal Revenue Code (F. 79, p. 96; 84, p. 101. *See also* F. 50, pp. 60–61).

CSMS and NHCMA have adopted, disseminated and enforced ethical restrictions on physician advertising, solicitation and contract practice which have restrained and eliminated competition between and among physicians (*see* pp. 254–79, *infra*). These activities have rebounded to the economic benefit of their members.

The record clearly establishes that respondents are engaged in a substantial number of activities that have a direct economic benefit for their members. It is equally clear from the record that respondents are engaged in a substantial number of activities of an educational, scientific or charitable nature which benefit their members, if at all, in an indirect manner. It is virtually impossible to precisely measure which activities predominate in respondents' overall operations. Such a determination is unnecessary, however. Neither the courts nor the Commission has ever held that Commission jurisdiction is limited to nonprofit organizations whose sole *raison d'etre* is to [251] serve as a conduit for the commercial interests of members. Nor is there any precedent for the proposition that business activity conducted by a nonprofit organization *for economic objectives* as distinguished from charitable objectives, is exempt. To the contrary, the legislative history of the Federal Trade Commission Act discloses that, in 1914, Joseph E. Davies, Commissioner of the Bureau of Corporations (predecessor to the Federal Trade Commission) informed Senator Newlands, the Senate manager of the Federal Trade Commission Act, that trade associations should be covered notwithstanding the fact that "[a]s to some of the things done by these associations, no question as to their propriety can be raised." *Community Blood Bank,* v. *FTC,* 405 F.2d 1011, 1017 (8th Cir. 1969).

Since respondents are engaged continuously and substantially, as contrasted to incidentally or sporadically, in activities which have a pecuniary benefit for their members, it is concluded that they are subject to the jurisdiction of the Federal Trade Commission. The eleemosynary results of many of respondents' programs cannot provide a shield for the restraint of trade resulting from its other programs. *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773, 787 (1975). The public service aspect of professional practice is not controlling in

determining whether respondents are within the Commission's jurisdiction.

B. Commerce

AMA has stipulated that its acts and practices are in or affect interstate commerce (F. 14, p. 10; Tr. 2120, 2124). CSMS and NHCMA, however, claim that complaint counsel did not meet the burden of proving that their conduct is in or affecting interstate commerce (CSMS Conclusions of Law, pp. 14–19; NHCMA Conclusions of Law, pp. 6–8). The Connecticut respondents admit that substantial dollar amounts of Medicare, Medicaid and insurance payments are made to their members for medical services and that such payments derive from sources outside Connecticut. It is argued, however, that these facts relate to the practice of medicine by CSMS and NHCMA members and not to the challenged acts and practices of respondents. Thus, respondents insist there is no nexus between the acts and practices being challenged and interstate commerce (CSMS Conclusions of Law, p. 15; NHCMA Conclusions of Law, p. 6).

The Connecticut respondents also argue that the fact that some members may occasionally treat patients who reside in other states and the fact that some medications are [252] manufactured outside Connecticut and dispensed from pharmacies pursuant to prescription by physicians, some of whom are CSMS and NHCMA members, does not establish the required nexus with interstate commerce (CSMS Conclusions of Law, p. 17; NHCMA Conclusions of Law, p. 7). These respondents further argue that their ethical restrictions were concerned with Connecticut physicians in Connecticut and that occasional travel outside Connecticut to attend AMA conventions and occasional use of the interstate mails or interstate telephones are insufficient to establish that the challenged conduct is in or affecting interstate commerce (CSMS Conclusions of Law, p. 19; NHCMA Conclusions of Law, p. 7).

The restrictions on physician advertising and solicitation adopted, disseminated and enforced by the Connecticut respondents are in or affect interstate commerce in several respects. The restrictions affect the volume and destination of millions of dollars coming into Connecticut from out-of-state government and private health insurance sources in payment for medical care and related services rendered in the state; they have been undertaken as part of a nationwide conspiracy which restrains competition and commerce in every state; they are furthered through use of the United States mail and other interstate communications media and transportation facilities; they restrain advertisements by Connecticut physicians in

newspapers with interstate circulation and in out-of-state telephone directories; and, they affect the flow of patients into Connecticut from other states and countries.

The great majority of licensed physicians in Connecticut and New Haven County, respectively, belong to CSMS and NHCMA and have agreed to abide by the AMA ethical code. Because this code of ethics restrains, hinders and deters these Connecticut physicians from advertising, soliciting patients and engaging in the proscribed forms of contractual relationships, it necessarily affects the volume, destination and amounts of interstate payments into Connecticut for medical services. A physician who does not seek new patients by advertising must obviously forego the reimbursements he would receive if he attracted such new patients. Similarly, the ultimate destination of interstate insurance payments is necessarily affected when physicians [253] are restrained from competing with one another through advertising. For example, a physician in New Haven restrained by respondents' ethical restrictions from advertising physical examinations is likely to receive less patronage than if he had been able to advertise his prices and services. Accordingly, the physician will automatically receive a lesser volume of interstate Medicare, Medicaid and private insurance payments for his services. If the physical examinations are performed by other doctors, then the destination of the interstate payments has been affected. In *Hospital Building Co.* v. *Trustees of Rex Hospital,* 425 U.S. 738 (1976), the Supreme Court held that interference with revenue received by a hospital from out-of-state insurance companies affects interstate commerce. Whether the conduct affecting interstate commerce was directed at, or intended to affect, interstate commerce, is irrelevant. It is sufficient that interstate commerce has been affected. *Hospital Building Co., Id.* at 744–45.

Further, there need be no showing of the magnitude of the effect on interstate commerce. In *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773 (1975), the Court stated:

> The fact that there was no showing that home buyers were discouraged by the challenged activities does not mean that interstate commerce was not affected. Otherwise, the magnitude of the effect would control, and our cases have shown that, once an effect is shown, no specific magnitude need be proved . . . *Id.* at 785.

Use by the Connecticut respondents of the United States mails and other interstate transportation and communications facilities in transmitting and receiving interpretations of the challenged ethical restrictions and copies thereof and in attending AMA conventions where many of the challenged ethical restrictions have been

discussed and approved, provide "an adequate basis for Commission jurisdiction." *Tysons Corner Regional Shopping Center,* 85 F.T.C. 970, 988, 1015 (1975).

The Connecticut respondents have joined together with other state and local medical societies to form AMA and have adopted, as have these other societies, the AMA Principles of Medical Ethics to govern the conduct of their members. By [254] participating in concerted activities which restrain commerce throughout the country, CSMS and NHCMA have subjected themselves to Commission jurisdiction. As the Supreme Court has observed: "The Commission would be rendered helpless to stop unfair methods of competition in the form of interstate combinations and conspiracies if its jurisdiction could be defeated on a mere showing that each conspirator had carefully confined his illegal activities within the borders of a single state." *FTC* v. *Cement Institute,* 333 U.S. 683 696 (1948). *See also United States* v. *Wilshire Oil Co.,* 427 F.2d 969, 974–75 (10th Cir.), *cert. denied,* 400 U.S. 829 (1970).

The substantial volume of commerce involved, including direct federal government funding of Medicare and Medicaid, the participation of out-of-state third-party insurers, interstate laboratory testing and diagnostic evaluations, commercial flow of drugs and medical equipment and the inseparability of particular physician services from the interstate aspects of health care generally, together with the use of interstate communications and transportation facilities, provides a satisfactory basis for concluding that the acts and practices of respondents CSMS and NHCMA are in or affect interstate commerce and that these respondents are subject to Federal Trade Commission jurisdiction. *See* discussion at *Doctors Inc.* v. *Blue Cross of Greater Philadelphia,* 490 F.2d 48, 50–54 (1973).

III. RESTRICTIONS ON PHYSICIANS' ADVERTISING, SOLICITATION AND CONTRACTUAL RELATIONS

A. The Restrictions and their Anticompetitive Effects

It is not disputed that the AMA has made a significant public contribution through its health related activities from the date of its first meeting in 1847 to the present. Furthermore, it is not possible to give the AMA its just credit by a mere listing of the tremendous inroads it has made in the areas of medical education, medical licensure standards and public health programs, to name but a few. However, the history of the AMA is largely irrelevant for the purposes of this proceeding, which deals not with whether the AMA is deserving of public admiration but, rather, with what effects AMA

ethics policies have had on physician competition in recent years. Moreover, the AMA's history is not untainted, as evidenced by the criminal conviction over 30 years ago of the AMA and the [255] Medical Society of the District of Columbia for conspiring to restrain and obstruct the development of a group prepaid health plan. *American Medical Association* v. *United States,* 317 U.S. 519 (1943), *aff'd* 130 F.2d 233 (D.C. Cir. 1942).

Respondent medical societies exercise complete control over physicians' advertising, solicitation and contractual relations. Their control has effectively thwarted competition by physicians in the health care sector. To accomplish these ends, the AMA, CSMS, NHCMA, numerous other constituent and component societies and individual physician members have engaged in a persistent pattern of formal and informal enforcement of broadly based ethics rulings. The means utilized by medical societies in their efforts to perpetuate the fee-for-service physician in private practice and the "usual, customary and reasonable" method of fee reimbursement as the driving forces in medical care in the United States have been the AMA's Principles of Medical Ethics, the AMA's *Judicial Council Opinions and Reports* and sundry interpretations of each. Reliance by the AMA and by constituent and component medical societies upon these sources of ethics pronouncements has been extensive and cannot be disputed in view of the extensive evidence in this record.

Complaints about physician advertising and solicitation often have been submitted to local medical societies, including respondent NHCMA, by individual physicians in the same specialties as the accused doctors. Some of the complaining physicians have expressed concern about the competitive implications of the offending doctors' activities. In response to these complaints, the medical societies have taken restrictive ethics actions regarding the accused physicians.[21] On occasion, they have gone so far as to openly refer to and take into account the competitive concerns expressed by the complaining physicians.[22]

Complaints about health maintenance organizations' advertising and solicitation activities have been registered with local medical societies by physicians openly concerned about HMO competition with their fee-for-service practices. [256] Complaints about HMOs have also been made by competing health plans, including foundation health plans sponsored by local medical societies. (F. 104, pp. 137, 138). In response to these complaints, the medical societies have

[21] F. 98, pp. 124-29; 100, pp. 131-32; 112, pp. 147, 148; 113, pp. 148-50; 120-22, pp. 160-71; 136-37, pp. 194-98; CX 136, 137; Tr. 1739, 1743, 1745-47.

[22] F. 98, pp. 124-29; 100, pp. 131-32; 120, p. 162; 136, p. 196; CX 759, 764B, 10B, 2062A.

taken restrictive ethics actions regarding the accused HMOs and their physicians.[23]

Statements by officials of AMA and its constituent and component medical societies reveal their opposition to doctors competing with each other. In 1973, Edwin J. Holman, Director of the Department of Medical Ethics of AMA, stated to an AMA constituent society: "[I]f the day should ever come when physicians or groups of physicians would regularly utilize professional public relations staffs, then medicine would find its members competing *against* each other for selfish, personal reasons" (CX 272B) (emphasis in original). In 1974, the president of the Allegheny County Medical Society in Pittsburgh, Pennsylvania stated: "[A]s you may know, it is considered unethical for doctors to advertise or to compete for patients, as soap companies compete for buyers, in the marketplace" (CX 2182B). Dr. Stephen Biering, called by AMA to testify in this proceeding about the role medical societies should play in regulating physician advertising, believed it inappropriate for physicians to compete on the basis of price, quality and service in the delivery of medical care (Tr. 9544–45, 9547–48).

An official of the Catawba County [North Carolina] Medical Society stated to a class at Lenoir Rhyne College, in opposition to a medical directory the class was proposing:

> [S]omebody who reads the directory may choose a physician on the basis of fees, and get the cheapest doctor for example, and therefore it might become a point of competition between physicians to stress the fees and to work out a fee schedule that would be more advantageous than somebody else's (Tr. 2383–84. See also F. 135, pp. 192–94).

Other AMA and medical society documents and officials have indicated their opposition to competition among physicians in connection with advertising, solicitation and contract practice.[24] [257]

Respondents' ethical restrictions on advertising and solicitation seek to prevent any doctor from presenting his name or information about his practice to the public in any way that sets him apart from other physicians. AMA's 1971 *Opinions and Reports* allows the limited publication of information on physicians only in media which are open to all physicians on like condition (CX 462Z6 [Sec. 5, Op. 11]). AMA has declared that it is not unethical for a physician to authorize the listing of his or her name in a physician directory which is intended to list all physicians in the community on a uniform and nondiscriminatory basis. AMA's Guidelines for Tele-

[23] F. 102–07, pp. 134–43.

[24] *See* F. 123, p. 174; 148, pp. 212–13; CX 759, 764B, 2119B.

phone Directory Listings prohibit box advertisements by physicians in the Yellow Pages and require uniformity of size and face of type among the physician listings. AMA's position on listing physician's names in credit card plans is that the plan must be available to all physicians in an area (CX 98C, 100A). In 1973, AMA wrote to the Bergen County [New Jersey] Medical Society about the ethics of a preventive medicine clinic's magazine article describing its services. AMA stated:

> Aren't there many physicians in Bergen County engaged in preventive medicine in one way or another? . . . Isn't the description of medical facilities best left to the medical society, which speaks for all physicians . . .? If one physician extols his own services, facilities, competence, etc., what is to prevent another physician from doing likewise and then what is the need for a medical society at all? (CX 1747; F. 119, pp. 159-60).

AMA's ethical restrictions affect all facets of competition among physicians, from the sole practitioner desiring to announce the opening of a new office to the group practitioners wishing to disseminate information regarding preventive medical services. While the Findings of Fact detail numerous incidents of restrictive practices adversely affecting physicians' abilities to compete, several of the more aggravated and pronounced instances deserve individual mention as illustrative of the serious consequences that the restraints have had and continue to have upon the delivery of health care in the United States. [258]

Dr. Joseph LaDou formed the Peninsula Industrial Medical Clinic ("PIMC"), located in Sunnyvale, California, to offer a package of occupational health and safety services to local industry on a large scale. Santa Clara County, which encompasses Sunnyvale, is an industrial community that would benefit by receiving the type of services being offered by Dr. LaDou and PIMC. The only feasible way in which Dr. LaDou could make PIMC's services known would be by solicitation. However, the Santa Clara County Medical Society informed Dr. LaDou that he and other industrial physicians, as well as their sales agents, would be prohibited from making any direct contacts with companies through personnel officers and other executives, such as by a general promotional mailing. This ruling came about as a consequence of complaints about PIMC made to the medical society by a competing medical clinic. As a result of the medical society's ruling, Dr. LaDou and PIMC have had to curtail the services they were intending to offer to local industry, to the

detriment of consumers of occupational medical services in Santa Clara County.[25]

In 1973, Dr. Richard Hansen, director of a private rural hospital near Chattanooga, Tennessee, instituted a program called "Operation Heartbeat." The program planned to offer a package of tests to assess a patient's risk of heart attack or other coronary disease. The cost to each patient would be $25, which was about half of what would otherwise be charged for similar services in the area. In response, the Chattanooga and Hamilton County (Tennessee) Medical Society advised Dr. Hansen, both at a meeting to which he was summoned and in a letter sent to him by the Medical Society, that any future announcements for the program should avoid the appearance of advertising which, it was stated, is unethical. Dr. Hansen promptly dropped the Operation Heartbeat program.[26] The direct impediment to a service that would not only promote competition but also serve a vital public health need in a rural area is manifest. [259]

The Volunteer Medical Clinic, staffed by Drs. Ralph Robinson and Catherine Gilreath, performs abortions in Knoxville, Tennessee. An abortion at the Clinic costs $175, as compared with the $450–600 cost at Knoxville hospitals. To promote its services, the Clinic was advertising in local newspapers in 1975. In response to abortion clinic advertising, the Knoxville Academy of Medicine, an AMA component society, forbade members from affiliating with organizations that advertised in the public media. Consequently, Dr. Gilreath, the only physician on the Clinic staff with admitting privileges at any Knoxville hospital, resigned from the Clinic. Dr. Robinson, a board certified obstetrician-gynecologist and the twice elected president of his own Bell County (Kentucky) Medical Society, found himself unable to obtain staff privileges at a local hospital due to the furor over his advertising; this hampered the Clinic's functioning. In 1977, the Clinic ceased all advertising.[27] Its ability to secure patronage was demonstrably affected.

In 1973, Medi-Call, Inc., a firm located in Johnson County, Kansas, near Kansas City, Missouri, began offering a commercial physician house-call service. For a $50 annual charge, subscribers would receive two night house-calls by a physician; subsequent visits would cost $25 each. At the time, physicians were reluctant to make house-calls in the area Medi-Call planned to serve. Medi-Call began

[25] F. 98, pp. 124–29.

[26] F. 100, pp. 131–32. While Dr. Hansen later reinstituted the program, he did not resort to any advertising owing to the above-described encounter with the Medical Society. As a result, the program attracted minimal attention.

[27] F. 114, pp. 150–52.

advertising its services through radio, television newspapers and billboards; without such advertising, the firm could not hope to attract clients. Subsequently, the Area Medical Council, composed of the top officers of four AMA component medical societies in the area, informed Medi-Call that its advertising was unethical. The firm ceased promoting its services. The action of the medical societies led to the financial failure and termination of Medi-Call's physician house-call service.[28]

Dr. Edward Diethrich, an eminent cardiovascular surgeon, established the Arizona Heart Institute in 1971, in Phoenix. The Institute offered the latest methods for the study and treatment of cardiovascular problems, and charged fees which were often lower than similarly situated cardiovascular surgeons. Dr. Diethrich began promoting the Institute through various public media in order to get it off the ground. Dr. Diethrich received adverse reactions from the Maricopa County Medical Society, the AMA, the [260] American College of Surgeons and the Society of Thoracic Surgeons (the latter two are specialty societies). He was denied membership in both the MCMS and the AMA, and was placed on three years' probation by the two specialty societies. Dr. Diethrich and the Institute have since become less visible and have experienced difficulty in raising funds.[29]

Dr. Leon Zucker, an ophthalmologist in Waterbury, Connecticut, participated in a newspaper interview in 1976, regarding an operation he had performed in order to better inform the public about medical advances. Both CSMS and NHCMA, in response to complaints from other ophthalmologists who viewed the newspaper article as publicity, declared that Dr. Zucker's action constituted self-aggrandizement and unethical behavior. Fearful of medical society reprisal, which could have deprived him of his source of malpractice insurance, Dr. Zucker immediately acceded to requests to refrain from such behavior in the future. Dr. Zucker testified that he felt stigmatized by the matter and has since been reticent with regard to communicating information to anyone.[30] The economic motivation behind the informal use of medical society power, and the resultant harm to competition and the flow of innocent information are apparent.

In 1973, Public Citizen's Health Research Group of Washington, D.C. (a Ralph Nader-affiliated organization) undertook the compilation of a physician directory in Prince George's County, Maryland. The project was begun in light of the dearth of accessible consumer

[28] F. 117, pp. 154–56.
[29] F. 120, pp. 160–66.
[30] F. 121, pp. 167–68.

information regarding physician providers of medical care in the area. The response from the local and state medical societies was one of noncooperation and opposition; the consumer group was advised that a physician who supplied more than his identity, specialty and office hours would be acting unethically. As a result, the Health Research Group obtained a minimal response rate from physicians, thereby depriving consumers of worthwhile and beneficial information that would aid them in choosing a physician.[31]

In 1973, Dr. Harry Browne, a Nashville, Tennessee, pathologist, submitted a written proposal to Lewis County (Tennessee) Hospital. The proposal detailed how [261] the hospital's laboratory and pathology services could be improved; Dr. Browne also compared his proposed services and fees to those of the hospital's current pathologist, Dr. Jack Freeman. Upon seeing Dr. Browne's proposal, Dr. Freeman submitted an almost identical counter-proposal to the hospital which was accepted. The hospital experienced lower costs and a significant improvement in its laboratory and pathology services. The Nashville Academy of Medicine, Tennessee Medical Association and AMA all viewed Dr. Browne's action as in conflict with the AMA's Principles of Medical Ethics and advised him so. Dr. Browne deferred to the ethical guidance of the medical societies, and has since restricted his marketing activities.[32] Ironically, it was Dr. Freeman who initiated the complaint against Dr. Browne; and it was Dr. Freeman who upgraded the medical services being provided, although only in response to the competition presented by Dr. Browne.

In 1971, Dr. E.D. Davis and others began organizing the Florida Health Care Plan, Inc. ("FHCP"), an HMO in Daytona Beach, Florida. Earlier, in 1968, the Florida Medical Association adopted a statement, later approved by the AMA Judicial Council, declaring it unethical for a physician to be paid a salary for services provided. The FHCP includes contract physicians on fixed salaries. FHCP met with opposition from the state society and the Volusia County Medical Society. In 1977, two of FHCP's physicians applied for malpractice insurance from an insurance carrier controlled by the state medical society; the only other insurance carrier had substantially higher rates. The applications for insurance were rejected for the explicit reason that the two physicians were on fixed salaries. The physicians were forced to pay the higher rates of the other carrier.[33] The financial burden to the FHCP is indicative of the

[31] F. 133, pp. 187-91.

[32] F. 136, pp. 194-97.

[33] F. 103, pp. 135-37; 149, pp. 220-21.

obstacles placed in the path of health maintenance organizations, which pose a direct economic threat to the fee-for-service private practitioner.

Dr. James Warren is head of the Department of Obstetrics and Gynecology at Washington University Medical School in St. Louis. He is also medical director of the Washington University Center for Outpatient Gynecological Surgery. [262] In 1975, Dr. Warren prepared and distributed to St. Louis area physicians a brochure describing the Center's abortion services, including information on fees and facilities. The Center was ideally located adjacent to the hospital center which would be available for emergency treatments. The brochures, sent only to area physicians, met with opposition from several sources, including the state and local medical societies. Dr. Warren, fearful of disapprobation by the medical community, sent a letter of apology to two-thirds of the physicians on the St. Louis Medical Society's mailing list before action could be taken by any medical society. Shortly thereafter, the Ethics Committee of the St. Louis Medical Society recommended that Dr. Warren be censured. The Medical Society resolved the situation by getting Dr. Warren to write a second letter of apology, which was distributed to all Medical Society members along with a Medical Society report of the incident. Since this incident, Dr. Warren's medical clinic has never issued another brochure describing its activities.[34]

The Harvard Community Health Plan, an HMO in the Boston area affiliated with Harvard University, began operating in 1969. In order to familiarize the public with its method of financing medical services and, thereby, attract subscribers, the Plan began advertising in the news media. Physicians complained to the Massachusetts Medical Society that the Plan's advertising was attracting patients away from private practitioners and was unethical; in other words, the fee-for-service private practitioners were fearful of the economic competition posed by the plan. In response to discussions with the medical society, the Plan agreed to refrain from advertising. The motivating factor behind the refusal of the Plan's physicians to authorize advertising was fear of medical society reprisal. In late 1976, the Plan's physicians authorized limited advertising in light of the instant FTC proceeding among other things.[35] Were it not for their overriding belief that more expansive forms of advertising would prompt ethical objections by the Medical Society, the Plan's physicians could be expected to authorize the dissemination of more

[34] F. 99, pp. 130–31.
[35] F. 106, pp. 140–41.

extensive information in the media, with concomitant benefits to the public. [263]

An organization in Bergen County, New Jersey sought approval from the local medical society of a proposal to send a form letter to the Mayors and Councils of 72 communities offering physical examinations for the communities' firemen, police and volunteer ambulance corpsmen at $50 each. The AMA advised the local society that the proposal "is out and out solicitation" proscribed by the Principles of Medical Ethics (F. 95, pp. 118–19). A physician in Minnesota wrote to AMA about a pap smear clinic he was proposing to run for one week during which he would reduce his fee for a pap smear and pelvic examination by one-fourth. He requested an opinion as to whether he could alert the public through newspaper and radio announcements. The AMA advised that public announcements of the kind that was proposed should not be made by individual physicians (F. 95, p. 119).

The above examples demonstrate the extent to which the AMA, CSMS, NHCMA, countless other constituent and component societies and their physician members have gone to deprive the public of any semblance of meaningful competition among physicians. Respondents AMA, CSMS, NHCMA and other medical societies did not engage in these efforts independently of each other. To the contrary, they actively consulted with each other and followed the state of affairs in jurisdictions other than their own. Needing guidance, advice or merely assurance as to ethical positions already or soon to be taken, constituent and component medical societies repeatedly solicited and acted upon the advice of the AMA. The Principles of Medical Ethics, the 1971 *Opinions and Reports* and autocratic interpretations of each provided the beacon that guided each medical society initiative to its goal. The respondents and numerous other medical societies acted in concert with each other in the formal and informal promulgation and enforcement of ethical pronouncements that suppressed physician competition.[36] [264]

B. Justifications for the Restrictions

Several expert witnesses testified about the nature of health care delivery in the United States, the information available to assist consumers in making an informed choice of a physician, the information necessary to enable consumers to make such an informed choice, the probable effect of physician advertising and related activities upon the cost and availability of medical care, the

[36] *See* pp. 279–90, *infra*, for a more detailed discussion of the evidence which demonstrates the conspiracy that existed between AMA and its constituent and component societies.

probable effect of such advertising upon the physician-patient relationship and the practice of medicine, and the public interest in medical society regulation of physician advertising.

Witnesses called by AMA[37] testified that lack of knowledge does not usually inhibit patients from entering the health care system. Most consumers currently have access to sufficient information to allow them to make an intelligent choice of a physician. Information concerning physicians and their practices is available through the mass media, telephone directories, physician directories, medical societies and individual physicians' offices. People gain information about physicians from other doctors, relatives, friends, coworkers, employers, hospitals, departments of health and medical societies. People who do not have a regular physician often wait until they are sick and, then, present themselves at an emergency room. They will typically inquire about obtaining a physician at that time. AMA's witnesses concluded that widespread advertising by physicians is not likely to substantially enhance the quality or usefulness of this information, since advertising by its very nature conveys only the selected information the advertiser chooses to disclose (Tr. 9690–91, 7703–09, 9498–99, 9517, 6094–95). [265]

In the case of patients without financial resources, or in the event there is a large dollar difference between two comparable medical procedures, the cost of a physician's service is a factor in the choice of physician. Where, for example, there is a $25 difference in two medical procedures and third-party payment is involved, the difference in cost usually does not have a significant impact upon the consumer's decision. In emergency situations, price is rarely a factor. Dr. Halberstam stated that it is reasonable to assume that the cost of physician advertising will be passed along to patients in the form of higher fees. In addition, physician advertising can be expected to increase the demand for medical services, with the majority of this increased demand being for potentially unnecessary services (Tr. 7701–03).

AMA's experts testified that widespread advertising by physicians would have a deleterious effect upon the practice of medicine. For example, if physicians were allowed or encouraged to disseminate "objective" information concerning the number of cases of a particular disease which they have treated, inexperienced or unqualified physicians might well be encouraged to treat more cases of the

[37] AMA called the following witnesses to testify about physician advertising and its effects upon medical care: Dr. Robert S. Stone, Dean of the School of Medicine at the University of Oregon; Dr. Stephen Biering, Dean of the School of Medicine at Indiana University; Dr. Franz J. Ingelfinger, former editor of the *New England Journal of Medicine;* Dr. Michael Halberstam, a practitioner in Washington, D.C.; and Dr. Theodore Cooper, Dean of the Cornell University Medical College and a former top government health official.

disease. Similarly, allowing physicians to advertise the mortality or complication rates of their patients might discourage them from treating more difficult cases. Such advertising might also encourage overutilization of medical care, since physicians might tend to perform more and more relatively easy procedures or treatments on patients who did not necessarily require them. A physician might also choose to advertise the number of operations which he or she has performed. If the physician is being judged publicly on such a criterion, he might tend to "accummulate" a large string of operations. This motivation could also result in overutilization of medical services (Tr. 7695–97, 5332, 6089).

Further, fee advertising could cause a physician to alter his best medical judgment in order to stay with the fee which he advertised. Widespread physician advertising may lead the patient to believe that his or her physician is "selling" the recommended treatment, thus undermining the traditional relationship of trust and confidence and interfering with the quality of medical care (Tr. 5328, 5347, 5353–56, 7700, 9702).

Dr. Cooper testified that advertising of physicians' services also has the potential for consumer deception. Consumers are more vulnerable to deceptive advertising when they are sick than when they are well. A misleading [266] advertisement on behalf of a physician may lure a patient away from a source of responsible, continuing care to someone who may be less responsible (Tr. 6083–84, 6089). A physician's advertising of his medical credentials may result in consumer deception.

AMA's witnesses testified that a physician's advertising of prices generally will not enable a consumer to predict the cost of his or her specific medical care, since there is great diversity in the extent of care required by any individual. Price advertising is also unlikely to assist a consumer in making an informed choice of a physician, since price information alone cannot convey the quality of care which will be provided (Tr. 9504–05, 9692–94).

Dr. Ingelfinger testified that fee advertising has the potential for bait and switch tactics because the initial fee will often not cover further tests necessitated by complications or the need to confirm inconclusive results. He stated that advertising of the fee for a physical examination is misleading unless disclosure is made of the amount of time the physician spends with the patient, the thoroughness of the examination, whether the fee includes the taking of a history and what other tests and procedures are included in the fee (Tr. 5340–42, 5346). Advertising of new techniques which have not been generally accepted in the medical community can be deceptive

and hazardous. An example of such a situation is the Wagenstein method of treating ulcers by freezing the stomach, which was highly touted at first but which subsequently proved to be harmful (Tr. 5336–38).

Claims that one physician is better than another or is the best in a particular group are misleading because superiority cannot be objectively determined. Success depends on the kind of patient treated along with other factors, such as the degree of difficulty of each procedure, the general health of the patient and the kind of patient who is being treated. Thus, advertising of success rates in medicine is potentially misleading. Patient testimonials about physicians' services, even when based on truthful facts, are inherently misleading because of their statistical invalidity. No meaningful predictions about other cases can ever be made on the basis of one individual's medical experience. Anecdotal reports mean nothing unless one studies case histories or two groups of patients in a scientifically controlled setting (Tr. 5332–35, 6082, 9501–02, 9701). [267]

Promises of cures are deceptive because no medical procedure is always successful and all involve some degree of risk. Physician advertising may be deceptive unless it contains disclosure of the risks involved in the procedure being advertised (Tr. 5330–31, 6090).

Complaint counsel's witness, Dr. Robert H. Ebert,[38] testified that physicians should be allowed to advertise. Medicine has become increasingly complex in recent years and patients often are not aware of the choices available to them. It is difficult for patients to know about how to get into the health care "system," or to know about primary care physicians, specialists, hospitals, physician groups that provide a complete range of services, medical foundations, HMOs and prepaid medical plans. Dr. Ebert was of the opinion that most information available to patients today is communicated by word of mouth, rather than on a more orderly basis. He believes that advertising should supplement whatever information is already available. Dr. Ebert stated that the public is entitled to know what services are available in the health care system and that advertising can educate the public in this respect. Fee information is something the public is entitled to know and price advertising would provide access to it (Tr. 9318–21, 9354, 9409).

In testifying about HMOs, Dr. Ebert stated:

. . .it is very difficult for the general public to appreciate what is available in various kinds of systems. For example, it is now mandatory, I guess, through recent legislation

[38] Complaint counsel called as a witness Dr. Robert H. Ebert, President of the Milbank Memorial Fund and former Dean of Harvard University Medical School.

that there should be [a] choice in any firm of over 25 if an HMO exists in a region, that there should be at least a freedom of choice between that and an ordinary Blue Cross-Blue Shield or whatever commercial carriers may be offering. One of the great difficulties with this is it is not easy to get the best information about that choice. One gets some general descriptions of it [268] but very often it is not considered proper to list the physicians, who they are and what their background is and so on. It does seem to me the kinds of things that can be put into advertising that lists the services, that lists the costs, that lists the people and their qualifications, is valuable in terms of educating the public (Tr. 9321-22).

Dr. Ebert was also of the opinion that there are ways in which the quality of medical services can be utilized in advertising, and that any media is appropriate for medical advertising (Tr. 9322-32). Doctors have always solicited patients through social gatherings, membership in clubs, talks, presentations of papers and participation in church or community activities. Thus, solicitation by specialists in certain areas, for example in industrial medicine, would be in the public interest. Dr. Ebert stated his belief that advertising would not detract from the professionalism which is deeply engrained in physicians, but would tend to open up the "guild" philosophy which exists in medicine today.

Dr. Ebert is opposed to medical society regulation of advertising; in his testimony, he stated: "I say that because, again, I worry about this kind of guild philosophy, that it is too easy in a sense to use that in a way, and sometimes even inadvertently, as a weapon against anything new, any novel approach to the practice of medicine" (Tr. 9332). He believes the majority of physicians would not under any circumstances advertise falsely, and the threat of malpractice would be an enormous deterrent to false advertising. Dr. Ebert testified that restrictions on physician advertising were developed for another time when physicians were less trained and there was more concern about control of fringe people and quacks; today, physicians are well trained and of exceptionally high quality. The problem today is not control of false advertising, but "what more information can patients get and what can they learn about what is available in their community in a much more complex time." (Tr. 9334-35, 9333).

Controlling fringe practitioners through medical society regulation of advertising is, in Dr. Ebert's opinion, "rather indirect" (Tr. 9337), as brought out in his testimony: [269]

[W]ell, I would almost say since usually the people are outside of legitimate medicine and practice outside of the medical society and they don't belong and many of them are moving from one state to another ahead of the law, I would say that how they should be regulated is much more in the substance of what they do.

* * * * *

And it would seem to me that the medical society, in its concern, which is a legitimate concern for the welfare of the legitimate public, would be much more advised to go immediately where this practice is being carried out to see whether there is not a way of controlling it quite directly, because usually there is. I would have said quite honestly that the advertising by these fringe people might also be an advantage in the sense that it gives you evidence that it is going on. . . . I would be almost more worried if it was all underground and there was no way to know that this kind of thing was being kind of promulgated by word of mouth.

So I really think that one can clearly attempt to control, you are never going to control completely this sort of thing but one can follow up on it and do it rapidly enough so it simply makes it very uncomfortable for people to do that kind of practice or anything illegal. (Tr. 9337–38. *See also* Tr. 9395, 9400, 9403).

Dr. Ebert further believes that the public is capable of evaluating and utilizing physician advertising, physicians are not going to engage in making exaggerated claims in advertisements, advertising will not adversely affect the physician-patient relationship or affect a patient's confidence in a physician, advertising will not lead to overutilization of those medical facilities that are under the control of the physician, price advertising by physicians will not lead them to cut corners in the treatment or [270] diagnosis of patients, advertising may or may not cut medical costs, and advertising by legitimate physicians may actually dilute the effect of advertising by fringe practitioners (Tr. 9333, 9341–58, 9409–10. *See also* Tr. 7001–02, 5361–62). He stated that directories of physicians are helpful, but there is need to advertise that such directories are available to patients (Tr. 9354–55). Dr. Ebert believes that the majority of physician advertising will center around systems of health care rather than the sole practitioner (Tr. 9377, 9409).

Dr. Ebert supports the principle that medical societies should not exercise any control over physician advertising:

JUDGE BARNES: The issue here is whether to take all control away from the medical society as to advertising?

THE WITNESS: Yes.

JUDGE BARNES: That is the basic issue and I think that is what Mr. Costilo is seeking an answer to. The question is do you support that view?

THE WITNESS: Yes, I do. I support the view not (sic) to take away overall advertising because I think it now is ineffective in controlling a group of physicians who are operating outside of the framework of organized medicine anyway and it is limiting the information that can be given to the public by perfectly legitimate groups of physicians, therefore I do think the relief sought is proper and it should be taken away.

* * * * *

A. I think that what is important here is not the advertising per se, but what the physician does. I would think that untruthful advertising would certainly be the signal to find out whether his behavior as a physician was unethical in terms of his practice. Certainly, if it were, he should be expelled.

Q. But with respect to his advertising, should the local medical society regulate his advertising as advertising? [271]

A. No. I don't think they should. I think, and the reason for that, Your Honor, is not that in the blatant cases (pointing) it might not be useful there, but what is difficult is the gray areas. There is unfortunately the tendency to regulate rather more severely those things you don't happen to like personally, so I think the principle is a dangerous one. As I say, not in these blatant kinds of ads (pointing), but the principle, when applied to the grayer kind of area, I think the consequences could be such as to prevent perfectly responsible things from developing.

* * * * *

Q. . . .Should a medical society be able to expel a doctor if, in making an advertisement, the advertisement is concluded by the medical society to be likely to create inflated or unjustified expectations of favorable results?

A. I think my answer, Your Honor, is the same as I have given earlier, that I don't think that using the criteria of advertising is the appropriate criteria for expelling a member. I think an appropriate criteria would be what has actually happened to the patients of the doctor rather than the ad. As I indicated, I said that because of the potential that it could be misused.

Q. When you say "It can be misused," what do you mean?

A. The potential that it could be misused in those areas in which some question might be raised where the bias of an individual in the medical society might be such that they would tend to be more severe on a system they were less familiar with or didn't like or was more competitive with them, whereas, I think, on the basis of what the results are, where the medical society then does have that prerogative. (Tr. 9339-40, 9416-17, 9419-20). [272]

C. The Justifications are Without Merit

The arguments presented by respondents need not be looked at in isolation from similar arguments raised in other settings. The Supreme Court has already addressed itself on several occasions to the legality of ethical restrictions enacted by a "learned profession." *National Society of Professional Engineers* v. *United States,* 98 S. Ct. 1355 (1978); *Bates* v. *State Bar of Arizona,* 433 U.S. 350 (1977); *Virginia State Board of Pharmacy* v. *Virginia Citizens Consumer Council, Inc.* 425 U.S. 748 (1976); *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773 (1975). These cases, then, provide the contours within which

the restraints upon physician competition imposed by the AMA, CSMS, NHCMA and other medical societies must be analyzed.

The importance of advertising as the prime means by which information about the nature, price and availability of products and services is conveyed to the public is a well recognized fact. "Advertising is the traditional mechanism in a free-market economy for a supplier to inform a potential purchaser of the availability and terms of exchange." *Bates,* 433 U.S. at 376. As such, advertising "performs an indispensable role in the allocation of resources in a free enterprise system . . . [and] serves individual and societal interests in assuring informed and reliable decisionmaking." *Id.* at 364. Price advertising places pressure on sellers to reduce prices, instills cost consciousness in providers of services and informs the public about price alternatives. *Advertising of Ophthalmic Goods and Services,* 43 Fed. Reg. 23992, 23994-95 (FTC June 2, 1978). Advertising facilitates the entry of new and alternative providers of services into the marketplace; in the absence of advertising, such providers would be hard pressed to make their very existence known to the public. Through advertising, the public is presented with a wider array of choices and is better equipped to comparison shop among providers of the same services.

The record in this proceeding demonstrates the substantial anticompetitive effects of respondents' restrictions on physician advertising and the free flow of commercial information to the public. Physicians have been prevented from seeking customers by advertising or offering to provide services at a particular price, or by advertising their [273] services, availability or qualifications. As a result, it is more difficult for consumers to comparison shop for physicians' services, to locate physicians upon first arriving in a community, to change physicians, to find physicians who will accept the Medicare reimbursement schedule as payment in full, to become informed about group practices and HMOs and to benefit in many other ways from competition among the providers of health care services. The challenged restrictions have hindered the entry of new providers into the physicians' services market, including private practitioners, prepaid health care plans such as HMOs and other organizations and programs using innovative or alternative approaches in the delivery of health care. Physicians, prepaid health care plans and other medical organizations and programs that have been prevented and deterred from advertising and soliciting patronage have been injured economically, and the restrictions have made it more difficult for these physicians and organizations to continue to offer their services to the public and to compete effectively.

The Supreme Court has declared that there is no longer any automatic immunity from the antitrust laws based on the mere fact that a group constitutes a "learned profession." The Court stated: "[T]he cautionary footnote in *Goldfarb,* 421 U.S. at 788–89, n. 17 . . . cannot be read as fashioning a broad exemption under the Rule of Reason for learned professions." *Professional Engineers,* 98 S. Ct. at 1367. *See also Goldfarb,* 421 U.S. at 787–88.

There is also no merit to the contention that the ethical restrictions on advertising are necessary to guard against adverse effects on professionalism. The record evidence has clearly demonstrated that respondents' ethical strictures were motivated by economic objectives rather than by a need to maintain professionalism among physicians. Physicians are, perhaps, the most highly regarded profession, as a whole, in this country today (RX 915). To say that advertising would destroy that degree of public respect and tear into the physicians' self-image would be to deny the great skills and talent and the life-or-death judgmental abilities possessed by many physicians. "[T]he postulated connection between advertising and the erosion of true professionalism [is] severely strained." *Bates,* 433 U.S. at 368. *See also Virginia State Board of Pharmacy,* 425 U.S. at 768–770. [274]

Allowing advertising by physicians will not open the floodgates to widespread abuses with resultant detriment to the public. The overwhelming majority of physicians are honest, competent and dedicated and will not engage in false, misleading or deceptive advertising or other truly unethical forms of behavior. Respondents' arguments that because of advertising physicians will cut corners in their professional services, perform unnecessary treatments, or select out the easy procedures in order to compile an impressive success record, unduly denigrates a highly trained professional group. The Supreme Court has observed of other professions that advertising will not have such adverse effects: "We suspect that, with advertising, most lawyers will behave as they always have: They will abide by their solemn oaths to uphold the integrity and honor of their profession and of the legal system." *Bates,* 433 U.S. at 379. Nothing less should be said about physicians.

Further, high professional standards, including standards against dereliction in performance, are assured by state medical licensing boards[39] and state statutes regulating physician conduct, including advertising and solicitation.[40] Moreover, false or deceptive advertising is already prohibited in every state and the District of Columbia

[39] See F. 88, pp. 108–10.

[40] See Appendix B, pp. 310–12, *infra.*

in enacted laws preventing deceptive and unfair trade practices. *Ophthalmic Rule,* 43 Fed. Reg. at 23997, n. 89. The substantial penalties provided for under the Federal Trade Commission Act are a substantial deterrent to false or deceptive advertising. (15 U.S.C. 45(1).) Since not all physicians are members of medical societies, and therefore not subject to medical society ethical rules, those fringe practitioners who might be more likely to commit abuses remain unaffected by present ethical restrictions.[41] "Restraints on advertising . . . are an ineffective way of deterring shoddy work. An attorney who is inclined to cut quality will do so regardless of the rule on advertising." *Bates,* 433 U.S. at 378 "The advertising ban does not directly affect professional standards one way or the other." *Virginia State Board of Pharmacy,* 425 U.S. at 769. The same reasoning holds true for physicians. [275]

With regard to advertising by attorneys, the Supreme Court stated in *Bates:*

> We are not persuaded that restrained professional advertising by lawyers inevitably will be misleading. Although many services performed by attorneys are indeed unique, it is doubtful that any attorney would or could advertise fixed prices for services of that type. The only services that lend themselves to advertising are the routine ones: the uncontested divorce, the simple adoption, the uncontested personal bankruptcy, the change of name, and the like-the very services advertised by appellants. Although the precise service demanded in each task may vary slightly, and although legal services are not fungible, these facts do not make advertising misleading so long as the attorney does the necessary work at the advertised price. The argument that legal services are so unique that fixed rates cannot meaningfully be established is refuted by the record in this case: The appellee State Bar itself sponsors a Legal Services Program in which the participating attorneys agree to perform services like those advertised by the appellants at standarized rates. Indeed, until the decision of this Court in *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773 (1975), the Maricopa County Bar Association apparently had a schedule of suggested minimum fees for standard legal tasks. . . . We thus find of little force the assertion that advertising is misleading because of an inherent lack of standardization in legal services. Bates, 433 U.S. at 372–73.

The Court's response applies with equal force to the case of physician advertising. Services such as routine examinations, laboratory and diagnostic tests, immunizations and other short, simple procedures do lend themselves to meaningful advertising. The Relative Value Guides[42] promulgated by many medical societies indicate that there are base fees that can serve [276] as standards for even complex procedures.[43] More importantly, price advertising is only one of

[41] See discussion at F. 144, p. 206.

[42] *See* F. 33, p. 46; 60, p. 83; 63, pp. 85–86.

[43] During the period of federal price controls in the 1970's, federal regulation required all medical practitioners to post a sign in their facilities announcing the availability for public inspection of a schedule showing their

(Continued)

many types of information that could be disseminated once the ethical ban on advertising were lifted. Consumer directories, information about health maintenance organizations and medical clinics, more informative telephone listings, in person solicitation of corporate clients and other professionals and open houses are some of the means by which physicians could apprise the public of the range of available forms of health care delivery. The Supreme Court recognized that a well informed public represents, perhaps, the best means to the rational choice and utilization of services, for only a well informed public will perceive their own best interests. *Virginia State Board of Pharmacy,* 425 U.S. at 769–70. In *Bates,* the Court stated:

> [I]t seems peculiar to deny the consumer, on the ground that the information is incomplete, at least some of the relevant information needed to reach an informed decision. The alternative - the prohibition of advertising - serves only to restrict the information that flows to consumers. Moreover, the argument assumes that the public is not sophisticated enough to realize the limitations of advertising, and that the public is better kept in ignorance than trusted with correct but incomplete information. We suspect the argument rests on an underestimation of the public. In any event, we view as dubious any justification that is based on the benefits of public ignorance. *Bates,* 433 U.S. at 374–75.

To say that physicians are above "trade," and to assert that they are entitled to preserve their basic ethical values despite deleterious effects on [277] competition, would be to completely remove physicians from a marketplace setting, rather than admit that the services they offer, the delivery of which are both highly necessary and equally highly respected, might better comport with the public's needs were they subject to appropriate competitive factors, *i.e.,* advertising, solicitation and contract practice.

Respondents also argue that they do not proscribe advertising *per se,* but only that advertising which is misleading or deceptive.[44] The actual occasions on which medical societies interceded and effectively curtailed various forms of physician advertising show the fallacy of this argument. Dr. LaDou desired to acquaint the public with the advantages of preventive medicine and industrial medical services; he intended for his advertising to accomplish this objective.[45] He had hoped to bring his services to the attention of business executives, a

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customary prices for those services which accounted for 90 percent of their aggregate annual revenues (CX 2602). From this evidence, it can be inferred that physicians' fees are readily capable of being publicized in a nondeceptive manner.

[44] There is a real danger here, as Dr. Ebert has pointed out. Having your competitor determine whether your advertisement is false or deceptive has inherent risks. This power can be used as an anticompetitive weapon. One is more likely to closely regulate that which he dislikes or is unfamiliar with. Restrictions aimed at fringe practitioners are ineffective and prohibit legitimate advertising.

[45] See discussion at p. 258, *supra,* and at F. 98, pp. 124–29.

knowledgeable consumer group. Dr. Browne's proposal, stating the nature of and price for the laboratory and pathology services that he could offer, was intended to show that improved services did not require any increase in price.[46] Dr. Browne was dealing with hospital executives, again a knowledgeable group. These physicians, Dr. LaDou and Dr. Browne, and others posed obvious economic threats to medical societies and their members, who viewed the fee-for-service, private practice physician, in a noncompetitive setting, as the only viable means for delivering medical services. Neither Dr. LaDou, Dr. Browne nor the greater majority of physicians who engaged in advertising or who proposed to engage in some form of advertising, as recounted in the record evidence, misled or deceived the public. The information they hoped to [278] disseminate would only contribute to the pool of information on medical services available to the public, and thereby add to the breadth of the system of health care delivery in this country.

In considering the justifications for the ethical restrictions presented by respondents and the benefits to society engendered in competition among physicians, there are two modes of antitrust analysis. One category consists of agreements that are so "plainly anticompetitive" that they are "illegal per se;" the other category consists of agreements that must be subjected to the Rule of Reason analysis, which determines "whether the challenged agreement is one that promotes competition or one that suppresses competition." *Professional Engineers,* 98 S. Ct. at 1365. "Under [the Rule of Reason], the fact finder weighs all of the circumstances of a case in deciding whether a restrictive practice should be prohibited as imposing an unreasonable restraint on competition." *Continental T.V., Inc.* v. *GTE Sylvania, Inc.,* 433 U.S. 36, 49 (1977). In *Professional Engineers,* the Court held that a canon of ethics prohibiting the submission of competitive bids and refusing to discuss price until after an engineer was selected operated as an absolute ban on competitive bidding and violated Section 1 of the Sherman Act on its face. *Professional Engineers,* 98 S. Ct. at 1365–66.

The record evidence in this proceeding is overwhelming in establishing the anticompetitive effects of respondents' ethical restrictions, their economic motivations and their consequent harm to the public interest. The unreasonableness of the restraints on competition imposed by respondents AMA, CSMS, NHCMA and other AMA constituent and component medical societies needs no further elucidation. The ethical restrictions which the medical

[46] See discussion at pp. 260–61, *supra,* and at F. 136, pp. 194–97.

societies have imposed heavily tip the balancing scales against the needs of the public and in favor of the maintenance of the financial security of physicians. In such instance, the Rule of Reason is clearly violated. Since a record has been made that clearly demonstrates the unreasonableness of respondents' ethical restrictions, it is unnecessary to consider whether such activities also fall within a *per se* ban.

Respondents' ethical restrictions on advertising, solicitation and contract practice are also unfair under Section 5 of the Federal Trade Commission Act. A practice is unfair and violates Section 5 if it results in substantial [279] harm to consumers and offends public policy. *FTC* v. *Sperry & Hutchinson Co.,* 405 U.S. 233, 244–45 n. 5 (1972); *Spiegel, Inc.* v. *FTC,* 540 F.2d 287, 293 (7th Cir. 1976). That public policy supports advertising even where a professional group is involved was recognized by the Supreme Court in *Professional Engineers, Bates, Virginia State Board of Pharmacy, Goldfarb* and *Bigelow* v. *Virginia,* 421 U.S. 809 (1975). The Commission, most recently, has ruled in favor of a policy of providing information about commercial transactions to the public. *Advertising of Ophthalmic Goods and Services.* That respondents ethical practices have caused and continue to cause substantial injury to consumers has been established by the reasoning presented herein. Recent Supreme Court and Commission decisions leave no doubt that public policy strongly favors providing the public with information, not keeping them in ignorance.

The purported justifications for restrictions on advertising, solicitation and contract practice are an insufficient basis to overcome the substantial adverse effects on competition imposed by the restrictions and the strong public policy favoring the free flow of commercial information. As the Supreme Court stated: ". . . [W]e may assume that competition is not entirely conducive to ethical behavior, but that is not a reason, cognizable under the Sherman Act, for doing away with competition." *Professional Engineers,* 98 S. Ct. at 1367. Therefore, respondents' ethical restrictions are unfair and violate Section 5 of the Federal Trade Commission Act.

IV. RESPONDENTS HAVE ENGAGED IN A CONSPIRACY TO RESTRAIN COMPETITION

The record evidence establishes the existence of a conspiracy between the AMA and its constituent and component medical societies, including respondents CSMS and NHCMA. The degree and pattern of reliance by state and local medical societies upon the AMA for statements of official ethics policy, as well as for advice on ethical matters as they arise or are likely to arise, and the

dependence by the AMA upon the state and locals to implement and enforce those ethics policies become manifest in the internal structure and organization of the AMA and its constituent and component societies and in their working interrelationships. The prescriptions and proscriptions of AMA, as set forth in AMA's Principles of Medical Ethics, *Judicial Council Opinions and Reports* and other official pronouncements represent a pervading force in virtually all disciplinary actions undertaken by medical societies. To conclude, from respondents' admissions and from the parallelism between the nature of official policy on ethical issues as articulated by the AMA and as implemented and enforced by AMA member medical societies, that the striking uniformity of medical societies' positions [280] on ethics matters should have come about by mere chance or coincidence, as respondents have argued, rather than based on a common understanding and concerted activity is to adopt the impractical and ignore the reality.

To find otherwise than that the AMA and state and local medical societies were engaged in a conspiracy to restrain competition would be to ignore an abundance of evidence to the contrary. The record contains a more than sufficient quantum of independently admissible evidence to establish the existence of the conspiracy. There is also additional third-party documentary materials that were offered as evidence of the nature of the local medical societies, their actions and statements; these documents were provisionally admitted subject to connection to a conspiracy. Under the coconspirator rule[47] regarding statements that would otherwise be classified as hearsay, such documentary evidence from AMA's constituent and component societies is admissible against all respondents without the necessity of calling witnesses from these nonrespondent societies. The third-party documentary evidence provides further proof that supports and confirms the finding of a conspiracy. Moreover, this third-party evidence may be used as direct proof of the unlawfulness of the conspiracy.

A. The Conspiracies Being Challenged

The complaint alleges that respondents and others have agreed to prevent and hinder competition among physicians (Comp. ¶¶ 6 and 7). Respondents have engaged in two types of unlawful agreements. First, AMA has agreed with all of its constituent and component medical societies, including the Connecticut respondents, to promul-

[47] Rule 801(d)(2)(e) of the Federal Rules of Evidence, states:
"A statement is not hearsay if the statement is offered against a party and is a statement by a co-conspirator of a party during the course and in furtherance of the conspiracy."

gate and enforce ethics restrictions on physicians' advertising, solicitation and contractual relations. Second, each respondent medical society has engaged in concerted activity with its members by adopting the ethics restrictions, disseminating them to its members and agreeing to abide by them. [281]

B. The Legal Standard Governing Respondents' Activities

The core of conspiracy is a mutual understanding or agreement to accomplish an unlawful objective. The agreement is often described by the words, "meeting of the minds," "unity of purpose" or "common design and understanding." *American Tobacco Co.* v. *United States,* 328 U.S. 781, 810 (1946). So long as there is a mutual understanding to follow a common plan, a conspiracy may be found despite the lack of total uniformity among the conspirators. *FTC* v. *Cement Institute,* 333 U.S. 683, 715–16 (1948).

A formal or express agreement is not necessary to constitute an unlawful conspiracy, *American Tobacco,* 328 U.S. at 809, and will rarely be found in antitrust conspiracy cases. "It is elementary that an unlawful conspiracy may be and often is formed without simultaneous action or agreement on the part of the conspirators." *Interstate Circuit, Inc.* v. *United States,* 306 U.S. 208, 227 (1939). *See United States* v. *Masonite Corp.,* 316 U.S. 265, 275 (1942). Instead, the inherent nature of a conspiracy is often marked by a continuous course of conduct. To isolate out and separately analyze the individual components of a conspiracy would be to contradict the very theory that lies behind it. "Acts done to give effect to the conspiracy may be in themselves wholly innocent acts. Yet, if they are part of the sum of the acts which are relied upon to effectuate the conspiracy which the statute [the Sherman Act] forbids, they come within its prohibition." *American Tobacco,* 328 U.S. at 809. The agreement may be inferred from a course of conduct which could include communications among the coconspirators as well as seemingly concerted activities. "The character and effect of a conspiracy are not to be judged by dismembering it and viewing its separate parts, but only by looking at it as a whole." *Continental Ore Co.* v. *Union Carbide & Carbon Corp.* 379 U.S. 690, 699 (1962), quoting *United States* v. *Patten,* 226 U.S. 525, 544 (1913). This represents not only a rational legal and analytical approach to the instant factual situation, but a common sense view of it as well.

In *Interstate Circuit,* 306 U.S. at 226–27, the Supreme Court held that where concerted activity is contemplated and invited by a central, coordinating party and such [282] invitation is accepted by competitors knowing that their participation is essential to achieve

the purposes of the agreement, a conspiracy has been established. The kind and gravity of the conduct entered into that, taken as a whole, comprises the conspiracy may not only vary, but may defy categorization under traditional conspiracy concepts. "If persons devise some subtle, unique form of conspiracy tailored to best serve their own purposes which purposely leaves few tracks or fingerprints, it may violate the law even though it cannot be easily accommodated in the familiar mold of a simple and limited conspiracy." *United States* v. *Consolidated Packaging Corp.*, 575 F.2d 117, 126 (7th Cir. 1978).

It is not necessary to show that *every* constituent and component medical society participated in the agreement in order for a conspiracy to be established; "what is required . . . is substantial evidence from which such an agreement can be inferred." *Northern California Pharmaceutical Association* v. *United States,* 306 F.2d 379 (9th Cir. 1962), *cert. denied,* 371 U.S. 862 (1962). *See also Interstate Circuit,* 306 U.S. 208 (1939). Once a conspiracy has been established, only slight evidence is necessary to connect a particular participant to it; such evidence might be no more than a single act demonstrating, directly or inferentially, the intent to participate. *Consolidated Packaging,* 575 F.2d at 126–27; *United States* v. *Cadillac Overall Supply Co.,* 568 F.2d 1078, 1087 (5th Cir. 1978), *cert. denied,* 46 U.S.L.W. 3776 (June 19 1978). *See also Blumenthal* v. *United States,* 332 U.S. 539, 556–57 (1947).

In *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773 (1975), the Supreme Court decided that § 1 of the Sherman Act was violated by a minimum fee schedule for lawyers that was promulgated by a county bar association following the impetus provided by the state bar association in its fee schedule reports. The Court noted that enforcement of the fee schedule was aided by the prospect of professional discipline from the State Bar - a distinct possibility unmistakably present in the State Bar's ethical opinions - as well as the desire of attorneys to comply with announced professional norms. *Id.* at 781, 791 n. 21. However, there had been no formal disciplinary action to enforce the fee guidelines. *Id.* at 776–77. The Court concluded that "[t]he State Bar, by providing that deviation from County Bar minimum fees may lead to disciplinary action, has voluntarily joined in what is essentially a private [283] anticompetitive activity, and in that posture cannot claim it is beyond the reach of the Sherman Act." *Id.* at 791–92. The parallelism between *Goldfarb* and the instant set of facts is clear.

The second type of conspiracy challenged here, namely a conspiracy between each respondent medical society and its members, has

also been addressed by the Supreme Court. In *National Society of Professional Engineers* v. *United States,* 98 S. Ct. 1355 (1978), the Court held that a learned profession's canon of ethics prohibiting the submission of competitive bids amounted to an unlawful agreement among members of the society to restrain trade. "Petitioner's ban on competitive bidding prevents all customers from making price comparisons in the initial selection of an engineer, and imposes the society's views of the costs and benefits of competition on the entire market place." *Id.* at 1367. These words apply with equal force here. The Court further noted that "the cautionary footnote in *Goldfarb,* 421 U.S. at 788–89, n. 17 . . . cannot be read as fashioning a broad exemption under the Rule of Reason for learned professions." *Id.*

C. The Existence of a Conspiracy Is Established by Independently Admissible Evidence

The record evidence shows that respondent AMA served as the focal point of a plan to restrict physicians' advertising, solicitation and contractual relations. AMA provided the impetus for the Connecticut respondents and other state and local medical societies to act in concert with them in the restrictive practices detailed in the findings of fact, herein. The means by which such restraints were effected include the promulgation and distribution of the Principles of Medical Ethics, the *Opinions and Reports* and interpretations thereof, and communications with medical societies and individual physicians to promote compliance with these and other ethical pronouncements.

The structural hierarchy of the AMA and its member societies and the organizational network that allows them to function in an efficient and integrated manner reveal a close working relationship.[48] AMA is a federation of constituent (state) medical societies which, in turn, charter component (county and district) medical societies. [284] In most instances, a physician must join his or her state medical society to be eligible for AMA membership. Membership in a local society is usually a prerequisite to membership in a state society (F. 4–5, p. 6; 9, p. 8). The state societies usually collect AMA membership dues on behalf of AMA.

The local societies select the members of the state societies' governing bodies, and the state societies select the members of the AMA ruling body, the House of Delegates. The House of Delegates, representing the medical societies in the AMA federation, has adopted the Principles of Medical Ethics and has made adherence to

[48] See discussion at pp. 234–35, *supra.*

them a condition of membership in AMA. The House has approved and specifically adopted many of the ethical restrictions on physicians' advertising, solicitation and contractual relations that are contained in the *Opinions and Reports.* The House has declared it a prime purpose of AMA to maintain "ethical" standards among all members of the medical profession (CX 990Z10). Promulgation and enforcement of its code of ethics has been a principal function of AMA since its founding (CX 959Z28). The House of Delegates elects the members of the AMA Judicial Council. The Judicial Council issues interpretations of the Principles *(Judicial Council Opinions and Reports),* is empowered to institute disciplinary proceedings at the request of state societies against physicians who violate the Principles and has appellate jurisdiction over cases originated by constituent and component societies in ethical matters (F. 6, p. 7; 8, pp. 7–8; 85, p. 102; 86, pp. 105–06).

Often, the constitutions and bylaws[49] of constituent and component medical societies expressly state that a primary purpose of existence is to form and maintain, along with other medical societies, the AMA (F. 5, p. 6). The bylaws of these medical societies provide that AMA's Principles of Medical Ethics shall govern the conduct of their members (*See* Appendix A, *infra*). The AMA House of Delegates has adopted a resolution making state medical societies' own ethical principles binding upon the respective societies' members, provided that the principles are not inconsistent or in conflict with the Constitution and Bylaws of AMA (CX 1435Z20). AMA has also declared that when a physician disregards "local custom," as determined by the local medical society, he has acted unethically (F. 86, p. 104; CX 1349). Furthermore, AMA has declared it the duty and [285] obligation of its local medical societies to insure full compliance with the spirit and intent of the AMA Principles of Medical Ethics (CX 462Z9 [Sec. 5, Op. 20]), and has frequently urged its constituent and component medical societies to fulfill this obligation (CX 462Z1 [Sec. 4, Op. 9], Z2 [Sec. 4 Op. 14], Z5–6 [Sec. 5, Op. 9], Z6, [Sec. 5 Op. 11], Z6–7 [Sec. 5, Op. 12], Z7 [Sec. 5, Op. 13], Z9 [Sec. 5, Op. 20], Z10 [Sec. 5, Op. 23], Z40 [Sec. 10 Op. 4], Z45 [Sec. 10, Op. 13]; 26B, 54, 488B–C, 662B–C, 673A, E, 845, 1392C, 1810). AMA has also stated that the application of all of the opinions in the *Opinions and Reports* is the obligation of county medical societies (CX 489).

AMA has distributed thousands of copies of the Principles and the *Opinions and Reports,* which interpret the Principles to its state and local societies; these AMA member medical societies have, in turn,

[49] AMA has not challenged these documents on the grounds of authenticity or hearsay. Therefore, they are adjudged independently admissible evidence.

distributed copies throughout their organizational network (F.85, p.103), thus assuring that the Principles and the *Opinions and Reports* filter down to all physician members. By these actions, AMA has openly encouraged medical societies and consequently, member physicians to take part in the restrictive practices and thereby to participate in a conspiracy to restrain competition.

The hierarchy of the medical societies, their common members, the bylaws of the state and local societies, combined with AMA's Principles and its *Opinions and Reports,* constitute a prima facie showing of the conspiracy between AMA and its constituent and component societies, including the Connecticut respondents. Moreover, the actual restrictive practices, including the constant flow of communications between AMA, its member medical societies and individual physicians concerning ethics policy and ethics enforcement, further demonstrate the existence and extent of the conspiracy. AMA has prompted its constituent and component medical societies to apply its restrictions on physician advertising, solicitation and contractual arrangements to particular physicians and medical care organizations, has offered guidance to its member societies in interpreting and applying the restrictions and has expressed after-the-fact approval of specific restrictive actions taken by its member societies.[50] State medical societies including CSMS, [286] have prompted and participated with their local medical societies including NHCMA, in specific actions to interpret and enforce AMA's ethical restrictions on solicitation, advertising and contractual arrangements. Apparently feeling less qualified and less expert in the application of ethical pronouncements than the AMA, local societies have written to AMA to solicit its advice and opinions on numerous occasions. AMA's responses often take the form of advisory opinions, ethical policy statements and, where appropriate, have usually resulted in the informal enforcement by the local societies of the restrictions on physicians' advertising, solicitation and contractual relations contained in the Principles. Where the AMA receives communications from sources other than member medical societies, it often responds by referring ethical complaints and inquiries to the appropriate component medical society for action.

In sum, AMA acts as a clearinghouse for the dissemination of policy on ethic matters and, frequently, for the resolution of ethics complaints. AMA field officials, under the direction and guidance of

[50] AMA's Department of Medical Ethics, in internal reports, has stated that it "works closely" with the officers and staff of state and county medical societies on ethical matters, including those relating to advertising (CX 1766A, 1767A).

the AMA Judicial Council and its staff, act as intermediaries on matters of medical ethics between AMA and its constituent and component medical societies and others. In so doing, AMA field officials engage in many of the same activities as the AMA Judicial Council and its staff and routinely, in formal and informal ways, interpret and enforce, and assist and advise AMA's constituent and component medical societies and others in the interpretation and enforcement of, AMA's Principles of Medical Ethics and AMA's Judicial Council interpretations thereof.[51] The incessant obedience of the locals and their members to AMA's ethical dictates belies the possibility of mere coincidence. Instead, such concerted actions bespeak of a common conspiratorial undertaking.

Evidence independently admissible against the Connecticut respondents establishes their prima facie involvement in a conspiracy with AMA and other constituent and component societies.[52] NHCMA members are directly represented in the CSMS House of Delegates which, in turn, sends delegates to the AMA House of Delegates. Both CSMS and NHCMA have adopted, published and distributed to their members the AMA's Principles of Medical Ethics and interpretations of them; both have made adherence to the [287] Principles a condition of membership. NHCMA has explicitly provided that its members are bound by the AMA Principles as reflected in the opinions of the AMA Judicial Council (F. 86, p. 104). Both Connecticut respondents have communicated with AMA about matters relating to the Principles and, thereby, to the aforementioned restrictions on physicians, and both have engaged in informal enforcement of the AMA Principles (F. 95, pp. 119–20; 112, p. 147; 119, p. 160; 121, pp. 167–68; 123, pp. 172–73; CX 136A–F, 137). This is more than the "slight evidence" that is needed to connect a particular party to an ongoing conspiracy.

The record evidence[53] evinces, beyond any reasonable doubt, a "unity of purpose" and a mutual understanding on the part of the AMA, its constituent and component societies and the individual physicians that comprise the membership of those medical societies to promulgate, disseminate and enforce ethical restrictions on advertising, solicitation and contract practice. The orchestration of

[51] See Order Ruling on Complaint Counsel's Motion for Adverse Rulings and Other Relief Due To Noncompliance With Subpoena Duces Tecum By Respondent The American Medical Association, February 24, 1977, pp. 11–12.

[52] Since it is held that all medical societies and their individual physician members, not named as parties to this proceeding, are participants in the conspiracy, it follows that CSMS and NHCMA are also coconspirators aside from the quantum of evidence that is independently admissible against them.

[53] These specific instances of implementation of AMA ethical pronouncements to restrain competition among physicians are too numerous to repeat again here. Instead, reference is made to pp. 254–63, *supra*, and to Sections X and XI of the findings.

activities that effectively restrain physician competition throughout the United States is too harmonious to be suggestive of anything other than concerted action - a conspiracy - among physicians and their medical societies.

D. Third-Party Medical Society Documents

The third-party evidence admitted provisionally subject to connection to a conspiracy is made up of a large number of documents from the files of AMA's constituent and component societies. The documents consist primarily of communications between constituent and component medical societies and individual physicians, minutes of meetings of the state and local societies and other correspondence generally relating to ethics inquiries and complaints addressed by the state and local medical societies.[54]

Respondents have not challenged the authenticity of these documents. The main objections to them are on the grounds of relevancy and hearsay. There are several alternative evidentiary bases upon which the documents are admissible. [288]

First, the documents are admissible under the well established principle that out-of-court declarations of conconspirators are admissible against all of the conspirators once a *prima facie* showing has been made by independently admissible evidence that the parties were engaged in a combination, partnership or "common plan." This principle is based upon the agency relationship that comes into existence when a conspiracy has been established. It is not necessary to show by independent evidence that the combination was unlawful, for that "element of illegality may be shown by the [hearsay] declarations themselves." *Hitchman Coal & Coke Co.* v. *Mitchell,* 245 U.S. 229, 249 (1917). *See Schine Chain Theatres, Inc.* v. *United States,* 334 U.S. 110, 116–17 (1948); *United States* v. *United States Gypsum Co.* 333 U.S. 364, 388–93 (1948); *Bakers of Washington,* 64 F.T.C. 1079, 1137 (1964), *aff'd sub nom., Safeway Stores, Inc.* v. *FTC,* 366 F.2d 795 (9th Cir. 1966), *cert. denied,* 385 U.S. 932 (1967).

Since a conspiracy has already been established by independently admissible evidence, as described above, the third-party documents become admissible as declarations of the coconspirators in aid of the conspiracy. These documents provide further confirmatory evidence that buttresses the finding of a conspiracy to restrain competition. It is immaterial that the AMA or other parties to the conspiracy may not have known of the commission of the act or the making of the

[54] Most of the documents specifically refer to AMA's Principles of Medical Ethics and *Opinions and Reports* as the authority for ethics actions; almost all of those that do not are from societies which have adopted the Principles to govern their members.

declaration contained in the third-party document. The coconspirator doctrine attributes those acts and declaration to each partner in the conspiracy.

The third-party documents may, however, be used as evidence of the conspiracy itself. To reach this end, the basis for admissibility lies in the fact that the documents constitute nonhearsay and, therefore, are independently admissible.

The documents are not hearsay because they can be viewed as having been offered not for the truth of the matters stated, but rather for the fact that the statements contained in each document were made. *See United States* v. *Mesarosh,* 233 F.2d 449 (3d Cir. 1955); *rev'd on other grounds,* 352 U.S. 1 (1956); *Baush Mach. Tool Co.* v. *Aluminum Co. of America,* 79 F.2d 217 (2d Cir. 1935). Consequently, the third-party documents may be used to establish the conspiracy.

Since many of the third-party documents refer explicitly, as well as implicitly, to the AMA's Principles of Medical Ethics and to the *Opinions and Reports,* they constitute [289] additional direct evidence of a conspiracy. Indeed, the documents attest to the wide-ranging extent of the conspiracy to restrict physicians' advertising, solicitation and contractual relations. Those third-party medical society documents that do not either mention the Principles or directly refer to the AMA as the primary source of ethics pronouncements, form a pattern of advice and policy on ethics matters that is not only consistent with AMA views but unswervingly in line with almost all AMA ethics dictates. Such a pattern inexorably leads to the inference of conspiracy.

This proceeding is governed by the Federal Trade Commission's Rules of Practice, rather than by the Federal Rules of Evidence. *See FTC* v. *Cement Institute,* 333 U.S. 683, 705–06 (1948). A final ground for the admissibility of these documents is based upon Rule 3.43(b) of the Commission's Rules of Practice.[55]

There is no doubt as to the relevancy or materiality of the documents. They point towards the same type of practices that respondents are charged with, and frequently refer to and make mention of AMA's Principles of Medical Ethics, its *Opinions and Reports* and other ethics pronouncements. The third-party medical society documents give rise to an inference of conspiracy that finds full support in the evidence described above.

The only question lies in the reliability of the documents.

[55] Section 3.43(b) reads as follows:

Admissibility. -Relevant, material and reliable evidence shall be admitted. Irrelevant, immaterial, unreliable, and unduly repetitious evidence shall be excluded. Immaterial or irrelevant parts of an admissible document shall be segregated and excluded so far as practicable.

However, the documents largely consist of minutes of official meetings and correspondence generated during the normal course of operations and prepared contemporaneously with the transactions described therein. Documents such as these are akin to business records which are routinely admitted into evidence under an exception to the hearsay rule.[56] Evidence of this nature is traditionally accorded a high degree of reliability arising [290] out of the fact that such documents are among the types of materials that reasonable persons will rely upon in their daily business affairs. The authenticity of these documents has not been challenged. Therefore, they are admissible under Rule 3.43(b) and provide further evidence of conspiracy.

While AMA does not literally control its constituent or component medical societies, it exerts tremendous influence over them and, thus, over individual physicians, especially in the area of ethics complaints and inquiries. It is inappropriate to look at the relationship of AMA to state and local societies in terms of actual control. Medical societies are not corporations; there is no veil to be pierced.

The establishment of a conspiracy rests upon a strong factual showing. As various examples of the interdependence among the AMA and its constitutent and component medical societies along with individual incidents demonstrating the effects of their concerted activities are revealed, the record evidence builds increasingly to the finding of a conspiracy among physicians and medical societies to restrain physician competition in the United States. While there is no magical number denoting the quantum of evidence that is necessary to lead to the conclusion of conspiracy, in certain instances the cumulative import of facts adduced at trial will allow no other conclusion. The present case represents such a situation.

V. ABANDONMENT OR DISCONTINUANCE

Respondent AMA contends that the basis for any decision in this case should be AMA's *current* position on advertising, solicitation and contract practice as reflected in the 1977 *Opinions and Reports* (RX 1), and that there is no need to inquire into the antitrust implications of earlier editions of the *Opinions and Reports* (AMA Conclusions of Law, pp. 72–76, 120–122; AMA Post-Trial Brief, pp. 29–36). AMA contends that the Commission should determine the lawfulness, not of obsolete statements of the AMA, but of the current position of the Association. A ruling based on outdated statements in the 1971 edition would amount to "a sterile exercise of the

[56] *See, e.g.*, Fed. Rules Evid. Rule 803(6), 28 U.S.C.

Commission's power, an exercise engaged in simply to have an order on record" (AMA Post-Trial Brief, p. 34).[57] [291]

It is undisputed that AMA's Judicial Council did publish a 1977 edition of *Opinions and Reports* which differs from the 1971 edition. Complaint counsel contends, however, that AMA has not specifically rescinded the 1971 edition and that many of the restrictions on physician advertising, solicitation and contract practice have not been abandoned (Complaint counsel Brief, pp. 49–51; Complaint counsel Reply Brief, pp. 36–38; CPF pp. 276–281).

The facts of this record reveal complete reliance upon the 1971 *Opinions and Reports* by AMA and its constituent and component societies for interpretations of what is or is not ethical conduct in the areas of advertising, solicitation and contract practice. The 1971 edition has many detailed examples which can be followed in determining the ethical propriety of a physician's conduct; the 1977 edition is of a more summary nature (*Compare* CX 462 *with* RX 1). Based on the 1971 edition, many constituent and component societies promulgated codes and guidelines for their members. The AMA House of Delegates adopted the 1971 *Opinions and Reports* and other promulgations concerning ethical matters which were based on the 1971 edition; *i.e., Report on Physician-Hospital Relations* (CX 959) and "Guidelines on Telephone Directory Listings" (CX 534C–D, 533K, 673B–I). None of these publications has ever been specifically rescinded by the AMA House of Delegates, and the 1977 edition of *Opinions and Reports* has never been adopted by the AMA House of Delegates.

The 1977 edition of *Opinions and Reports* expressly "reaffirms the long-standing policy of the Judicial Council on advertising and solicitation by physicians" (RX 1, p. 30). The 1977 edition also states that, "The [Principles of Medical Ethics] proscribe the solicitation of patients" (RX 1, p. 30). There are other examples of equivocation in the 1977 edition, especially the use of "catch words" of limitation or restriction which were also utilized in the 1971 edition (F. 153, p. 229).

There has never been any communication from AMA to its constituent and component societies to revise or update their own ethical codes or guidelines so as to conform with the 1977 edition of the *Opinions and Reports*. The record is devoid of evidence that constituent and component societies [292] have revised, systematically or otherwise, their ethical codes and guidelines. In fact, the

[57] On January 14, 1977, AMA filed a Motion for Certification to the Commission of AMA's Motion to Reconsider Issuance of the Complaint because of changed circumstances—the issuance of the 1977 *Opinions and Reports*. After certification of the motion, the Commission, on April 26, 1977, denied the motion.

record contains a number of incidents which strongly establish that constituent and component societies are continuing to enforce AMA's ethical interpretations as contained in the 1971 edition of the *Opinions and Reports.* Several witnesses testified that their advertising policy still conformed to the 1971 interpretations (*See* F. 152–53, pp. 226–31, for detailed findings on the issue of discontinuance).

The message that the new *Opinions and Reports* conveys to AMA's component and constituent societies and to individual member physicians is not one of clear and unambiguous abandonment of the prior ethical restrictions. At no time has the AMA House of Delegates or the Judicial Council ever publicly and explicitly declared to its affiliated societies and members that its earlier ethical pronouncements have, in fact, been officially rescinded or superseded by issuance of the 1977 *Opinions and Reports.* The deeply imbedded hostility to advertising, solicitation and contract practice by physicians — apparent in the testimony of respondent AMA's own surrebuttal witnesses and in the recent activities of some of AMA's constituent and component societies[58] — confirms that respondents have not made an unequivocal and effective discontinuance of the challenged practices and cannot show with reasonable certainty that the challenged practices will not recur. Further, AMA's purported discontinuance or abandonment, *i.e.,* the publication of the 1977 *Opinions and Reports,* occurred subsequent to the issuance of the complaint in this matter on December 19, 1975. In November 1975, the AMA Judicial Council formally sanctioned an updated edition of the 1971 *Opinions and Reports.* On April 9, 1976, the Judicial Council issued a revised statement on physician advertising and solicitation. The content and format of the new edition of the *Opinions and Reports* was approved by the Judicial Council on June 25, 1976. The revised statement by the Judicial Council was published in the 1977 *Opinions and Reports* in March 1977 (F. 152, pp. 226–27).

From the above sequence of events it is apparent that any definitive action on revising the 1971 *Opinions and Reports* was taken *after* the complaint herein had issued. Failure of AMA to take more positive steps to ensure that a complete and unequivocal discontinuance of the challenged practices was effected, with the Commission's complaint outstanding, leads to the conclusion that a discontinuance or abandonment was never intended. [293]

[58] See especially the inability of Florida physicians associated with an HMO to obtain low-cost malpractice insurance in 1977, through the Florida Medical Association because of the opposition of that Association and the Volusia County Medical Society to physicians associated in the contract practice of medicine. (F. 149, pp. 220–221).

VI. THE REMEDY

Having found a conspiracy to restrain competition, the effects of which have been to deprive consumers of the free flow of commercial information that is indispensable in making informed economic decisions, and to interfere with the freedom of physicians to make their own decisions as to their employment conditions, it is necessary to devise a remedy that will open the channels of communication and prevent obstruction to physicians and, *inter alia,* HMOs in their contractual arrangements. It is well established that "the Commission has wide discretion in its choice of a remedy deemed adequate to cope with unlawful practices" and that, so long as the remedy selected has a "reasonable relation to the unlawful practices found to exist," the courts will not interfere. *Jacob Seigel Co.* v. *Federal Trade Commission,* 327 U.S. 608, 611 (1946). *See also Federal Trade Commission* v. *Cement Institute,* 333 U.S. 683, 726 (1948); *Federal Trade Commission* v. *Colgate-Palmolive Co.,* 380 U.S. 374, 392 (1965); *L. G. Balfour Co.* v. *Federal Trade Commission,* 442 F.2d 1 (7th Cir. 1971)[59] Having established a violation, the Commission must "be allowed effectively to close all roads to the prohibited goal, so that the order may not be by-passed with impunity." *Federal Trade Commission* v. *Ruberoid Co.,* 343 U.S. 470, 473 (1952). *See also Federal Trade Commission* v. *National Lead Co.,* 352 U.S. 419 431 (1957). As the Supreme Court has explained, "[O]nce the Government has successfully borne the considerable burden of establishing a violation of law, all doubts as to the remedy are to be resolved in its favor." *United States* v. *E. I. duPont de Nemours & Co.,* 366 U.S. 316, 334 (1961).

Recent Supreme Court decisions have emphasized the need for the free flow of commercial information. Commercial speech serves to inform the public of the availability, nature, and prices of products and services, and thus performs an [294] indispensible role in the allocation of resources in a free enterprise system. In short, such speech serves individual and societal interests in assuring informed and reliable decisionmaking. *Bates* v. *State Bar of Arizona,* 433 U.S. 350, 364 (1977); *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.* 425 U.S. 748, 765 (1976).

In acknowledging the significance of commercial speech to the public, the Court has not hesitated to strike down barriers that inhibit the dissemination of commercial information. The Court has also made it abundantly clear that Congress did not intend to

[59] The Supreme Court, in a very recent antitrust decision, stated: "[T]he standard against which the order must be judged is whether the relief represents a reasonable method of elininating the consequences of the illegal conduct." *National Society of Professional Engineers* v. *United States,* 98 S. Ct. 1355, 1368 (1978).

exclude professional associations from antitrust regulation. *Professional Engineers,* 98 S. Ct. at 1362–68; *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773, 787 (1975). *Virginia State Board of Pharmacy* at 766–770.

Purported justifications for withholding commercial information from the public have not been persuasive. The Court's position, clearly articulated in recent decisions, is that people will perceive their own best interests if they are well enough informed. The best way to accomplish this is to open the channels of communication, not close them. Information cannot be foreclosed from the public on the purported bases that the products or services might be harmful, or that the advertising information might be incomplete or some of it deceptive, or that the public might misunderstand the information. The solution is not to keep the public in ignorance, but to insure that opportunities are available to provide the public with more information.

AMA argues that it is not opposed to the dissemination of truthful, objective information about physicians' services that will be helpful to consumers. AMA contends that its position on advertising and solicitation is reasonable in that it combats deception, enhances the physician-patient relationship, and guards against a lowering of the quality of medical care received by patients (AMA Reply Brief, p. 54–55, 66). Even assuming that AMA's intentions are altruistic, the record shows that its restrictions have had the effect of depriving consumers of the information necessary to make an informed choice of health care and insulating physicians from the give and take of the marketplace. New methods of health care have been discouraged, restricted and, in some instances, eliminated. That some of the effects of respondents' ethical restrictions may have been to prevent inferior services or insure ethical behavior is not a sufficient justification for permitting respondents [**295**] to impose continuing restraint on competition. There are other methods to accomplish respondents' purported objectives without the substantial restraints on competition which inherently flow from respondents' ethical restrictions.

In fashioning a remedy, it is observed that the Supreme Court has indicated that there is a role for a professional society to play in the regulation of the ethical standards of its members. *Bates,* 433 U.S. at 369 n. 20, 373 n. 28, 379, 384; *Professional Engineers* at 1367–69. The Order which will be entered in this proceeding will take into account this expression by the Court. Respondents will be permitted to participate in setting ethical guidelines for the conduct of their

members, after first obtaining the permission and approval of the Federal Trade Commission.

AMA has presented certain evidence that state boards of medical examiners and the Federal Trade Commission have neither the resources nor the inclination to regulate physician advertising (AMA Proposed Findings, pp. 440–448). The purpose of this evidence is to bolster the argument that governmental agencies are not adequate to protect the public from deceptive advertising and therefore medical society regulation is necessary to protect the public interest (AMA Conclusions of Law, p. 142; AMA Reply Brief, p. 64). The evidence presented by AMA is not persuasive.

The history of the Federal Trade Commission over the years is replete with proceedings concerning false and deceptive advertising and promotional practices involving drugs, cosmetics, devices and medical services, including such items as bust developers, hair preparations, bedwetting devices, arthritis cures and weight reducing and control devices and remedies.[60] The Wheeler-Lee amendment to the Federal Trade Commission Act,[61] passed in 1938, was enacted to broaden the powers of the Commission so as to provide more effective control over false advertisements of foods, drugs, devices and cosmetics.[62] For the first time, the Commission was given authority to enjoin false and deceptive advertising. Recent actions by the Commission in [**296**] this area of regulation include proceedings entitled *Simeon Management Corporation,* Docket 8996 [87 F.T.C. 1184] (weight reduction clinics), *Travel King Inc., et al.* Docket 8949 [86 F.T.C. 715] (physic surgeons), *Porter & Dietsch, Inc.,* Docket 9047 [90 F.T.C. 770] (weight control products), *American Home Products Corp.,* Docket 8918 [Initial Decision, Administrative Law Judge Hyun, dated September 1, 1978] (headache or pain remedies), and *Karr Preventative Medical Products Inc.,* Docket 9109 [94 F.T.C. 1080] [Complaint issued April 26, 1978] (acne remedy). The penalties provided for in the Federal Trade Commission Act may well be a substantial deterrent to false and deceptive advertising by physicians. As noted by the Commission in the recently issued trade regulation rule on the advertising of ophthalmic goods and services, all of the 50 states have laws prohibiting false and deceptive advertising. *Advertising of Ophthalmic Goods and Services,* 43 Fed. Reg. 23992, 23997 n. 89 (FTC June 2, 1978). Thus, it cannot be concluded in this proceeding or, indeed, in any proceeding that governmental regulation of false and deceptive advertising, although

[60] *See* CCH Trade Reg. Rep. ¶¶ 7739, 7741, 7743, 7745, 7747, 7749, 7751, 7780–85.

[61] 52 Stat. 114, 15 U.S.C. 52, *et seq.*

[62] H.R. Rep. 1613, 75th Cong., 1st Sess.

at times perhaps imperfect, must give way to private regulation to protect the public.

Respondent AMA argues that if any order is entered in this proceeding on the advertising aspect of this case, "it should be limited to prohibiting regulation of advertising when respondents have no reason to believe that such advertising is untruthful, deceptive, or otherwise lacking in information which would help consumers make an informed choice of physician" (AMA Conclusions of Law, pp. 8, 146–147). If an order is entered on contract practice issues, AMA contends that it should be limited to "remedying any specific violations that have been established" (AMA Conclusions of Law, p. 150). Respondents CSMS and NHCMA suggest that such respondents could be ordered not to restrict their members from publishing in the print media truthful, objective and verifiable information relating to physicians and their practices, or relating to routine services and procedures performed by the physicians (CSMS Conclusions of Law, pp. 36–37).

Respondents have contended throughout this proceeding that the only restrictions they have imposed on their members were intended to prevent deception of the public and to protect the quality of medical care, and that they have not opposed the dissemination of truthful information which will assist consumers in making an informed choice of a physician. The record evidence is otherwise, however, it establishes with clear conviction that respondents have prevented the dissemination of truthful, objective information that could provide substantial benefits to the public. These restrictions have been carried out over a long period [297] of time as a common understanding between AMA, CSMS and NHCMA and over 2,000 other medical societies throughout this country and their members. These restrictions must be completely eliminated and physicians must be given the unfettered opportunity to present to the public information which the public needs and is entitled to receive, subject only to governmental, not medical society, restrictions.

Since the unlawful restrictions have been effectuated through a conspiracy involving the constituent and component societies of AMA, it is necessary that any order entered in this proceeding eliminate the restrictions at all levels of the medical society federation. AMA strenuously objects to any provision in an order requiring it to instruct state and local societies to take or desist from taking action (AMA Conclusions of Law p. 9). AMA contends that subjecting independent and autonomous organizations to an order in a proceeding to which they were not parties "violates due process" (AMA Reply Brief, p. 64).

The restrictions with which this proceeding is concerned, and which the record shows to be unlawful, have involved constituent and component medical societies at the very heart of the ethics enforcement process. Local medical societies have been the initial enforcers of the ethical restrictions—this is the very core of the agreement or understanding. Leaving such societies free to carry on with the ethical restrictions would convert this proceeding into an empty exercise in futility. The order must provide an effective remedy that cannot be "by-passed with impunity." *Federal Trade Commission* v. *Ruberoid,* 343 U.S. at 473.

There is precedent for an order that will require state and local societies to abide by the Order entered herein if they desire to remain within the AMA federation of organizations. The order entered by the United States District Court in *Professional Engineers* required the national society to revoke the charter of, and to refuse affiliation to, any state society which engaged in conduct found to have been unlawfully engaged in by the national society in combination and conspiracy with its members and state societies (Complaint Counsel Reply Brief, Appendix pp. 1–8). This order provision was not overturned on appeal. *Professional Engineers,* 98 S. Ct. at 1368–69 (1978). [298]

In a recent proceeding, the Commission ordered respondents to cease and desist from dealing with parties who respondents knew were engaged in practices which the Commission found to be unlawful. *National Housewares, Inc.,* 90 F.T.C. 512, 596, 603 (1977). Furthermore, orders issued in antitrust proceedings in the courts and Commission orders entered in adjudicative proceedings often affect the rights of third-parties who were not parties to the proceedings. These orders have been upheld in the courts on review and found not to violate due process of any party. *See United States* v. *International Boxing Club of New York, Inc.,* 171 F. Supp. 841, 842 (S.D.N.Y. 1957), *aff'd.* 358 U.S. 242, 247 (1959); *L. G. Balfour Co.* v. *Federal Trade Commission,* 442 F.2d 1, 23 (1971).

Accordingly, the Order found to be necessary to remedy the unlawful conduct disclosed by the record and entered herein will require respondents to cease and desist from the practices found to be unlawful, to revoke and rescind any existing ethical principles or guidelines which restrict physicians' advertising, solicitation or contractual relations, to provide adequate notification to its members and affiliated societies of the terms of the Order and to deny affiliation to any society that engages in any practices which violate the terms of the Order. The Order will permit respondents to issue ethical guidelines affecting advertising and solicitation relations by

physicians in the future with permission of and approval by the Federal Trade Commission, which has the organizational flexibility and know how to work with respondents and assure that such guidelines as are approved are in the public interest.

CONCLUSIONS OF LAW

1. The Federal Trade Commission has jurisdiction over respondents and over the subject matter of this proceeding.

2. Each of the respondents is a "corporation" within the meaning of Section 4 of the Federal Trade Commission Act and is subject to the jurisdiction of the Federal Trade Commission.

3. The challenged acts, practices and methods of competition of respondents are in, and affect, commerce within the meaning of the Federal Trade Commission Act. [299]

4. Respondents American Medical Association, Connecticut State Medical Society, New Haven County Medical Association, Inc., constituent and component medical societies of the American Medical Association, component societies of Connecticut State Medical Society and members of respondents and such constituent and component medical societies have conspired, combined and agreed to adopt, disseminate and enforce ethical standards which ban physician solicitation of business, severely restrict physician advertising and prohibit certain contractual arrangements between physicians and health care delivery organizations and between physicians and nonphysicians.

5. The above conduct has hindered, restricted, restrained, foreclosed and frustrated competition in the provision of physicians' services throughout the United States and caused substantial injury to the public.

6. The aforesaid acts, practices and methods of competition engaged in by respondents American Medical Association, Connecticut State Medical Society and New Haven County Medical Association, Inc. in concert of action with each other, with constituent and component medical societies of the American Medical Association and Connecticut State Medical Society and with the members of respondents and such other constituent and component medical societies constitute unfair methods of competition and unfair acts or practices in or affecting interstate commerce and are in violation of Section 5 of the Federal Trade Commission Act.

7. The Order entered in this proceeding is necessary to remedy the violations of law which have existed and to protect the public now and in the future. [300]

ORDER

I.

It is ordered, That respondents American Medical Association, Connecticut State Medical Society and New Haven County Medical Association, Inc., and their delegates, trustees, councils, committees, officers, representatives, agents, employees, successors and assigns, directly or indirectly, or through any corporate or other device, in or in connection with the purchase, sale, distribution or delivery of physicians' services in or affecting commerce, as "commerce" is defined in the Federal Trade Commission Act, do forthwith cease and desist from:

A. Restricting, regulating, impeding, declaring unethical, interfering with, or advising against the advertising or publishing by any person of the prices, terms or conditions of sale of physicians' services, or of information about physicians' services, facilities or equipment which are offered for sale or made available by physicians or by any organization with which physicians are affiliated;

B. Restricting, regulating, impeding, declaring unethical, interfering with, or advising against the solicitation through [301] advertising or by any other means, of patients, patronage, or contracts to supply physicians' services, by any physician or by any organization with which physicians are affiliated;

C. Restricting, regulating, impeding, advising on the ethical propriety of, or interfering with the commercial terms or conditions on which any physician contracts or seeks to contract for the sale, purchase or distribution of his or her professional services;

D. Restricting, interfering with, or impeding the growth, development or operations of any prepaid health care delivery plan or of any other organization which offers physicians' services to the public, by means of any statement or other representation concerning the ethical propriety of their operations, activities, or relationships with physicians; and

E. Inducing, urging, encouraging, or assisting any physician, or any medical association, group of physicians, hospital, [302] insurance carrier or any other nongovernmental organization to take any of the actions prohibited by Paragraphs A through D above. *Provided, however,* that nothing in this Order shall be construed to prohibit respondents, their constituent or component organizations or their members from reporting in good faith to governmental authorities any alleged violation of law, including but not limited to:

(1) Reporting to appropriate governmental authorities any advertising, solicitation or representation by a physician which they have a reasonable basis for believing is false or deceptive, along with the basis for such belief;

(2) Reporting to appropriate governmental authorities any case of uninvited, in-person solicitation of actual or potential patients who because of their special circumstances are vulnerable to harassment or duress. *Provided, further,* that after this Order has become final for two years, nothing herein shall prohibit respondents from formulating, adopting and [303] disseminating to their constituent and component medical organizations and to their members ethical guidelines governing the conduct of their members in respect to advertising and solicitation activities, if respondents first obtain permission from and approval of the guidelines by the Federal Trade Commission.

II.

It is further ordered, That respondents:

A. Serve a copy of this Order by mail upon each of their present members and upon each constituent and component organization of respondents, within sixty (60) days after this Order becomes final.

B. Provide each new member of each respondent and each constituent and component organization of respondents with a copy of this Order at the time the member is accepted into membership.

C. Remove from respondent American Medical Association's Principles of Medical Ethics and the *Judicial Council Opinions and Reports,* and from the constitution and bylaws and any other existing policy statement or [304] guideline of respondents, any provision, interpretation or policy statement which is inconsistent with the provisions of Part I of this Order.

D. Require as a condition of affiliation with any respondent that any constituent or component organization agree by action taken by the constituent or component organization's governing body to be bound by the provisions of Part I of this Order.

E. Terminate their affiliation with any constituent or component organization which, after the effective date of the Order, to respondents' knowledge engages in any act or practice prohibited by Part I of this Order.

III.

It is further ordered, That, within sixty (60) days after this Order becomes final:

A. Respondent American Medical Association publish a copy of this Order in the *Journal of the American Medical Association* and in *American Medical News;* [305]

B. Respondent Connecticut State Medical Society publish a copy of this Order in *Connecticut Medicine;* and

C. Respondent New Haven County Medical Association, Inc. publish a copy of this Order in *Issues and Insights.*

IV.

It is further ordered, That respondents, within ninety (90) days after this Order becomes final, file a written report with the Federal Trade Commission setting forth in detail the manner and form in which they have complied with this Order. [306]

APPENDIX A

Constitutions and Bylaws of AMA's constituent and component medical societies providing that AMA's Principles of Medical Ethics shall govern the conduct of their members and that unethical conduct shall be grounds for expulsion:

Medical Society	Constitution and/or Bylaws
Allegheny County Medical Society	CX 2185, pp. 10, 13, 15, 17, 40, 42
Arizona Medical Association, Inc.	1871I, K–L
Bexar County Medical Society	472C, G
California Medical Association	477I, L, Z–6
Camden County Medical Society of the State of New Jersey	747L–M, R
Catawba County Medical Society	2226C, G
Chattanooga and Hamilton County Medical Society, Inc.	1904I, M, V
Chicago Medical Society: The Medical Society of Cook County	2025M, N
Colorado Medical Society	2307Z–9, Z–22, Z–27
Connecticut State Medical Society	991D, L–M (*See* 1404I, J)
Dallas County Medical Society	1905D, F, W–X
Medical Society of the District of Columbia	1976R–S, V [307]
Florida Medical Association	2543C, K

Hampden District Medical Society	1990E, I
Hartford County Medical Association, Inc.	1657A, G
Honolulu County Medical Society	1828G, S
Illinois State Medical Society	1915C, P, Q
Jackson County Medical Society	1908A, D
Jefferson County Medical Society	1872E, I–J
Johnson County Medical Society	2020L, G–H
Kentucky Medical Association	1827H–I, J
King County Medical Society	1979E, R
Kitsap County Medical Society	474B, G, J
Knoxville Academy of Medicine	47G, H–I
Lane County Medical Society	2131D, H, R
Lehigh County Medical Society	2017H, F
Los Angeles County Medical Association	476G, J, Z–15
Louisiana State Medical Society	1901Q, Z–33
Maricopa County Medical Society	1568E [308]
Medical and Chirurgical Faculty of the State of Maryland	2050Z–22, Z–24
Massachusetts Medical Society	885E, Y
Michigan State Medical Society	1833K, M
Missouri State Medical Association	1877I
Multnomah County Medical Society	1874E, L, Z–5
Nashville Academy of Medicine and Davidson County Medical Society	1825E, M
Medical Society of New Jersey	1889O–P, U–V
New Mexico Medical Society	1883Y, Z–14
New Haven County Medical Association	1404I
Medical Society of the County of New York	1876T, X
Pennsylvania Medical Society	1886H, J, R

Philadelphia County Medical Society	756A, M, N
Pierce County Medical Society	135A–B, F, H
Prince George's County Medical Society	689K, D
Santa Clara County Medical Society	748N
St. Louis Medical Society	983E
Tarrant County Medical Society	1894A, E [309]
Tennessee Medical Association	14H, L
Texas Medical Association	1899D, U
Travis County Medical Society	1882B, N, Z–9
Medical Society of Virginia	1879Z–8, O–P, Z–5
Volusia County Medical Society	1961K, P, D–E
Washington State Medical Association	475G–H, O, M–N
State Medical Society of Wisconsin	1912B, G [310]

APPENDIX B

State Statutes Regarding Physician Advertising and Solicitation

In 1975, at the commencement of the proceedings in this case, a substantial majority of states had statutes which prohibited or restricted advertising by physicians. Ten states declared any form of physician advertising to be illegal:

(a) Arixona, Ariz. Rev. Stat. §32–1401 (10)(C), §33–1451 (1976) (RX 706);
(b) Arkansas, Ark. Stat. Ann. §72–613(m) (1975) (RX 707);
(c) Florida, Fla. Stat. Ann. §458.1201(1) (f) (1976) (RX 710);
(d) Georgia, Ga. Code Ann. §84–916(a)(6) (1976) (RX 711);
(e) Louisiana, La. Stat. Ann. §37–1285(19) (1976) (RX 717);
(f) Michigan, Mich. Stat. Ann. §14.542(11) (1), (11)(27)(g), (1976) (RX 719);
(g) Missouri, Mo. Ann. Stat. §334.100(12) (1976) (RX 721);
(h) Ohio, Ohio Rev. Code Ann. §4731.22(b)(5) (1975) (RX 727);
(i) Tennessee, Tenn. Code Ann. §63–619 (1976) (RX 734); and,
(j) Utah, Utah Code Ann. §§58–12–36(4), 58–1–25(1) (1973) (RX 736).

Eight states prohibited advertising in an "unethical" manner:

(a) Delaware, Del. Code Tit. 24, §1741(9) (1974) (RX 709);
(b) Idaho, Idaho Code §54–1810(c) (1976) (RX 713); [311]
(c) Maine, Me. Rev. Stat. tit. 32, §3282(A)(B) (1977) (RX 718);
(d) Nebraska, Neb. Rev. Stat. §71–147(11)–(13) (1976) (RX 722);
(e) North Dakota, N.D. Cent. Code §43–17–31(11) (1960) (RX 726);
(f) Rhode Island, R.I. Gen. Laws §§5–37–4, 5–37.1–5 (1976) (RX 731);
(g) South Carolina, S.C. Code Ann. §40–47–200 (7) (1975) (RX 732); and,
(h) Wyoming, Wyo. Stat. §33–340 (1975) (RX 740).

Four states prohibited all advertising except notices of openings or closings of a practice or listing in a directory:

(a) Alaska, Alaska Stat. §§08.64303(b)(1), 08.64.380(3)(D) (1977) (RX 705);
(b) Illinois, Ill. Rev. Stat. ch. 91, §§16a(13), 16a-1 (1976) (RX 714);
(c) New Jersey, N.J. Stat. Ann. §45.9.16 (1976) (RX 723); and,
(d) Oklahoma, Okla. Stat. Ann. tit. 59 §§503, 509(2) (1977) (RX 728).

Sixteen states made it illegal for a physician to engage in misleading or deceptive advertising:

(a) Alabama Ala. Code §§34-24-90 (1975) (RX 704);
(b) Connecticut, Conn. Gen. Stat. §20-44 (1958) (RX 708);
(c) Hawaii, Haw.Rev.Stat. §§453-8, (5) (6) (1975) (RX 712);
(d) Iowa, Iowa Code Ann. §§147.55-(7) (1976) (RX 715);
(e) Kansas, Kan. Stat. §§65-2836(b), 65-2837(g) (1976) (RX 716); **[312]**
(f) Mississippi, Miss. Code §73-25-29(8)(c) (1976) (RX 720);
(g) New Mexico, N.M.Stat.Ann. §§67-5-9(9), (B)(9) (1975) (RX 724);
(h) North Carolina, N.C.Gen. Stat. §§90-14, 9014(8) (1975) (RX 725);
(i) Oregon, O.Rev.Stat. §677.190(10) (1971) (RX 729);
(j) Pennsylvania, Pa.Stat.Ann. tit. 63, §421.15 (a)(92) (1976) (RX 730).;
(k) Rhode Island, R.I.Gen.Laws §§5-37-4, 5-37.1-5 (1976) (RX 731);
(l) South Dakota S.D. Codified laws §§36-4-29, 36-4-30 (5) (1977) (RX 733);
(m) Texas, Tex. Rev. Civ. Stat. Ann. art. 4505(6) (1976) (RX 735);
(n) Vermont, Vt. Stat. Ann. tit. §§ 1353(2), 1361 (1977) (RX 737);
(o) Virginia, Va. Code §§54-316, 54-317(4) (1977) (RX 738); and,
(p) Washington, Wash.Rev.Code §§18.72.030(4), 18.72.250 (1975) (RX 739).

Alabama also provides for suspension or revocation of a medical license for any violation of the Principles of Medical Ethics as set forth in the *Opinions and Reports* of the Judicial Council of the AMA (RX 704B).

OPINION OF THE COMMISSION

BY CLANTON, *Commissioner:*

The complaint in this case was issued on December 19, 1975, charging that the American Medical Association (AMA), the Connecticut State Medical Society (CSMS), and the New Haven County Medical Association, Inc. (NHCMA) violated Section 5 of the Federal Trade Commission Act ("Act")[1] through ethical restrictions on advertising and solicitation, as well as other competitive restrictions. The AMA is the largest medical and professional association in the world. (ID 6) Its membership includes approximately 200,000 physicians, representing 53 percent of all doctors in the nation and 72 percent of office-based practitioners. (RX 658) The AMA is a federation of 55 constituent associations, representing states, commonwealths, territories, and insular possessions. (RX 220, p.27, CX

[1] 15 U.S.C. 45(a)(1)(1976).

990E) Each of these constituent societies has in turn chartered component societies representing smaller geographic areas such as counties. (CX 990E) There are approximately 2,000 component societies in the AMA. (RX 220, p.27) Membership in a component society is a prerequisite to membership in a constituent association and membership in a constituent association is a prerequisite to membership in the AMA. (ID 6) [2]

CSMS is a constituent society of AMA composed of eight component county medical societies, one of which is NHCMA. In 1975, CSMS had approximately 4,400 members, representing approximately 82 percent of the physicians registered in Connecticut. NHCMA had approximately 1,200 members in 1975, representing approximately 71 percent of the physicians registered in New Haven County. (ID 8-9)

The AMA House of Delegates, which is composed of delegates from each constituent or state society, is the official legislative and national policymaking body of AMA with authority to amend the AMA *Constitution and Bylaws,* and the *Principles of Medical Ethics ("Principles").* (ID 7) The AMA operates eight standing committees on specific subjects, known as Councils. *Id.* One of these councils, the Judicial Council, has responsibility for interpreting the AMA *Constitution and Bylaws,* and the *Principles.* (Tr. 3982)

The case against respondents focuses upon their ethical code and interpretations of this code. The AMA adopted a *Code of Ethics* at its first meeting in 1847. (ID 102) With minor revisions, the language and concepts of the original code remained unchanged until 1957. In that year, AMA's House of Delegates adopted a shortened version of the *Code of Ethics,* entitled *The Principles of Medical Ethics,* consisting of ten brief sections. As noted above, the Judicial Council interprets the *Principles* and hears actions based on infractions of the *Principles. Id.* The Judicial Council's interpretations are periodically published under the title *Opinions and Reports of the Judicial Council ("Opinions and Reports").*

The gravamen of the complaint in this case is that respondents, through their ethical canons, agreed to prevent or hinder their members from soliciting business, by advertising or otherwise, from engaging in price competition, and from otherwise engaging in competitive practices. The complaint alleged that these agreements constitute unfair methods of competition and unfair acts or practices in violation of Section 5.

Following an extended trial, the Administrative Law Judge (ALJ) concluded that the Commission possessed jurisdiction over the respondents' practices since each of the respondents is a "corpora-

tion" within the meaning of Section 4 of the Act, and because the challenged acts, practices, and methods of competition are in or affect commerce. With respect to the merits, the law judge found that respondents, their constituent and component medical societies, and their members have agreed to adopt, disseminate and enforce ethical standards that ban physician solicitation of business and severely restrict physician advertising. Additionally, the ALJ held that respondents have unlawfully sought to prevent or hinder certain contractual arrangements between physicians and health care delivery organizations and between physicians and nonphysicians. [3]

To remedy the violations found as well as to protect the public now and in the future, the ALJ issued an order that requires, *inter alia,* respondents to cease and desist from restricting advertising, solicitation, and certain contract practices of their members for a minimum of two years. At the end of this period, the order permits AMA to develop and disseminate ethical guidelines with respect to advertising and solicitation, on condition that respondents first obtain the Commission's approval of these guidelines.

Respondents argue in their appeal to the Commission that they are not "corporations" as defined in Section 4 of the Act. Although AMA concedes that its activities fall within and affect interstate commerce, CSMS and NHCMA urge the Commission to overrule the ALJ's finding of interstate commerce jurisdiction. All respondents object to the finding of a conspiracy, with AMA asserting that it should not be held accountable for the activities of its member societies and the Connecticut respondents attempting to disassociate themselves from proof involving AMA and unnamed state and local societies. With respect to the alleged restraints on advertising, solicitation and contractual arrangements, AMA rests its case primarily upon recent modifications to its ethical positions disseminated after issuance of the complaint and, together with the Connecticut respondents, challenges the sufficiency of the evidence to sustain the law judge's conclusions.

I JURISDICTION

A. Of "Corporations" Under Section 4

At the outset, the Commission must determine whether it has jurisdiction over the respondents. Section 5(a)(2) of the Act[2] extends

[2] 15 U.S.C. 45(a)(2)(1976).

the Commission's jurisdiction to "persons, partnerships, or corporations" and Section 4 defines "corporation" to include:

> any company, trust, so-called Massachusetts trust, or association, incorporated or unincorporated, which is organized to carry on business for its own profit or that of its members, and has shares of capital or capital stock or certificates of interest, and any company, trust, so-called Massachusetts trust, or association, incorporated or unincorporated, without shares of capital or capital stock or certificates of interest, except partnerships, which is organized to carry on business for its own profit or that of its members.[3]

In analyzing whether this language applied specifically to respondents, the ALJ felt that the Commission could "assert jurisdiction over nonprofit organizations whose activities [4] engender a pecuniary benefit to its members if that activity is a substantial part of the total activities of the organization, rather than merely incidental to some non-commercial activity." (ID 238)[4]

Respondents challenge this formulation of the legal standard under Section 4, but their briefs reflect some differences regarding the standard to be applied. AMA argues that the sole inquiry under Section 4 should be to determine whether the respondent is carrying on business in order to accumulate gain for distribution to its shareholders or members. Focusing on the organization's purpose rather than its activities, NHCMA suggests that the proper test is whether the respondent has been organized for the purpose of engaging in business activities to provide gain to its members. Finally, CSMS urges a combination of the criteria suggested by the other respondents. It says that the test should be whether the respondent has been organized *and* operated to profit its members.

We are satisfied that the ALJ has articulated the proper test for examining whether respondent is a "corporation" within the meaning of Section 4. The substantiality test appropriately places the principal focus upon the nature of respondents' activities and is supported by precedent. *National Commission on Egg Nutrition,* 88

[3] 15 U.S.C. 44 (1976).

[4] The following abbreviations will be used in this opinion:

ID	-	Initial Decision page number
Tr.	-	Transcript page number
CX	-	Complaint Counsel's exhibit number
RX	-	Respondent AMA exhibit number
RCX	-	Respondent's CSMS exhibit number
RNHX	-	Respondent's NHCMA exhibit number
RAB	-	Respondent AMA Appeal Brief
RCAB	-	Respondent NHCMA Appeal Brief
CAB	-	Complaint Counsel's Answering Brief
TROA	-	Transcript of Oral Argument before the Commission
App.A	-	Appendix A of this Opinion

F.T.C. 89, 177 (1976) *modified* 570 F.2d 157 (7th Cir. 1977), *cert. denied,* 99 S. Ct. 86 (1978).[5] Clearly, Congress did not intend to bring "any and all nonprofit corporations regardless of their purposes and activities" within the Commission's jurisdiction. *Community Blood Bank of the Kansas City Area, Inc.* v. *F.T.C.,* 405 F.2d 1011, 1018 (8th Cir. 1969). On the other hand, the legislature did not provide a "blanket exclusion" from FTC jurisdiction for all nonprofit corporations, since it recognized that certain "corporations ostensibly organized not-for-profit, such as trade associations, were merely [5] vehicles through which a profit could be realized for themselves or their members." *Id.* at 1017. Thus, the "mere form" of incorporation is not dispositive; it is the "reality" of a respondent being in law and in fact a charitable organization (the determination of which must necessarily be conducted on an ad hoc basis) that places it beyond the Commission's reach. *Id.* at 1018–19.

Respondents contend that for the Commission to assert jurisdiction over them, it must find that they are engaged in some undertaking for the purpose of realizing gain for ultimate distribution to their members. They argue that it is improper for the Commission to focus upon activities which provide only an "economic benefit" for their members. (RAB 17–18) It is clear, however, that an organization may fall within the ambit of Section 4 even though it only "indirectly" pursues profit for its members. *National Commission on Egg Nutrition, supra,* 517 F.2d at 488.[6] Section 4 does not require a transfer or delivery of monetary profits to the members of a nonstock corporation, only that the activities of the corporation provide pecuniary benefits to its members. AMA itself concedes as much when it acknowledges that the Commission has exercised jurisdiction many times in the past over trade associations. (RAB 19)[7] Its effort to distinguish these cases on grounds that the entities involved were devoted primarily to enhancing the pecuniary benefit

[5] In the related preliminary injunction action, the district court held that the respondent was a "corporation" within the meaning of Section 4 by virtue of the fact that many of its members were connected with the egg industry and because its activities "directly promote[d], at least to some extent, the financial health of the egg industry." F.T.C. v. *National Comm'n on Egg Nutrition,* 1975–1 Trade Cas. (CCH) ¶60, 246 at 65,967 (N.D. Ill. 1974), *rev'd on other grounds,* 517 F.2d 485 (1975), *cert. denied* 426 U.S. 919 (1976).

There is some support for the notion that a respondent is subject to FTC jurisdiction if one of its purposes is noncharitable in nature, perhaps only to the extent of its noncharitable activities. *See Community Blood Bank, supra,* 405 F.2d at 1022. ("[W]e hold . . . [t]hat under § 4 the Commission lacks jurisdiction over nonprofit corporations without shares of capital, which are organized for and actually engaged in business for *only* charitable purposes, and do not derive *any* 'profit' for themselves or their members . . . ."). (Emphasis supplied.) In view of our determination, *infra,* that respondents are subject to the Commission's jurisdiction under the substantiality test, we need not determine whether jurisdiction might exist under some alternative test.

[6] The district court's opinion also supports the proposition that jurisdiction may attach even though there is no actual distribution of profits to the respondent's members. *National Comm'n on Egg Nutrition, supra,* 1975–1 Trade Cas. (CCH) ¶60, 246 at 65,967.

[7] This authority is well established. *E.g., FTC* v. *Cement Inst.,* 333 U.S. 683, 687 (1948); *Fashion Originator's Guild of America* v. *FTC,* 312 U.S. 457, 461 (1941); *FTC* v. *Pacific States Paper Trade Ass'n,* 273 U.S. 52 (1927).

of their members implicitly recognizes that the degree of pecuniary benefit conferred is the fundamental issue, not whether the benefit is physically distributed. [6]

AMA may have abandoned the contention offered below that for an organization to be subject to the Commission's jurisdiction, profit-seeking must play a dominant role in its activities. *Compare* RAB 25 *with* TROA 101. The Connecticut respondents continue to maintain, however, that a respondent is exempt from prosecution if its activities are substantially educational, scientific, and charitable in nature, *i.e.*, even if its commercial activities predominate. RCAB 8; RNAB 4–5. This latter formulation turns the correct standard on its head, in our view, permitting a corporation to escape liability before the Commission for anticompetitive practices, despite the fact that a major portion of its operations provide a pecuniary benefit to its membership. While commercial activity which is only incidental to the eleemosynary functions of a nonstock corporation may not support a claim of jurisdiction, *Egg Nutrition,* 88 F.T.C. at 178–79; *cf. Community Blood Bank,* 405 F.2d at 1017, an organization which exists in substantial part for the pecuniary benefit of its members surely comes within Section 4.

On a slightly different tack, AMA asserts that the legislative history of the Act reveals a congressional intent not to subject professional societies to Commission jurisdiction. In support of this proposition, it cites a decision construing a provision of the Florida antitrust statute,[8] the absence of professional society testimony on the bills that became the Federal Trade Commission Act, and the fact that the 95th Congress failed to enact legislation which would have given the Commission jurisdiction over all nonprofit corporations. We think respondent makes too much of too little. In essence, AMA would have us infer an exemption from the Act for a particular class of organizations, persons and corporations based upon the absence of specific statutory language or legislative history reflecting a congressional desire to have the Act apply to this class. The incredible sweep of such a position and the extraordinary demands it would place upon the legislature perhaps explain why it is unsupported by any precedent of which we are aware.

With respect to the inaction of the 95th Congress, it is well-settled

[8] In *Feminist Women's Health Center, Inc.* v. *Mohammad,* 586 F.2d 530 (5th Cir. 1978), the court held that the medical profession was not "any person" within the meaning of the Florida antitrust law. In considering it unlikely that the 1915 Florida legislature intended its statute to apply to the medical profession, the court applied state law and, in so doing, relied heavily on a recent state appellate court interpretation to that effect. *Mohammad, supra* at 552–53. However, the court reversed a decision granting summary judgment to defendants on a Sherman Act count, following the holding of *Goldfarb* that the learned professions are not exempt from the Sherman Act.

that "the views of a subsequent Congress form a hazardous basis for inferring intent of an earlier one."[9] The peril is particularly acute when the subject of congressional inaction is broader in scope than the point [7] for which it is cited. As noted by AMA, the legislation before the 95th Congress would have amended Section 4 to remove the nonprofit exemption altogether, exposing true charitable organizations to the jurisdiction of the Commission. Even assuming that the 95th Congress had some special insight into the intent of a Congress which preceded it by more than sixty years, it is impossible to fathom with any confidence the significance for this case of congressional inaction on the specific amendment recently considered.[10]

We find no reason to differ with the ALJ's conclusion that respondents are engaged substantially in activities which confer a pecuniary benefit upon their members. AMA's own statements belie any suggestion that such activities are only incidental to eleemosynary functions. One of the purposes for which AMA was founded in 1847 was to promote "the usefulness, honor and interest of the medical profession. . . ."[11] The AMA's articles of incorporation, as amended in 1902, stated that one of the objects of the Association was "safeguarding the *material* interests of the medical profession. . . ." (CX 1355–H) (emphasis added). Additionally, the proceedings of AMA's House of Delegates in 1975 indicate that the association continues to exist as "an organization of and for the medical profession." (CX 1042J) [8]

Promotional literature and other material sent by AMA to its members sound the recurring theme that the Association is substantially engaged in protecting the rights and fostering the interests of American doctors. (CX 1532B, 1224, 1528, 1545D, 232D, 2630) For

[9] *United States* v. *Price*, 361 U.S. 304, 313 (1960); *see also United States* v. *Southwestern Cable Co.*, 392 U.S. 157, 170 (1968); *Rainwater* v. *United States*, 356 U.S. 590, 593 (1958); *United States* v. *United Mine Workers*, 330 U.S. 258, 281–82 (1947).

[10] The then Chairman of the Commission, Calvin J. Collier, testifying on behalf of the Commission, supported the amendment on grounds that it would avoid the often time-consuming proof necessitated by the *Community Blood Bank* analysis. Chairman Collier expressed the view that, where anticompetitive or deceptive behavior is involved, there was little reason for identifying "charitable" corporations, since the harm to the public is the same whether the corporation engages in such behavior for profit or for charity. H.R. Rep. No. 95–339, 95th Cong., 1st Sess. at 54 (1977). The excerpt from the Report of the House Committee on Interstate and Foreign Commerce, quoted by AMA, indicates only that certain minority members of the committee were concerned not that the Commission could properly exercise jurisdiction over an entity found to be "organized to carry on business for its own profit or that of its members," but rather that the proposed amendment would *extend* the Commission's jurisdiction to encompass genuine nonprofit organizations. *Id.* at 120.

[11] Memorandum in Support of Respondent American Medical Association's Motion for Summary Decision Dismissing the Complaint for Lack of Jurisdiction at 12–13 (March 24, 1976) (Quoting from the preamble to AMA's Constitution, adopted in May 1847).

AMA suggests that reliance upon references to the "interests" of physicians overlooks the fact that physicians have policy goals unrelated to profit maximization. While certain of these references are admittedly ambiguous, consideration of the record as a whole leaves little doubt that one of the purposes for which AMA was organized and for which it continues to operate is the economic betterment of its members.

example, a pamphlet sent to AMA's membership in 1974, entitled "What Do You Get For Your Dues?", emphasizes the "remarkable range of tangible benefits and services" provided by AMA membership and describes these benefits and services as "invaluable - personally and professionally." (CX 259C, D) The same pamphlet specifically refers to insurance programs, AMA's retirement plan, physician placement service, publications (such as *Prism,* a socio-economic magazine), authoritative legal information and guidelines, and "professional management information and guides to increase the productivity and profitability of your practice." (CX 259D)[12] The record provides ample substantiation for these promotional statements. (ID 57–59) Practice management programs warrant particular attention because they have been assigned a high priority by AMA and because they present some of the most "tangible benefits" to the association and its members. (CX 1543Z–10) We find it significant that expenditures for this program have more than doubled in the last three years. (ID 57)

According to AMA, the most important of all the tangible benefits and services they offer is the fact that a member has "an effective and influential national spokesman to represent [his/her] views, interests and rights." (CX 259Z–13) The record supports this assertion, describing legislative and lobbying efforts by AMA with respect to price controls on physicians' fees, Medicare, national health insurance, health maintenance organizations (HMOs), the Keogh Act, malpractice insurance legislation, and other issues affecting the financial health of AMA's membership. (See ID 41–49) AMA's intercession on behalf of its members with insurance carriers, such as Blue Shield, government medical care programs, and hospital administrators also provides economic benefits. (ID 50–53) The record of this proceeding documents additional pecuniary benefits in the form of litigation and substantial public relations activity in support of its legislative program. (ID 52–56)

Our determination that AMA engages in substantial activities for the economic benefit of its membership is intended in no way to denigrate the many valuable eleemosynary activities in which AMA is engaged. Respondent's educational, scientific, and public health efforts represent a laudable public service recognized by this agency and the country as a whole. Such activities do not, however, provide immunity from the laws designed to protect the public from anticompetitive practices. [9]

The record also persuades us that the Connecticut respondents

[12] See also CX 245D, reproduced at ID 40. It is noteworthy that AMA's "medicolegal" symposiums have frequently focused on the business practice aspects of the profession. (ID 58)

exist in substantial part for the economic advantage of their members and that the law judge's finding in this regard should be upheld. (*See* ID 73–101, 241–51) Without reiterating all of the various economic activities referenced by the ALJ, we note that both CSMS and NHCMA have promoted the economic interests of their members through lobbying and legislative efforts, through sponsorship of insurance plans such as the Professional Liability Insurance Program, and through relationships with third-party payers. Moreover, both of these respondents have played key roles in the formation of "Foundations for Medical Care," an alternative to HMO's operating on a prepaid basis with fee-for-service physicians.[13]

Record evidence concerning the CSMS *Relative Value Guide ("RVG")* provides added support to the ALJ's finding. The *RVG* provides a precise description and identification in coded form of the services rendered by physicians. (CX 1175D) When utilized with a conversion factor, a relative value guide can be used to generate a fee schedule. *Id.* CSMS first adopted the *RVG* in 1965, republished it in 1971, and distributed it to its membership and to third-party payers up until 1977. (I.D. 85–86) CSMS recommended no specific conversion factors, but did advise its members to check with other physicians in the community to derive an "appropriate" conversion factor. (CX 1171A) Although there is some evidence that third-party payers in Connecticut used their own or different relative value scales and that CSMS advised its members to use the precise coding approved by the specific third-party payer, the record also shows that the *RVG* was utilized by the NHCMA Peer Review Committee to decide complaints regarding members' fees and by the New Haven County Foundation for Medical Care. (CX 1178, 2424C, 2425, 2433) Based on this evidence, we conclude that the *RVG* provided important economic benefits to CSMS and NHCMA members.

The Connecticut respondents object to the law judge's finding that the benefits of AMA membership may be imputed to CSMS and NHCMA and that the benefits of CSMS membership may be imputed to NHCMA. This finding was based on the requirements that a physician must be a member of NHCMA in order to join CSMS and must be a member of both NHCMA and CSMS in order to join AMA. Clearly, little weight should be given to the fact that NHCMA was formed several years prior to CSMS or that both

[13] Respondents argue that the primary purpose of each of these functions is to advance societal welfare through better public health. We have already addressed the contention that to fall within the Commission's jurisdiction, an association must exist primarily for the economic benefit of its members. Likewise, it is unnecessary for the Commission to find that the dominant purpose or effect of any particular activity is profit-making so long as the aggregate total of activities providing any pecuniary gain represents a substantial part of a respondent's overall operation.

organizations predate the creation of the AMA. [10] AMA and CSMS provide valuable benefits to their members and membership in CSMS and/or NHCMA is the *sine qua non* of obtaining these benefits. The fact that approximately half of NHCMA's and CSMS' members chose to join the AMA provides some indication that these benefits were more than negligible. Consequently, we believe it proper to take into account the pecuniary advantages provided by the larger associations.

In light of this evidence regarding the economic activities of all three respondents, the Commission finds it difficult to discern the "striking similarities" alleged to exist between the respondents in this docket and the Kansas City Area Hospital Association ("KCAHA"), a respondent in the *Community Blood Bank* case. By contrast to our findings here, KCAHA funds never "inured to the benefit of any of [its] members" and were utilized "exclusively" for educational and charitable purposes. *Community Blood Bank, supra,* 405 F.2d at 1020. Here, there is abundant record evidence that respondents have engaged in activities providing pecuniary benefits to their members. Respondents' membership serves to distinguish them from the hospital association involved in *Community Blood Bank,* providing further evidence that they exist in substantial part for the profit of their members. Of the 43 member hospitals of KCAHA, 21 were incorporated as not-for-profit charitable or religious associations, 12 were instrumentalities of federal, state, or local governments, and only 2 were organized as proprietary corporations. *Community Blood Bank, supra,* 70 F.T.C. at 767, 405 F.2d at 1020 n. 16.

The KCAHA also differs from respondents in that it is exempt from Federal income tax as a charitable organization pursuant to 26 U.S.C. 501(c)(3)(1976), whereas respondents qualify for an exemption under 26 U.S.C. 501(c)(6)(1976).[14] [11] The latter provision exempts "business leagues, chambers of commerce, real estate boards, boards of trade or professional football leagues. . . ."[15] By contrast, the KCAHA and the American Medical Association Education and

[14] Affidavit of John F. Kelly at 2 (April 5, 1976), attached to Complaint Counsel's Memorandum in Opposition to Respondent's Motion for Summary Decision Dismissing the Complaint for Lack of Jurisdiction (April 8, 1976) ("Kelly Affidavit"); CX 1393.

[15] Section 1.501(c)(6)-1 of the Internal Revenue Regulations defines a "business league" as:

> . . . an association of persons having some common business interest, the purpose of which is to promote such common interest and not to engage in a regular business of a kind ordinarily carried on for profit. It is an organization of the same general class as a chamber of commerce or board of trade. Thus, its activities should be directed to the improvement of business conditions of one or more lines of business as distinguished from the performance of particular services for individual persons. Treas. Reg. §1.501(c)(6)-1 (1958).

Research Foundation, an AMA subsidiary, come within Section 501(c)(3) of the Code, 26 U.S.C. 501(c)(3)(1976).[16] This provision exempts from Federal income tax:

> Corporations, and any community chest, fund, or foundations, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition . . ., or for the prevention of cruelty to children or animals . . . .

Respondents contend that it makes no difference under what provision an organization is tax-exempt, so long as it is not required to pay any tax. We recognize that a respondent's status as either a §501(c)(3) or (6) tax-exempt organization does not obviate the relevance of further inquiry into a respondent's operations and goals. Nevertheless, the tax-exempt status is certainly one factor to be considered. Rulings of the Internal Revenue Service are not binding upon the Commission, *Ohio Christian College,* 80 F.T.C. 815, 848 (1972), but a determination by another Federal agency that a respondent is or is not organized and operated exclusively for eleemosynary purposes should not be disregarded. Here, respondents' inability to qualify under §501(c)(3) simply means that the IRS does not consider them to be organized and operated "exclusively" for charitable goals, a fact that sets them apart from the KCAHA.[17] [12]

AMA and NHCMA also appeal from the ALJ's determination that their ethical restrictions on advertising, solicitation and contract practice provide a substantial economic benefit to their members. In AMA's view, the law judge's finding amounts to the circular contention that a corporation is subject to Commission jurisdiction whenever it engages in anticompetitive behavior.[18] This argument has potential merit only in a case in which the jurisdictional finding is premised solely upon respondent's illegal acts, and in which the illegal activity does not confer a substantial economic benefit upon the respondent's members.[19] We cannot adopt the view that challenged acts and practices which provide some pecuniary benefit to an organization's membership should not be judged against the substan-

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[16] *Kelly Affidavit* at 2.

[17] Of course, failure to qualify as tax exempt under §501(c)(3) does not by itself necessarily mean that a respondent is within the reach of Section 4 of the FTC Act, since, as we have discussed *supra,* the pecuniary benefit of its activities to its members must constitute a substantial part of its activities under Section 4.

[18] AMA also references its arguments, considered *infra,* that it has not imposed the alleged restrictions and that there is no evidence that these restrictions have affected its members' financial position. NHCMA simply states that the ALJ's finding is a conclusion on the merits and not a proper finding on the jurisdictional issue.

[19] A respondent could also come within Section 4 based on the alleged illegal activity alone if that activity conferred economic benefits upon its members and represented a substantial portion of its overall operations. *Cf. National Comm'n on Egg Nutrition, supra,* 517 F.2d at 488.

tiality criterion along with other activities simply because such acts and practices coincidentally violate Section 5.

Finally, AMA charges that the law judge improperly rejected the budgetary analysis which it offered to quantify the proportion of its activities devoted to the economic benefit of members. At trial, AMA offered the testimony and report of its expert witness, Dr. Frederick Sturdivant, who classified respondents' activities as follows:

(1) Category A - education, scientific, and association activities;[20]
(2) Category B - indirect economic benefit;
(3) Category C - direct economic benefit;
(4) Category D - miscellaneous (RX 743, p. 5)

Dr. Sturdivant then analyzed each of AMA's 318 project request forms from 1977 and, after consulting with appropriate AMA officials where necessary, assigned each project to a specific category. (Tr. 6428, 6459) Dr. Sturdivant's [13] report indicates that AMA allocated 90.6% of its budget to Category A activities,[21] leading him to conclude that AMA "is a professional association engaged overwhelmingly in scientific and educational activities." (RX 743, p. 28) Dr. Sturdivant's analysis indicates that 5.8% of the budget had a direct or indirect economic benefit to members (Categories B and C), and 3.6% belonged in the miscellaneous group (Category D). *Id.*

Dr. Paul Feldstein, complaint counsel's expert witness, criticized the Sturdivant Report generally on grounds that a budgetary approach is unsuitable for examining the economic relationship of an association of health professionals to its members. (CX 2586-C, -D) Dr. Feldstein also found certain specific deficiencies with the Sturdivant Report. The correction of these deficiencies led him to the conclusion that between 35 and 43 percent of AMA's budget provides economic benefit to its members. (CX 2586-D)

The resource allocation decisions of an organization certainly provide one perspective on the purposes of that organization. However, there are analytical problems with such an approach, since a small budget allocation may have a disproportionate benefit

[20] Category A was further subdivided as follows:
1) lay public education;
2) journals and scientific publications;
3) scientific policy;
4) other scientific;
5) data on physicians and health care;
6) medical quality control and education;
7) government interface; and
8) organizational maintenance and operations. (RX 743, p.7)

[21] The percentages set forth in the text reflect our recalculation of Dr. Sturdivant's percentages to take account of the nine projects omitted from his original computations and noted at RX 743, p. 8. Seven of the nine projects not classified by Dr. Sturdivant have been allocated to Category D.

to members. Additional difficulties arise when the focus is a professional association, inasmuch as the activities of such a group do not fit neatly into economic and non-economic pigeonholes. Certain legislative and lobbying activities, for example, may have economic as well as public health or welfare objectives.[22] Likewise, a professional association's legal counsel may be essential to achievement of that association's eleemosynary goals, yet spend a significant portion of time advising members on the commercial aspects of their profession. These observations are especially applicable to AMA. (CX 2586 O-Q, Tr. 8882, 8988, 9066-71, 9082-83, 9128) Indeed, disaggregation of AMA's budget into economic and non-economic components is especially problematic due to the fact that AMA has consolidated many of its programs in recent years, reducing the number of programs from 583 in 1975 to 318 in 1977 and presumably enlarging the number of distinct activities contained in individual programs. (Tr. 6428-29) [14]

Apart from some general discomfort with application of the budgetary approach to this case, we entertain certain reservations as to the validity of Dr. Sturdivant's findings. At the outset, we note that Dr. Sturdivant had done no previous work with respect to the medical profession or, for that matter, any professional or not-for-profit association. (Tr. 6416-17) Because of his background and because proper classification of each of AMA's activities necessitated an understanding of those activities, Dr. Sturdivant was compelled to rely upon the program descriptions contained on the AMA request forms prepared after the complaint was filed[23] and on supplemental information provided by AMA officials. (Tr. 6431, 6459) In view of the clear opportunity for manipulation of the input to Dr. Sturdivant's study and the absence of any procedural safeguards to minimize the likelihood of manipulation, we are particularly reluctant to give his report any weight. *See Philadelphia Carpet Co.*, 64 F.T.C. 762, 776 (1964), *aff'd per curiam*, 342 F.2d 994 (3d Cir. 1965).

In addition to these problems, we find Dr. Sturdivant's report deficient in a number of other respects. First, we do not view it as appropriate to consider organization maintenance in the non-economic benefit category. Most of these activities are neutral in nature and should be excluded from the calculation. Others, such as the funds allocated to the Advisory Committee on Services to Young

[22] The Commission considers Dr. Sturdivant's decision to include all legislative and lobbying efforts in Category A as particularly suspect. As we indicated *supra*, a number of these activities have a direct economic impact on AMA's members. Moreover, Dr. Sturdivant conceded that he had conducted only a summary review of AMA's legislative positions and was unaware, for example, of the AMA's activities with respect to the Keogh Act. (Tr. 6458-59)

[23] These forms were prepared in May or June 1976. Dr. Sturdivant testified that he did not know what instructions had been given to the individuals who prepared the project descriptions. (Tr. 6431)

Physicians might, upon examination of its recommendations, be included in Category B or C.[24] Second, Dr. Sturdivant failed to include expenditures by entities established by the AMA with Association funds, such as the American Medical Assurance Company,[25] which perform significant economic services for AMA's membership. (Tr. 6451) The Sturdivant Report is also vulnerable to charges that the classification criteria were not applied in a consistent fashion. (CX 2586-M) Lastly, the wide variations in expenditures for legislative and political activities by AMA from year to year may make it inappropriate to use any single year as a basis for a budgetary analysis of the AMA. (CX 2586-K, L) [15]

Accordingly, we affirm the ALJ's finding that respondents are "corporations" within the meaning of Section 4.

B. Interstate Commerce Jurisdiction

Although the AMA admits that its challenged activities fall within the Commission's interstate commerce jurisdiction, (Tr. 2120, 2124) CSMS and NHCMA contend that they are local organizations with local concerns and that their acts and practices cannot be considered, as they were by the ALJ, to be in or to affect commerce. We find little merit in these arguments. CSMS and NHCMA were not charged with acting independently to restrict the practices of Connecticut physicians. The complaint alleges and the Commission finds, *supra* at 18, that all three respondents have conspired with others to restrict advertising, solicitation, and certain contract practices of their members throughout the United States. The participation of respondents along with other AMA constituent and component societies in this nationwide conspiracy, taken together with AMA's stipulation that its acts and practices are in and affect interstate commerce, thus leave little room for doubt that the alleged activities of CSMS and NHCMA also fall within interstate commerce. As the Supreme Court has stated:

> The Commission would be rendered helpless to stop unfair methods of competition in the form of interstate combinations and conspiracies if its jurisdiction could be defeated on a mere showing that each conspirator had carefully confined his illegal activities within the borders of a single state. (*FTC* v. *Cement Institute,* 333 U.S. 683, 696 (1948).)

Even apart from the involvement of the Connecticut respondents

[24] Dr. Sturdivant included this in Category A because he saw it as an aspect of attracting and retaining young physicians in the AMA. (Tr. 6571) Under this approach, almost any project providing economic benefit to AMA's members could be considered part of the organization's maintenance activities.

[25] This company provides reinsurance for medical liability insurance companies owned by state medical societies. (ID 54)

in this national conspiracy, there is ample proof of an interstate commerce nexus in the aggregation of factors cited by the law judge. (ID 252) Foremost among these is the impact the restrictions have upon out-of-state public and private funds providing payment for medical services rendered in Connecticut. Respondents' ethical restrictions affect the volume and destination of these payments, which total several million dollars per annum. (ID 10, 252) Although CSMS and NHCMA concede the substantiality of these payments, they argue that they relate to the practice of medicine by their members, not to their own challenged acts, and that the record merely demonstrates that individual activities of their members may affect interstate commerce. In our view, respondents' argument reflects a misunderstanding of the applicable law and unduly cabins the jurisdiction of the Commission, contrary to the recently expressed intent of Congress. [16]

The legislative history of the Magnuson-Moss Act[26] reveals that Congress broadened the Commission's jurisdiction so that it would encompass "acts or practices which, although local in character, affect interstate commerce." H.R. Rep. No. 93-1107, 93d Cong., 2d Sess. at 45 (1974).[27] Since Section 1 of the Sherman Act has been held to apply to contracts, combinations, or conspiracies which, however local their immediate objectives, substantially and adversely affect interstate commerce, *Mandeville Island Farms* v. *American Crystal Sugar Co.*, 334 U.S. 219, 234 (1948), acts or practices within Sherman Act jurisdiction must a fortiori be subject to FTC jurisdiction. Accordingly, it is instructive to look to cases construing the Sherman Act for initial guidance as to the reach of Section 5.[28]

Such cases provide substantial precedent for the ALJ's conclusion. In *Hospital Bldg. Co.* v. *Rex Hospital Trustees,* 425 U.S. 738 (1976), for example, the Court reversed a summary dismissal on jurisdictional grounds since the complaint alleged that petitioner's purchases of out-of-state medicines and supplies and its revenues from out-of-state insurance companies would be less than they otherwise would be if respondents and their co-conspirators succeeded in blocking petitioner's planned hospital expansion. Assuming in this case that each of respondents' members does not have an equal desire to advertise or solicit customers (TROA 32), the revenues of some physicians subject to the alleged restrictions unquestionably will be affected by those restrictions.

[26] Pub. Law No. 93-637, 88 Stat. 2183 (1974).

[27] One of the reasons for the amendment was to obviate the inordinate expenditure of time and effort required to marshal evidence needed to satisfy purely jurisdictional technicalities.

[28] Of course, practices that affect commerce in a less than substantial way may nonetheless be within the Commission's jurisdiction.

A year earlier in *Goldfarb, supra,* 421 U.S. at 783, the Court determined that a minimum fee schedule for title examinations imposed by the county bar association had a sufficient nexus with interstate commerce because a substantial portion of mortgage funds used to purchase homes in the county came from outside the state. The Court further noted that substantial loan money was guaranteed by the United States Veterans Administration and the Department of Housing and Urban Development, both of which were headquartered out-of-state. Because lenders require title examinations as a condition of making loans, the Court held that the legal services at issue were an integral part of an interstate transaction and that a restraint on those services substantially affected commerce under the Sherman Act. *Id.* at 784–85. [17] Just as the minimum fee schedule deprived consumers of free competition in the title search market, respondents' ethical restrictions have a significant impact upon the volume, price, and distribution of medical services in the State of Connecticut. And, whereas the financing of property in *Goldfarb* was affected only indirectly by the restraint through the title examination requirement, the restraint here affects the very services being financed by out-of-state funds. Rather than a restriction going to an integral but collateral service, as was involved in *Goldfarb,* the restraint before us is more analogous to a restriction intended to prohibit the sale of property that would otherwise be financed with out-of-state funds.[29]

The Sherman Act real estate cases cited by respondent are distinguishable because they do not involve the broader jurisdictional standard of Section 5. In addition, these cases are factually different from the case at bar. Unlike physicians, whose services are the principal cause of interstate health insurance payments, real estate brokers have been found to be neither necessary nor integral participants in the interstate aspects of realty financing and insurance. *McLain* v. *Real Estate Bd. of New Orleans,* 583 F.2d 1315 (5th Cir. 1978), *cert. granted,* 99 S. Ct. 2159 (1979). In *Bryan* v. *Stillwater Bd. of Realtors,* 578 F.2d 1319 (10th Cir. 1977), plaintiff's contention that he had been unlawfully expelled by the defendant was found to have no logical nexus with allegations that the defendant's conduct occured in interstate commerce. In *Income Realty & Mortgage, Inc.* v. *Denver Bd. of Realtors,* 578 F.2d 1326 (10th

[29] In *State of Arizona* v. *Maricopa Medical Soc'y,* 1979-1 Trade Cas. (CCH) ¶62,694 (D. Ariz. 1979), a medical society was found to be affecting commerce through alleged price fixing. The court there found that while the sales by physicians of their services were not interstate transactions, ¶62,694 at 77,894, the alleged price-fixing affected the sale of services by physicians and the sale of services by physicians directly affected the health insurance premiums and claim payments that cross state lines. *Id.* at 77,894–95. The restraints involved in this case have much the same effect upon health care payments. *See also United States* v. *American Soc'y of Anesthesiologists, Inc.,* 1979-2 Trade Cas. (CCH) ¶62,739 (S.D.N.Y. 1979).

Cir. 1978), plaintiff's allegation was limited to the conclusory statement that the parties were engaged in the interstate brokerage of real estate.

We therefore concur in the ALJ's finding that the challenged practices of the Connecticut respondents are in and affect interstate commerce. [18]

II LIABILITY

The focus of this case is the legality under Section 5 of respondents' restrictions upon the advertising, solicitation, and contractual practices of their members. The nature, scope, and impact of these restrictions are specifically at issue. All respondents challenge the adequacy of the evidence to sustain a finding that they have unreasonably and unfairly restricted physicians' advertising, solicitation, and contractual arrangements. While AMA does not directly defend its 1971 guidelines, which were in effect at the time this proceeding was commenced, it argues that our focus should be upon ethical guidelines adopted *pendente lite* and that, in any event, it is not responsible for enforcement actions taken by state and local medical societies. CSMS and NHCMA both emphasize their individual autonomy and assert that the evidence is insufficient to connect them in a conspiracy with AMA. They further allege that they were given insufficient notice of the allegation of conspiracy involving their members. We address each of these issues below, beginning with the conspiracy allegations.

A. Conspiracy

Evidence adduced at trial provides substantial proof of a conspiracy to impose the challenged ethical restrictions: first, between and among respondents and other constituent associations and component societies, and second, between respondents and their members. We note at the outset that the structure of respondent's organization—a single national organization, state or constituent associations, and local or component societies—is conducive to development of system-wide consensus on ethical matters to which all members must adhere. The governing structure of the AMA reflects this hierarchical system in that members of the AMA House of Delegates are selected by constituent associations and members of the constituent societies' ruling bodies are selected by their respective component societies. (ID 7)

The record also describes the various steps taken by respondents to insure that all of their members follow the same or substantially

similar ethical guidelines. The constitutions and bylaws of AMA, CSMS, and NHCMA, as well as most of AMA's other constituent and component medical societies make compliance with AMA's *Principles of Medical Ethics* a requirement of continued membership. (CX 990I, 991D, 1404I, ID 306–09) Although state associations may apply their own principles of professional conduct to their members, those principles may not be inconsistent with the *Constitution and By-Laws* of the AMA. (CX 1435Z–20)[30] Moreover, AMA has said that a physician acts "unethically" when he or she disregards "local custom," and has urged its [19] component societies to "exercise great caution to insure full compliance with the spirit and intent of the *Principles.* (CX 210, 462Z–9) Although the Connecticut respondents argue to the contrary, AMA has stated that county societies are required to apply all of the interpretations contained in the *Opinions and Reports* (CX 489). It is evident, therefore, that the *Principles* and the *Opinions and Reports* play a central role in delineating the ethical standards for physicians in this country.

In addition to promulgation and distribution of broad ethical pronouncements to constituent and component societies, AMA has provided ethical advice to local societies in specific situations. (CX 54, 168, 768B, 1287)[31] AMA refers complaints and inquiries on ethical matters to the appropriate state or local societies and constituent associations refer complaints and provide guidance to component societies. (ID 105) In short, the record of this proceeding substantiates the involvement of respondents, as well as affiliated medical societies, in the enforcement of the challenged ethical restrictions. (*See* ID 118–24, 133–44, 146–48, 152–60, 172–76, 187–94, 198–99, 212–21, 223–26) These enforcement activities were fully consistent with the *Principles* and interpretations of the *Principles* found in AMA's *Opinions and Reports.* Indeed, there is no evidence before us that state or local medical societies have ever strayed far from the ethical norms established by AMA.

Measured against recent decisions involving conspiracy allegations in a professional association context, there can be little dispute over the law judge's findings on the conspiracy issue.[32] In *Goldfarb,*

[30] A member of the AMA must comply with the *Principles* in order to retain his or her membership. (CX 990I)

[31] On occasion, AMA's advice has ventured beyond ethical interpretations to guidance regarding enforcement action. For example, Mr. Edwin J. Holman, then secretary to AMA's Judicial Council, suggested that the Saginaw County Medical Society advise a physician that a sign posted on his lawn advertising medical treatments should be removed. (CX 91A) Alternatively, Mr. Holman suggested that the local society promulgate guidelines and, if the offending physician did not remove the sign after an appropriate period of time, bring charges of unethical conduct against the physician. (CX 91A, B)

[32] Respondents' reliance upon *UMW* v. *Coronado Coal Co.*, 259 U.S. 344 (1921) and *Coronado Coal Co.* v. *UMW,* 268 U.S. 295 (1924), is misplaced. The Court there rejected claims of a conspiracy between the International and its local unions in connection with damage caused to the Coronado Coal Company's Prairie Creek mine, finding that the interference with the coal company was neither initiated, participated in, or ratified by the International. *Id.,*

(Continued)

supra, 355 F. Supp. 491, [20] 494–96 (E.D. Va. 1973), the district court found that the Virginia State Bar and the Fairfax County Bar Association had agreed to fix prices. The district court noted that the Virginia State Bar had played only a minor role in the matter. However, holding that defendants were engaged in a "classic illustration of price fixing," 421 U.S. at 783, the Supreme Court dispelled any doubt as to the culpability of the state defendant:

> Of course, an alleged participant in a restraint of trade may have so insubstantial a connection with the restraint that liability under the Sherman Act would not be found, see *United States* v. *National Assn. of Real Estate Boards,* 339 U.S., at 495; however, that is not the case here. The State Bar's fee schedule reports provided the impetus for the County Bar, on two occasions, to adopt minimum-fee schedules. More important, the State Bar's ethical opinions provided substantial reason for lawyers to comply with the minimum-fee schedules. Those opinions threatened professional discipline for habitual disregard of fee schedules, and thus attorneys knew their livelihood was in jeopardy if they did so. Even without that threat the opinions would have constituted substantial reason to adhere to the schedules because attorneys could be expected to comply in order to assure that they did not discredit themselves by departing from professional norms, and perhaps betraying their professional oaths. (421 U.S. at 791 n. 21).

It is noteworthy that the record in *Goldfarb* was devoid of proof that the state association had sent letters or referred complaints to the county bar associations. Nor was there any evidence that the state bar had coordinated the activities of its constituent societies with respect to specific fact situations. In fact, the uncontradicted evidence showed, as it does here with respect to AMA, that the Virginia State Bar had never taken any disciplinary action against an attorney for failing to adhere to the fee guidelines. *Goldfarb, supra,* 355 F. Supp. at 496. The case thus stands for the proposition that a professional association may take part in a conspiracy in restraint of trade even though its participation is limited to promulgating ethical guidelines with the intent that affiliated societies will enforce those guidelines and that members will follow them.[33] [21]

A conspiracy involving a professional society, affiliated national

259 U.S. at 393. Indeed, the union's constitution provided that no district was permitted to engage in strikes involving all or a major portion of its members without sanction of the International, and that a district could order local strikes only on their own responsibility. *Id.*, 259 U.S. at 384–85. AMA's role in the promulgation and enforcement of the ethical restrictions at issue in this proceeding is considerably more extensive than the role of the International in the Prairie Creek incident.

[33] As such, the conspiracy here is different in character from that considered in *Interstate Circuit* v. *United States,* 306 U.S. 208 (1939), where a conspiracy was inferred, in large measure, from the fact that without "substantially unanimous" action on the part of all distributors there was a risk of a substantial loss of business and goodwill. *Id.* at 222. By contrast, promulgation of a code of ethics implies agreement among the members of an organization to adhere to the norms of conduct set forth in the code. The extent to which members abide by the ethical standards does not bear upon the existence of a conspiracy, rather it indicates how effective the conspiracy has been in carrying out its objectives.

and state societies, and its members, was established in the *Professional Engineers* case, a case remarkably similar to the facts in this docket. *United States* v. *National Society of Professional* Engineers, 389 F. Supp. 1193, 1201 (D.C.C. 1974), *vacated,* 422 U.S. 1031 (1975) *aff'd on rehearing,* 404 F. Supp. 457 (D.D.C. 1975), *aff'd and modified,* 555 F.2d 978 (D.C. Cir. 1977), *aff'd* 435 U.S. 679 (1978).[34] The National Society of Professional Engineers (NSPE), which counted as members 17 percent of the registered engineers in the United States, was affiliated with professional engineering societies in each state. *Id.* at 1195. Enforcement of the NSPE Code of Ethics was principally left to these state societies, although NSPE developed disciplinary procedures for the state societies to follow and played a significant role in coordinating and encouraging state society enforcement efforts. *Id.* at 1196.[35] State societies were autonomous in the sense that NSPE had no authority to compel an affiliated society to take any action or to refrain from taking any action; NSPE's only power over affiliated societies was the power to withdraw their charters of affiliation. *Id.* at 1213. NSPE's actions were characterized as successful by the district court, inasmuch as there were few significant defections by NSPE members from the ethical restriction upon bidding practices. *Id.* at 1196.

AMA attempts to distinguish the *Professional Engineers* case by suggesting that NSPE was found to have violated the antitrust laws on the basis of its own code of ethics, not on the basis of actions by state or local affiliates. AMA Reply Brief at 14. Such an argument, however, misperceives the thrust of that case, since, as in the instant matter, the conspiracy determination in *Professional Engineers* was supported by evidence that the NSPE promulgated the anticompetitive ethical guidelines and assisted state officials in enforcing those guidelines.[36] [22]

We further reject the notion proffered by AMA that the autonomy of its constituent and component societies and their voluntary adoption of an ethical code precludes a finding of conspiracy. The law is clear that a conspiracy may be found whether or not one conspirator exercises control over the actions of its co-conspirators. *FTC* v. *Cement Institute,* 333 U.S. 683 (1948); *cf. United States* v.

[34] *See also United States* v. *Texas State Bd. of Public Accountacy,* 464 F. Supp. 400 (D.Tex. 1978), *aff'd and modified,* 592 F.2d 919 (5th Cir. 1979) (conspiracy found between the state board and accountants holding permits to practice in Texas on basis of acquiescence of permit holders in ban on competitive bidding under threat of disciplinary action by state board).

[35] Authoritative interpretations of NSPE's Code of Ethics are contained in the opinions of NSPEC's Board of Ethical Review. *Professional Engineers, supra,* 389 F. Supp. at 1214.

[36] The district court noted that NSPE officials had promoted and coordinated enforcement with officials from affiliated societies in the District of Columbia, Pennsylvania, North Carolina, West Virginia and Kentucky in connection with a West Virginia airport project. *Id.* at 1210–12.

Texas State Bd. of Public Accountancy, supra, 464 F. Supp. at 403. Certainly, the autonomous status of the affiliated societies in the *Professional Engineers* case did not absolve the NSPE of liability in the face of evidence showing that the NSPE encouraged and coordinated state and local enforcement activity. *Professional Engineers, supra,* 389 F. Supp. at 1196, 1201, 1213.[37]

The Connecticut respondents argue that the trial record does not even contain "slight evidence"[38] connecting CSMS and NHCMA to the alleged conspiracy of AMA and other medical societies. Both respondents further maintain that they were afforded insufficient notice of the second prong of complaint counsel's conspiracy theory charging a conspiracy between respondents and their members.[39]

In our view, the evidence is more than sufficient to connect the Connecticut respondents to the conspiracy involving AMA and other medical societies restricting the advertising, solicitation, and contract practices of their members. As the ALJ noted (ID 283–87), there is not only evidence generally of the ties between AMA and its member societies on ethical matters, from which an inference can be drawn as to the Connecticut respondents' involvement in the conspiracy, but there is also independent evidence of specific actions by these respondents directly linking them to the conspiracy. Moreover, the evidence of affirmative acts by the Connecticut respondents is bolstered by the absence of any proof whatsoever demonstrating that CSMS and NHCMA ever took any position in conflict with AMA's challenged restraints. [23]

The CSMS has adopted the *Principles* (CX 991D). While it has not formally adopted the *Opinions and Reports,* it has indicated that the "policies of the AMA are guides to our action" (Tr. 8282) and has cited the recommendations of the Judicial Council in discouraging a senior citizen discount program for medical services. (CX 30) Moreover, CSMS has stated that "advertising is prohibited by medical ethics." (CX 30) Consistent with this position, the vice president of CSMS filed a complaint in his official capacity with NHCMA, charging Dr. Leon Zucker with unethical publicity in connection with a newspaper article reporting surgery performed by Dr. Zucker. (CX 2006A, *see also* ID 167–68.) In another incident, a member of the CSMS Council, the executive body of CSMS, filed a complaint with the NHCMA against Dr. Sugn Liao, regarding

[37] We note that local societies are not so autonomous that they are permitted to have less stringent restrictions upon advertising or solicitation than those found in the 1977 edition of *Opinions and Reports.* (App. A, p. 1)

[38] Once a conspiracy is established, only "slight evidence" is needed to connect a particular participant with that conspiracy. *United States* v. *Cadillac Overall Supply Co.*, 568 F.2d 1078, 1087 (5th Cir. 1978), *cert. denied,* 437 U.S. 903 (1978); *United States* v. *Consolidated Packaging Corp.*, 575 F.2d 117, 126 (7th Cir. 1978).

[39] AMA apparently does not contest the finding of a conspiracy between it and its members. (RAB 33–47; *but see* TROA 17)

newspaper and TV advertising for an acupuncture clinic opened by Dr. Liao. (CX 701A; *see also* ID 160.) With respect to the contract practice allegations, the record shows that the CSMS House of Delegates approved resolutions disparaging the corporate practice of medicine and supporting the traditional fee-for-service method of compensation. (CX 1344Z–9, –10, –11)

The evidence concerning respondent NHCMA is equally incriminating. NHCMA bylaws provide that "[t]he principles of medical ethics of the AMA as reflected in the Judicial Council shall govern the conduct of members," (CX 1404I) creating a strong inference that members of NHCMA are bound by the *Opinions and Reports* as well as the *Principles*. While this evidence alone is sufficient to sustain a finding of liability against NHCMA, the record also documents the actions taken by NHCMA against Drs. Zucker and Liao, (ID 160, 167–68)[40], and investigation by NHCMA of a radiology clinic to determine if it was soliciting patients (CX 782–86), action against Dr. Zucker on another occasion for telephone directory listings outside the area in which Dr. Zucker's office was located, (CX 136A, B) and efforts by NHCMA to limit announcements of office openings and relocations to one newspaper insertion. (CX 81)[41] [24]

With respect to the Connecticut respondents' position regarding inadequate notice of a conspiracy between them and their members, we note that the complaint alleged a conspiracy between "respondents and others." (Complaint ¶¶6–7) Complaint counsel's trial brief explained, however, that the case-in-chief would only challege "an agreement among respondents and their affiliated medical societies to hinder competition among medical doctors." Trial Brief of Counsel Supporting the Complaint at 1 (April 18, 1977). Although complaint counsel described AMA as "a collective body of individual entrepreneurs" during the case-in-chief, (Tr. 503–04) this brief reference was clearly inadequate to correct the impression previously conveyed in the trial brief. An articulation of the alternative theory, i.e., a conspiracy between respondents and their members, is found in complaint counsel's conspiracy memorandum filed prior to defense hearings, but even this statement conflicts with other sections of the memorandum. Memorandum on Conspiracy Law and Related Evidence Questions at 2, 19 n., 26 (November 7, 1977).

[40] The testimony of Dr. Tierney, who received the complaints against Dr. Zucker as president of NHCMA, reflects some concern regarding the accuracy of the headline of the article which formed the basis for the complaint. (Tr. 8483) This headline characterized the operation performed by Dr. Zucker as "rare," whereas Dr. Tierney felt the term "uncommon" to be a more appropriate description of its frequency of occurrence. *Id.* The minutes of the NHCMA Board of Censors meeting with Dr. Zucker, however, reflect a concern with "personal aggrandizement," and do not allude in any respect to a deception problem. (CX 695C,D)

[41] NHCMA's reliance upon the advice of AMA and AMA's dependence upon NHCMA for enforcement action is also well-documented. (CX 672–73A, 783, 784A, 785)

Complaint counsel's proposed findings submitted to the ALJ after trial contain the first clear statement of the alternative conspiracy theory. Proposed Findings of Fact and Conclusions of Counsel Supporting the Complaint at 260 (July 27, 1978). Respondents had an opportunity to address this theory before the law judge and before the Commission on appeal from the initial decision and in fact addressed the evidence in support of this theory in their appeal briefs. (RCAB at 48; RNAB at 38) Moreover, respondents do not allege and we do not understand how the allegation of a conspiracy between them and their members would necessitate the introduction of evidence additional to that already offered to rebut the alleged conspiracy between respondents and other constituent and component societies. We conclude, therefore, that any incertitude which may have existed with respect to complaint counsel's conspiracy allegations during trial did not prejudice CSMS and NHCMA since all facts relevant to the alleged unlawful acts were fully litigated. *See Golden Grain Macaroni* v. *FTC,* 472 F.2d 882 (9th Cir. 1972), *cert. denied,* 412 U.S. 918 (1973); *Armand Co., Inc.* v. *FTC,* 84 F.2d 973 (2d Cir. 1936), *cert. denied,* 299 U.S. 597 (1936). [25]

B. Restrictions on Advertising and Solicitation

As its principal defense to the charge of unlawfully restricting the advertising and solicitation of its members, AMA asserts that it should not be judged on the basis of what it characterizes as "obsolete" positions contained in the 1971 *Opinions and Reports,* but rather that the Commission should consider instead the statements contained in the 1977 *Opinions and Reports.* Respondent contends that the appropriate standard for judging this ethical code is the rule of reason. Analyzed according to this standard, AMA suggests that the record is devoid of proof establishing that it has unlawfully suppressed competition. With respect to its prior ethical position, as articulated in the 1971 *Opinions and Reports,* AMA argues that it neither enforced this position nor engaged in a conspiracy with constituent and component societies (TROA 29, 34). It concedes, however, that some statements contained in the 1971 *Opinions and Reports* could be construed as prohibiting price advertising and that state and local societies might have violated the law. (TROA 30–31, 33).

Before examining the facts of record, it is necessary to determine whether respondent's restrictions should be tested under a *per se* standard or according to the rule of reason. The ALJ found it unnecessary to consider whether AMA's restrictions constituted a *per se* violation of Section 5 since he concluded that the rule of reason

was clearly violated. Complaint counsel agree with this assessment but nonetheless urge that the restrictions on advertising and solicitation imposed by respondents should be considered illegal on their face. (TROA 91–92)

These restrictions do represent a restraint upon price advertising (ID 118–22, 132, 154, 193), and it is true that restraints on the advertising of prices have previously been considered *per se* illegal by some courts. *United States* v. *Gasoline Retailers Association, Inc.*, 285 F.2d 688 (7th Cir. 1961); *United States* v. *The House of Seagram, Inc.*, 1965 Trade Cas. (CCH) ¶71,517 (S.D. Fla. 1965). Moreover enforcement of these restrictions by disciplinary action that threatens or results in the loss of valuable privileges associated with membership has earmarks of a group boycott, long considered a violation of the antitrust laws without regard to business justifications. *Klor's, Inc.* v. *Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959); *Fashion Originators' Guild* v. *FTC*, 312 U.S. 457 (1941).[42] [26]

But while *per se* rules are considered a valid and valuable tool of antitrust enforcement, *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 99 S. Ct. 1551, 1556 (1979), we are not prepared to classify the challenged restraints as *per se* illegal in this instance and thereby preclude analysis of procompetitive justifications offered on their behalf. Professional restraints on advertising and solicitation have not previously been subject to extensive scrutiny under the antitrust laws, and the courts have been reluctant to classify practices as *per se* violations before acquiring sufficient experience with them. *Broadcast Music, supra*, 99 S. Ct. at 1556–7. In addition, we recognize that professional services may differ in some respects from other businesses. *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 696 (1978); *Goldfarb, supra*, 421 U.S. at 788–89 n.17. Arguments suggesting that competition is contary to the public interest are not cognizable under the rule of reason, but other justifications for ethical norms, such as the facilitation of nondeceptive advertising, may be procompetitive and must be taken into account. *Professional Engineers, supra*, 435 U.S. at 692, 696.

We turn then to consideration of the reasonableness of respondents' advertising and solicitation guidelines.[43] The test of legality is "whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may

[42] These restrictions further evince in certain respects the characteristics of a horizontal allocation of customers, (ID 171–73) also considered to be *per se* illegal under the antitrust laws. *United States* v. *Topco Associates, Inc.*, 405 U.S. 596 (1972); *Addyston Pipe & Steel Co.* v. *United States*, 175 U.S. 211 (1899).

[43] While it is unnecessary in this case for us to distinguish between the analysis required under Section 1 of the Sherman Act and Section 5, it is important to note that acts or practices that fall short of violating the Sherman Act may nonetheless traverse the more encompassing standard of illegality defined by Section 5.

suppress or even destroy competition." *Chicago Board of Trade* v. *United States,* 246 U.S. 231, 238 (1918); *Professional Engineers, supra,* 435 U.S. at 691. To assess the legality of the restrictions under a rule of reason analysis, we must examine their nature, purpose and effect on competition, including in the calculus any possible procompetitive impact. *Chicago Board of Trade* v. *United States,* 246 U.S. 231, 238 (1918). As the Court observed in *Professional Engineers, supra,* the unreasonableness of trade restrictions can be based either

> (1) on the nature or character of the contracts, or
> (2) on surrounding circumstances giving rise to the inference or presumption that they were intended to restrain trade and enhance prices. (435 U.S. at 690)

Thus, the contours of the analysis required under the rule of reason will vary somewhat depending upon the nature of the restraint. [27]

Evaluation of AMA's *Principles of Medical Ethics,* the 1971 *Opinions and Reports,* and assertions of AMA, state and local medical society officials, allows little latitude for dispute over the nature and scope of respondents' restrictions at the time the complaint was issued.[44] The *Principles* make clear that physicians should "uphold the dignity and honor of the profession" and "should not solicit patients."[45] All solicitation, whether direct or indirect, is forbidden, and "solicitation" is defined in the 1971 *Opinions and Reports* as any "attempt to obtain patients or patronage by persuasion or influence." (CX 462Z–6)[46] Hence, it is fair to say that almost all advertising and promotional activity is proscribed, with a few narrowly circumscribed exceptions. *See, generally* ID 115–118. A doctor may only furnish the public with information regarding his or her name, type of practice, location of office and office hours, and this information must be communicated through the "accepted local media," which includes "telephone listings, office signs, professional cards, and dignified announcements." (CX 462Z–6) Although the guidelines in theory permit listing in a physician or telephone

[44] We reject respondents' suggestion that the focus for determining liability should be ethical positions or statements disseminated after issuance of the complaint. AMA does not contend that this case is moot. Consequently, its 1977 edition of *Opinions and Reports* is properly assessed in the context of relief rather than of liability. *See infra* at 45–57.

[45] AMA's first *Code of Ethics,* adopted in 1847, contained the following section:

> It is derogatory to the dignity of the profession to resort to public advertisements or private cards or handbills, inviting the attention of individuals affected with particular diseases—publicly offering advice and medicine to the poor gratis, or promising radical cures; or to publish cases and operations in the daily prints, or suffer such publications to be made;—to invite laymen to be present at operations,—to boast of cures and remedies,—to adduce certificates of skill and success, or to perform any other similar acts. These are highly reprehensible in a regular physician. (*Percival's Medical Ethics,* App. III at 226 (C. Leake ed. 1927).)

[46] Our discussion here also encompasses solicitation restraints applicable to medical organizations through contract practice restrictions imposed upon physicians. (CX 462Z–13)

directory, or the sending of announcements regarding follow-up treatments or the opening or removal of an office (CX 462Z–6, –7, –8), the AMA has strictly limited the manner in which its members may utilize these media for solicitation of new patients. [28]

Analysis of the effect of these far-reaching restraints upon the health care market necessitates an awareness of the role advertising and solicitation play in the efficient operation of a competitive economy. Advertising serves to disseminate "information as to who is producing and selling what product, for what reason, and at what price." *Virginia State Board of Pharmacy* v. *Virginia Citizens Consumer Council,* 425 U.S. 748, 765 (1976). Advertising thus performs an indispensable function in the allocation of resources in a free enterprise system. *Bates* v. *State Bar of Arizona,* 433 U.S. 350, 364 (1977).[47] Bans on advertising increase the difficulty of finding the lowest cost seller of acceptable ability or quality, isolating sellers from competition and reducing the incentive to price competitively. *Id.* at 377. Entry barriers are often lower with advertising than they would be in its absence, allowing new competitors to penetrate the market. *Id.* at 378. As a result of easier entry and lower search costs, prices are often lower when advertising is unrestrained. *Id.* at 377.

Given the integral function of advertising and other forms of solicitation to the workings of competition in our society, we begin with the recognition that AMA's broad proscription of advertising and solicitation has, by its very essence, significant adverse effects on competition among AMA's members. *See Professional Engineers, supra* 435 U.S. at 692–93; *Smith* v. *Pro Football, Inc., supra,* 593 F.2d at 1183; *Mardirosian* v. *American Institute of Architects,* 1979–2 Trade Cas. (CCH) ¶62,745 (D.D.C. 1979). While the nature or character of these restrictions is sufficient alone to establish their anticompetitive quality, the record contains additional corroborative evidence of significant anticompetitive effects. [29]

The ALJ's initial decision documents at great length the impact that respondents' restraints have had in several specific situations and we need not reiterate the details of each incident. (ID 118–52, 154–56, 160–68, 171–97, 258–63) This evidence is susceptible to no interpretation other than that ethical principles of the medical profession have prevented doctors and medical organizations from disseminating information on the prices and services they offer,

[47] The Court has also stated:

> The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain—quality, service, safety, and durability—and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers. (*Professional Engineers, supra,* 435 U.S. at 695.)

Clearly, a patient does not have the opportunity to select among alternative offers if, because of ethical bans, he or she is ignorant of the choices available.

severely inhibiting competition among health care providers. Because prepaid health care plans and other alternative providers depend heavily on advertising to announce their existence and explain their programs (Tr. 478, 482–84, 1556), the advertising restrictions have had an even harsher impact on such organizations.

AMA's principal argument on the issue of anticompetitive effects is that the record contains no evidence that its restrictions have raised prices. In particular, respondent claims the record contains no systematic study of prices. Moreover, AMA suggests a number of factors which militate against a price impact, including the ready availability of fee information by word-of-mouth, the significance of professional reputation, accessibility, and patient satisfaction, the impact of public and private health insurance, and the unresponsiveness to price advertising of demand for emergency and specialty care. (RAB 53–54)

We do not agree with AMA that an impact upon physician fees must be demonstrated in order to characterize respondent's ethical restraints as unreasonably anticompetitive. Nor do we accept the contention that proof of an effect upon fees can only be shown by means of a full-blown econometric study. The task of identifying the precise impact of the restrictions and segregating fully effects owing to other forces in the marketplace may render such a study infeasible.

Nevertheless, the record evidence is sufficient, in our view, to establish an adverse effect upon fees. First, there is proof that advertising of low cost services has been suppressed. (ID 118–22, 124–43) Moreover, physician directories entered into evidence by respondents demonstrate that prices vary widely for such basic services as initial office visits, return office visits, and house calls, even among physicians in the same specialty. (RX 267 at 8, 407, 666 at App. C, RNHX 149) There are also substantial variations for off-hour physician's services and diagnostic and operative procedures. (Tr. 633–36, 1357–58, 1815) Price variations among family and general practitioners sometimes exceed 500 percent for such basic services as immunizations, pap smears, pelvic examinations, and urinalysis. (RX 666, App. C) [30]

The evidence indicates, moreover, that specific fee information is important to consumers, that consumers lack access to fee and other information necessary to make an informed choice of a physician, and that information obtained by word-of-mouth does not fill this need. (ID 110, 112–14) Given these circumstances, economic theory suggests that price differences for equivalent services would dimin-

ish with price advertising and the concomitant reduction in search costs.[48]

AMA's attempt to discount the impact of its effective ban on price advertising is not wholly without merit. To be sure, other factors, such as reputation for quality service and referrals, accessibility, need for emergency care, and even bedside manner, are likely to weigh heavily in the choice of a physician and effect some disparity in prices.[49] Furthermore, the extent to which medical services are covered by Medicare, Medicaid, or private health insurance will reduce *pro tanto* the patient's interest in fee information. A patient requiring immediate attention is not apt to seek out the lowest-priced emergency room. But these considerations do not fully explain the vast price disparity evidenced in the record, nor do they contradict the record evidence demonstrating the value of fee information to most consumers. At most, they imply that consumer sensitivity to price is a function of their out-of-pocket expenses[50] and that other factors may be paramount over price considerations in specific situations.[51] [31]

Inquiry into the purpose of the challenged ethical restrictions lends additional support to our finding of substantial anticompetitive effects. We recognize respondents' concern about false and deceptive advertising, but their objectives go far beyond this concern. Indeed, the record describes several instances in which a disdain for competition, not false or deceptive advertising, appears to be the sole motivation for suppressing promotional activities. AMA and local medical society officials have repeatedly spoken out against physicians "competing against each other for selfish, personal reasons" (CX 272B) and against "overly aggressive competition." (CX 10B) For example, Dr. Stephen C. Biering, Chairman of AMA's section on medical schools, testified that it would be inappropriate for physicians to compete with other physicians on the basis of price, quality, and service and that doctors should not compete in the commercial sense under any circumstances. (Tr. 9544–45, 47–48; *see also* ID 174, 193, 212–13, 256–57)[52]

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[48] G. Stigler, "The Economics of Information," *The Organization of Industry*, 186–87 (1968). This is not the first time that evidence of price disparity has been attributed to advertising restraints. *See Bates, supra*, 433 U.S. at 377; *Virginia Pharmacy, supra*, 425 U.S. at 754 n.11, 763–64.

[49] Advertising may affect the importance of these factors to a patient. For example, without advertising, reputation information may be difficult or costly to obtain, as may information about the availability of new services.

[50] Third party payments accounted for 69.7% of personal health care expenditures in 1977. U.S. Dep't of Health, Education, and Welfare, *Health, United States, 1978*, at Table 153 (1978). However, it is not known what percentage of the population has full or nearly full coverage for medical expenses.

[51] Between 10 and 25% of all physician contacts occur on an emergency basis. (Tr. 6116–17)

[52] When asked by AMA's counsel what he meant in saying that physicians should not compete in the commercial sense, Dr. Biering replied:

> I mean by that that a physician would say, come to my office. You can get better, quicker and at less

(Continued)

Our finding of substantial adverse effects on competition is supported, therefore, by the underlying nature of the restrictions, extensive evidence of direct competitive injury cited by the ALJ, proof of price disparity for physician services, and evidence concerning the purpose of the restraints. In order to determine whether the restraints are unreasonably anticompetitive, however, it is necessary to balance the alleged procompetitive virtues of the challenged restraints against these anticompetitive evils. We are hampered somewhat in this task since AMA does not really defend the statements contained in the 1971 edition. Instead, it essentially limits its defense to justification of the 1977 *Opinions and Reports,* maintaining that this later position regulates and thereby promotes competition among physicians. Respondent contends that competition flourishes when consumers receive truthful information, but that dissemination of false or deceptive information is ultimately anticompetitive. (RAB 57–58) Because there are many similarities between the 1971 and 1977 *Opinions and Reports,* it is fair to take into [32] consideration in adjudicating the legality of AMA's ethical restrictions those arguments offered in connection with post-complaint modifications of these restrictions.

In *Professional Engineers, supra,* the Court considered the Society's claim that competitive pressure to offer low-price engineering services would encourage deceptive bidding and adversely affect the quality of the work, thereby impairing public health and safety. In responding to these contentions, the Court emphasized the competitive focus of a Rule of Reason analysis:

> Contrary to its name, the Rule [of Reason] does not open the field of antitrust inquiry to any argument in favor of a challenged restraint that may fall within the realm of reason. Instead, it focuses directly on the challenged restraint's impact on competitive conditions. (435 U.S. at 688.)

In rejecting the Society's defense, the Court further explained:

> Ethical norms may serve to regulate and promote this competition, and thus fall within the Rule of Reason. But the Society's argument in this case is a far cry from such a position. We are faced with a contention that a total ban on competitive bidding is necessary because otherwise engineers will be tempted to submit deceptively low bids. Certainly, the problem of professional deception is a proper subject of an ethical canon. But, once again, the equation of competition with deception, like the similar equation with safety hazards, is simply too broad; we may assume that

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expense. I use a less expensive hospital and so on than my colleague across the street, which precisely is what commercial advertising does. It exhorts the public to buy something because it is cheaper, better, more available, etc. And physicians, simply, are not in the business of selling a product or guaranteeing results. (Tr. 9548)

While any claim that results are guaranteed would raise obvious problems, Dr. Biering's objection to advertising is clearly much broader.

competition is not entirely conducive to ethical behavior, but that is not a reason, cognizable under the Sherman Act, for doing away with competition. (435 U.S. at 696). (Footnote omitted.)

Ethical restraints can be justified under the rule of reason, therefore, only if they promote competition, rather than merely other social goals, and if they are not overly broad.[53]

In view of this background, we accept the contention that an ethical precept narrowly directed toward false or deceptive advertising and unfair solicitation may enhance competition by insuring the communication of accurate information in a manner that allows it to be processed unburdened by unscrupulous practices. Respondent's restrictions are of a different kind, however, reflecting a belief that the best way to interdict false and deceptive advertising and overreaching [33] by physicians is to proscribe practically the full spectrum of advertising and solicitation activities. The evidence confirms that the restrictions have been applied as an absolute ban governing situations in which the dangers contemplated by respondent are imperceptible if they exist at all. For example, a form letter from *Anthropometrics* to approximately 50 presidents of corporations announcing establishment of an Executive Fitness Control Center to provide comprehensive physical exams and follow-up therapy to corporate executives was considered unethical solicitation. (ID 146) In another instance, the AMA indicated that a letter from a group of radiologists to physicians was objectionable if it was designed to solicit referrals. (CX 783A) It is evident from these examples that AMA's effective ban on advertising and solicitation applies "with equal force to both complicated and simple projects and to both inexperienced and sophisticated customers." *Professional Engineers, supra,* 435 U.S. at 692.

Implicit in AMA's argument is the proposition that any less inhibitory restraint on advertising or solicitation will be likely to encourage false and deceptive advertising and unfair practices by physicians. But AMA has simply not demonstrated that a broad ban is necessary to ensure that advertising is nondeceptive and that solicitation is inoffensive to vulnerable classes of consumers. We note initially that the record does not document widespread abuses among the 47.4% of licensed physicians in the United States who are not members of AMA. (RX 658, 660)[54] Moreover, a substantial

[53] *See also Smith* v. *Pro Football, Inc., supra,* 593 F.2d at 1187; *Mardirosian, supra,* 1979-2 Trade Cas. (CCH) at ¶78,247. In *Smith,* the D.C. Circuit suggested that a practice could survive the rule of reason only if it has positive, economically procompetitive benefits that offset its anticompetitive effects, "or, at the least, if it is demonstrated to accomplish legitimate business purposes and to have a net anticompetitive effect that is *insubstantial.*" *Smith, supra,* 593 F.2d at 1188-89 n. 68 (emphasis in original).

[54] *See* AMA's Proposed Findings of Fact, 330-369.

majority of states have statutes governing advertising by physicians as well as medical licensing boards that can take action against physicians in the event abuses occur. (ID 108–10, 310–12) And we think it fair to presume that the vast majority of physicians will advertise their prices and services in a nondeceptive fashion and will avoid solicitation practices that take unfair advantage of their patients. *See Bates, supra,* 433 U.S. at 379.[55]

We conclude, therefore, that AMA's justification for the challenged restraints bears no reasonable relationship to legitimate, procompetitive concerns and that such justification is entitled to little weight in the overall balance of competitive effects. Whether viewed alone, or in conjunction with other evidence of purpose and effect, AMA's restraints on advertising and solicitation unreasonably impede competition. We accordingly find that these restrictions are unfair methods of competition in violation of Section 5. [34]

In addition to finding AMA's restrictions on advertising and solicitation to be unfair methods of competition, the Commission concurs with the ALJ's determination that the same restraints also constitute unfair acts or practices. The Commission may, like a court of equity, consider "public values beyond simply those enshrined in the letter or encompassed in the spirit of the antitrust laws.[5]" *FTC* v. *Sperry & Hutchinson Co.,* 405 U.S. 233, 244 (1971).[56]

AMA offers nothing to undermine the finding that the position on advertising and solicitation espoused in the 1971 *Opinions and Reports* results in substantial harm to consumers and offends public policy.[57] We doubt that it could do more on this record even if it wished. As noted before, there is considerable evidence that consumers lack access to information important in choosing a physician. (ID 110–14) AMA's wholesale restrictions on advertising and solicitation impede communication of this information resulting in significant fee disparity and economic harm to consumers. Many patients, unable to locate a physician, turn to emergency rooms for care that

[55] A state, acting on behalf of the interest of its citizens, is undoubtedly entitled to greater latitude in preventing deception and unfair practices than a professional association representing the interests of horizontal competitors. *Compare Friedman* v. *Rogers,* 99 S. Ct. 887 (1979) *with Professional Engineers, supra,* 435 U.S. at 699; *see also American Medical Ass'n* v. *United States,* 130 F.2d 233, 247–50 (D.C. Cir. 1942), *aff'd,* 317 U.S. 519 (1943).

[56] In footnote 5, the Court stated:

> The Commission has described the factors it considers in determining whether a practice which is neither in violation of the antitrust laws nor deceptive is nonetheless unfair:
>
> "(1) whether the practice, without necessarily having been previously considered unlawful, offends public policy as it has been established by statutes, the common law, or otherwise—whether, in other words, it is within at least the penumbra of some common-law, statutory, or other established concept of unfairness; (2) whether it is immoral, unethical, oppressive or unscrupulous; (3) whether it causes substantial injury to consumers (or competitors or other businessmen)." (405 U.S. at 244–45 n.5.) (Citation omitted.)

See also Spiegel, Inc. v. *FTC,* 540 F.2d 287, 293 (7th Cir. 1976).

[57] AMA seeks instead to have the Commission adjudicate the fairness of the 1977 edition. AMA Reply Brief 24–25.

could be provided at less expense in a doctor's office. (ID 154, CX 959Y–Z1, Tr. 2312, 5415–16, RX 72 at 76) While it is impossible to quantify precisely how much of the aggregate annual expenditures for physician services[58] represents consumer injury attributable to the challenged restrictions, we are convinced that the record in this case supports a finding of substantial injury.

Nor can it be questioned that broad bans on advertising and solicitation are inconsistent with the nation's public policy. "Advertising is the traditional mechanism in a free-market economy for a supplier to inform a potential purchaser of the availability and terms of exchange." [35] *Bates, supra,* 433 U.S. at 376. And "[i]t is a matter of public interest that [purchasers'] decisions, in the aggregate, be intelligent and well informed." *Virginia Pharmacy, supra,* 425 U.S. at 765. Apart from its economic function, commercial advertising may convey important information of general public interest. *Bates, supra,* 433 U.S. at 364; *Virginia Pharmacy, supra,* 425 U.S. at 764. On a more individual level, restraints on the advertising of medical services, like the suppression of prescription drug price information, have a disproportionate effect on the poor, the sick, and the aged. *Id.* at 763. Given the prevailing disparity of prices, information as to who is charging what "could mean the alleviation of physical pain or the enjoyment of basic necessities." *Id.* at 764. [36]

C. Contract Practice

The complaint in this docket also challenges under Section 5 certain restrictions imposed by respondents with respect to the contractual activities of their members. The *Principles* state that:

> A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care. (CX 462Z–12)[59]

Several provisions of the 1971 *Opinions and Reports* interpreting this precept are alleged by complaint counsel to have anticompetitive effects and to be unfair acts or practices. They concern three general categories of activities:

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[58] $19 billion was spent in 1974. (CX 989D)

[59] The AMA *Principles* had a provision on contract practice as early as 1912. That provision stated:

> It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and the individual physician, and lowers the dignity of the profession. (*Percival, supra,* App. V at 268–69)

The current language was apparently adopted in 1957. (CX 1435Z–19)

1) contractual arrangements which affect the adequacy of fees, involve underbidding, or preclude the free choice of a physician;

2) compensation of physicians on a basis other than the traditional fee-for-service norm; and

3) physician arrangements with non-physicians.

For the reasons set forth below, we conclude that each of AMA's restrictions addressed to these activities is an unreasonable restraint of trade and hence an unfair method of competition.[60] Though the *Principles* couch the ethical standard in terms of preventing impairment of medical judgment and deterioration of medical care, the interpretations, [37] as reflected in the *Opinions and Reports*, bear little relation to those objectives. Whatever the extent to which quality of care concerns are cognizable under the antitrust laws—*e.g.*, where the restrictions have procompetitive virtues or have little effect on competition, *cf. Professional Engineers, supra*, 435 U.S. at 696, n.22—the restraints here go far beyond anything that might be reasonably related to the goal of preventing use of improper medical procedures. Moreover, as will be pointed out below, some of the restrictions are similar to practices that have long been condemned as unreasonably anticompetitive.

1) Adequacy of Fees, Underbidding, and Free Choice

Opinion 3 of Section 6 of the *Opinions and Reports* lists several contractual restrictions that are unfair or unethical. These are:

(1) When the compensation received is inadequate based on the usual fees paid for the same kind of service and class of people in the same community.

(2) When the compensation is so low as to make it impossible for competent service to be rendered.

(3) When there is underbidding by physicians in order to secure the contract.

(4) When a reasonable degree of free choice of physicians is denied those cared for in a community where other competent physicians are readily available.

(5) When there is solicitation of patients directly or indirectly. (CX 462Z-12, -13)

The use of the above-described standards for determining whether a contract is ethical received the approval of the House of Delegates

[60] We reject the notion, however, that these restrictions also constitute unfair acts or practices. Complaint counsel has simply not adequately articulated a theory by which these ethical restraints can be considered under the *S&H* standard. *Sperry & Hutchinson, supra*, 405 U.S. 244.

in 1927. (CX 1435S,T) Although the record does not indicate the motivation for the 1927 action, AMA's anticompetitive purpose is evident in the Minority Report to a 1932 report of the Committee on the Costs of Medical Care, entitled "Medical Care for the American People." (CX 2085Z–32–65) The Minority Report, which was endorsed by the House of Delegates in 1933 as "expressive, in principle, of the collective opinion of the medical profession," (CX 1435Z–42) provides a valuable insight into the thinking of the AMA at a point in time reasonably contemporaneous with incorporation of the five standards into the *Opinions and Reports.* After reiterating the five factors noted above, the Minority Report states:

> One of the strongest objections to industrial medical services, mutual benefit associations, so-called health and hospital associations, and other forms of contract practice is that there has been found no means of preventing destructive competition between individuals or groups concerned with these [38] movements. This injects a type of commercialism into medical practice which is harmful to the public and the medical professions and results in inferior quality of medical service.
>
> One of the pernicious effects of contract practice schemes is that each of them stimulates the launching of other similar schemes until there are many in the field competing with each other. The first may have safeguards against many of the abuses of contract practices, but as new ones are formed the barriers are gradually broken down in order to secure business.
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> * * * * *
>
> The minority recognizes the advantage of group practice under certain conditions, especially in communities where practically all of the physicians can be joined in one, or at the most, two groups. (CX 2085Z–39, –40, –44)

With respect to the voluntary insurance systems operated through contracts with organized groups of the medical profession, the Minority Report stated that these systems were:

> . . . giving rise to all the evils inherent in contract practice . . . . Wherever they are established there is solicitation of patients, destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician, and demoralization of the professions. It is clear that all such schemes are contrary to sound public policy and that the shortest road to commercialization of the practice of medicine is through the supposedly rosy path of insurance. (CX 2085Z–46; *see also* CX 2085Z–40, –42, –57, –58)

With this background in mind, we turn to consideration of the specific restrictions encompassed within Opinion 3.[61]

[61] The restraints on solicitation by organizations with which a physician has contracted are considered above in conjunction with AMA's general restraints on advertising and solicitation.

AMA's ethical restrictions regarding the adequacy of compensation received by physicians received brief attention at trial.[62] However, the law is clear that agreements [39] that seek to place a floor under price are illegal *per se. United States* v. *Socony-Vacuum Oil Co.,* 310 U.S. 150, 223 (1940); *Goldfarb, supra,* 421 U.S. at 781–83. Although there is no evidence that these provisions have had the effect of raising physicians' fees or preventing fees from falling below a particular level, an actual impact on prices need not be found in order to establish a conspiracy to fix prices. "[A] conspiracy to fix prices violates §1 of the [Sherman] Act . . . though it is not established that the conspirators had the means available for accomplishment of the objective. . . ." *Socony, supra,* 310 U.S. at n. 59.

It is evident from a facial examination of AMA's ethical provisions and from evidence concerning adoption of these restraints that they are designed to limit price competition among doctors. Respondent does not suggest any alternative motive cognizable under the antitrust laws. Moreover, the existence of a restriction on underbidding alongside these ethical precepts reinforces the perception that a physician is to a large degree insulated from price competition. *See Goldfarb, supra,* 421 U.S. at 781–82. Respondent's argument that it has never made any attempt to enforce these provisions is irrelevent, since "subtle influences may be just as effective as the threat or use of formal sanctions to hold people in line." *United States* v. *National Ass'n of Real Estate Bds.,* 339 U.S. 485, 489 (1950); *see also Goldfarb, supra,* 421 U.S. at 781, 791 n.21. We believe that this restriction is so akin to the more traditional forms of price fixing that it should be treated in the same fashion. Accordingly, we hold that the provisions governing adequacy of compensation are *per se* unreasonable and hence unfair methods of competition.

AMA's ban on "underbidding by physicians in order to secure [a] contract" (CX 462Z–13) also requires a little discussion. An interpretation of this restriction approved by AMA's Judicial Council (CX 539B) makes clear that the only bidding activity permitted is a bid submitted in answer to a personal request when the physician knows that his or hers is the only quote requested:

> However, when a form letter is sent through the mails requesting a medical doctor to bid against what could be a large group of the local medical society, several ethical questions are raised. The first question, in order of importance, is whether or not an

[62] The record does show that as late as 1974, the Judicial Council was distributing a model contract for emergency room physicians, approved by the House of Delegates, which required fees to "conform generally with those customarily charged in the locality and nearby localities for comparable services." (CX 868, 869A–D, 954C; *see also* CX 1155E, AMA's model partnership agreement for members of hospital medical staffs, which includes a parallel provision on usual and customary fees.)

affirmative response to such a general invitation to bid for use of the physician's professional services would be within keeping of the dignity of the medical profession? Secondly, a doctor would know by the type of request tendered to him that he probably is going to be competing against many of his associates for a specific contract or employment. Wouldn't this be a competitive force of so great a magnitude that it would cause a deterioration of the quality of the medical service rendered? . . . .

Thirdly, wouldn't such a request, if answered, make an inroad into the concept of professionalism in that it reduces the profession to a business? . . . . [40]

. . . [I]t is also my opinion that where the request lowers the dignity of the medical profession and causes or *reasonably* could cause a deterioration in medical service, then a bid in answer to such a request would be unethical. (CX 1158D) (Emphasis in original.)

This explanation leaves little room for doubt that the ban on "underbidding" has both the purpose and the intrinsic effect of suppressing competition even in the absence of formal enforcement efforts. As with the competitive bidding ban considered in *Professional Engineers,* "no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement." *Professional Engineers, supra,* 435 U.S. at 692; *see Texas State Bd. of Pub. Accountancy, supra,* 464 F. Supp. at 402. Again, the record is devoid of any procompetitive justification offered by respondent and we are aware of none. Thus, we are compelled to conclude that the restriction on bidding by physicians is an unreasonable restraint of trade and an unfair method of competition.

Respondent's 1971 edition of *Opinions and Reports* states that in a community where other competent physicians are readily available, a contract to deliver medical services is unethical unless there is a reasonable degree of free choice of physicians. (CX 462Z–13; *see also* 462L–N) This position, which also traces its origin to the House of Delegates' action of 1927, was reaffirmed in a Judicial Council decision of 1947 (CX 1435Z–57) and in a 1959 House of Delegates action. (RX 308 at 29) The 1932 Minority Report makes clear that the purpose of this provision is primarily the anticompetitive one of suppressing the activities of competitors, not solicitude for the rights of patients.[63] Given this background, it is logical to infer that the ethical restriction has had the effect of impairing competition from alternative providers in the medical service market by discouraging use of innovative arrangements that can deliver services at lower cost. In the absence of mitigating evidence of procompetitive effects, we find the restriction unreasonably restrictive of competition and an unfair method of competition. [41]

[63] Indeed, this restraint is but another way of accomplishing the objectives of the restriction on non-fee-for-service compensation.

2) Non-Fee-for-Service Compensation

AMA's support of the fee-for-service method of compensation is extensively documented in the record of this proceeding. The 1971 *Opinions and Reports* state that:

A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee. (CX 462Z–13; *see also* CX 462Z–14)[64]

While such a restriction does not have a direct impact on price, it clearly limits the ability of hospitals, prepaid health plans, and other lay organizations to dealing with physicians on the traditional basis of fee-for-service and precludes the use of salaries or other arrangements that may be more cost efficient. The purpose of this restriction is manifest: to retain for the physician the full profit generated by his or her services and to preclude competition by group health plans, hospitals and other organizations not directly under the control of physicians.[65] The record is replete with instances in which this restriction has been applied, including enforcement action taken after issuance of the complaint in Texas and Florida. (ID 219–21; *see also* [42] ID 212–18)[66] This evidence corroborates the anticompetitive nature of the restraint.

AMA argues generally that there has been a failure of proof with respect to the contract practice aspect of the case, yet it does not directly dispute the evidence referenced above. Indeed, AMA's emphasis on the 1977 position suggests that it all but concedes the illegality of earlier statements effective as of issuance of the

[64] This restriction was also published in AMA's 1974 *Report on Physician-Hospital Relations.* (CX 959Z–2, –64)

[65] Respondent's purpose is set forth with unusual clarity in the 1971 *Opinions and Reports:*

> There are insurance companies administering workmen's compensation benefits wherein the salaries or fees paid to the physician by the insurance company are so much below the legal fees on which the premium paid by the industry is based as to furnish a large direct profit to the insurance company. Certain hospitals are forbidding their staffs of physicians to charge fees for their professional services to 'house cases' but are themselves collecting such fees and absorbing them in hospital income. Some universities, by employing full-time hospital staffs and opening their doors to the general public, charging such fees for the professional care of the patients, as to net the university no small profit, are in direct and unethical competition with the profession at large and their own graduates. They are making a direct profit by a practice of questionable legality, from the professional care. (CX 462Z–13)

[66] In *American Medical Ass'n* v. *United States,* 130 F.2d 233 (1942), *aff'd,* 317 U.S. 519 (1943), the AMA and the Medical Society of the District of Columbia were convicted of a conspiracy to hinder and obstruct operations of Group Health Association, Inc. Group Health was a non-profit corporation organized by government employees to provide medical care and hospitalization on a risk-sharing prepayment basis, utilizing salaried physicians. In reinstating the indictment, the court of appeals noted that the conspiracy reflected AMA's long opposition to risk-sharing plans for medical service as well as the fear of its members of competition from doctors connected with such plans. *United States* v. *American Medical Ass'n,* 110 F.2d 703, 707 (D.C. Cir. 1940).

It is not clear from the reported opinions whether AMA's hostility toward Group Health was premised upon the fact that it employed physicians as opposed to general fears regarding competition posed by risk-sharing plans. Nevertheless, we think AMA's prior conviction is relevant background to the contract practice issues of this case and the evidence demonstrating continued opposition by the medical profession to alternative providers of medical care.

complaint. Respondent does point to the competitive vitality of Health Maintenance Organizations (HMOs) in general, arguing that a Staff Report to the Commission entitled, "The Health Maintenance Organization and Its Effects on Competition" (1977) demonstrates the commercial success of HMOs. Apart from the fact that the report was not admitted into evidence for the truth of its contents, (Tr. 7754) its conclusions have little relevance to this proceeding. That opposition to HMOs may have lessened over time does not negate the fact that the restrictions exist and have been enforced with anticompetitive effects. Moreover, complaint counsel's case with respect to the fee-for-service restriction is not limited to HMOs but includes evidence regarding group [43] health plans (CX 580), corporations (ID 213–14, CX 822–24), hospitals (ID 215–18), and a medical clinic (CX 814–15).[67]

Once again, in light of the anticompetitive character of the restraints and the absence of any countervailing justifications, we find that respondent's efforts to prevent the use of alternatives to the fee-for-service concept are unreasonable and constitute an unfair method of competition in violation of Section 5.

3) Arrangements between Physicians and Non-Physicians

Partnerships and similar relationships between physicians and non-physicians, which involve the sharing or splitting of professional fees, are unethical according to *The Principles of Medical Ethics* and the 1971 *Opinions and Reports.* (CX 1189A, 462Z–15, –16, 1153–54, 1196) The *Opinions and Reports* also state that physicians may form professional associations and professional corporations only if ownership and management of the affairs of the corporations remain in the hands of licensed physicians. (CX 462Z–15, –16) According to AMA, these provisions were designed to avoid problems that can occur when a non-physician partner or associate advocates medically unsound treatment which the physician is powerless to oppose. They are also ostensibly intended to prevent consumers from believing that the non-physician partner or associate has skills or training equal to that of the physician or that the physician is supervising all work when he or she is not.[68] [44]

[67] The AMA disclaims any involvement in the difficulties of the Florida Health Care Plan (FHCP). (RAB 8, 59) While direct action was taken against FHCP by the state and county medical societies, this action was premised upon AMA's ethical guidelines concerning contract practice for the profit of lay groups. (*See* CX 825, 2544, 2564–65, 2572E.) AMA's participation in state and local efforts to hinder operation of the FHCP is also seen in its transmittal of "anti-HMO" information to the county society. This material was provided in order to give the society and its members "all of the necessary information and 'ammunition' to rebut HMO activities in your area." (CX 2101A) Dr. Davis, the President of FHCP, interpreted AMA's offer of assistance to mean: "We don't like you and we are going to do all we can to destroy you." (Tr. 9219)

[68] AMA's Proposed Conclusions of Law at 139.

Complaint counsel's proof regarding these restrictions shows that they were enforced and that association with a non-physician can benefit doctors.[69] Admittedly, the competitive effects of these restrictions may not be as severe as some of the contractual restraints previously discussed. Nevertheless, the organizational impediments at issue here preclude on their face a wide variety of professional ventures by physicians that may involve some financial or other type of association with non-physicians (be they lay persons or other health care professionals). It is difficult to see how such sweeping ethical proscriptions are needed to prevent deception or to prevent non-physicians from having undue influence over medical procedures,[70] and, not surprisingly, respondent offers no satisfactory explanation. Moreover, these restrictions overlap to some extent with the restraints on non-fee-for-service forms of practices, since in both instances lay persons will derive financial benefits from their association with physicians. Indeed, the requirement that all corporations and associations be owned and managed by physicians could be used to prevent physicians from associating with many HMOs or prepaid health care plans, irrespective of quality or deception factors.

By keeping physicians from adopting what may be more economically efficient business formats in particular situations—as evidenced in part by the examples cited in the record—the restraints inevitably have an adverse effect on competition. Due then to the overbreadth of these restrictions and their inherent anticompetitive characteristics, we hold that they constitute unfair methods of competition under Section 5. [45]

III RELIEF

A. Abandonment

AMA maintains that the Commission should accord considerable weight to its voluntary abandonment of the positions outlined in the 1971 edition of *Opinions and Reports* and should judge respondent on the basis of its current positions contained in the 1977 edition of *Opinions and Reports,* relevant excerpts of which are set forth in Appendix A of this opinion. AMA does not assert that the case is

[69] Complaint Counsel's Proposed Findings at 256–59.

[70] In fact, of those provisions of the 1971 *Opinions and Reports* interpreting Section 6 of the *Principles of Medical Ethics,* only Opinion 6 (dealing with relationships between psychiatrists and psychologists) is specifically limited to the issue of allocating responsibility for matters involving professional judgment. That Opinion states that "[i]n relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist any matter requiring the exercise of professional medical judgment."

moot; instead, it argues that there is no cognizable danger of recurrent violation.

The record of this proceeding reveals, however, that at the time of issuance of the complaint in December 1975 (six months after *Goldfarb*), AMA's Judicial Council had only begun to review its ethical guidelines. Hence, abandonment took place, if at all, after commencement of this lawsuit. The limited, ambiguous steps undertaken by AMA subsequent to issuance of the complaint, ostensibly to bring its ethical code into conformity with the law, provide further justification for an order in this case. Far from assuring that the ethical restrictions found violative of Section 5 have been completely abandoned by respondent, the 1977 edition of *Opinions and Reports* is itself evidence that there is a perceptible risk of a recurrence of the practices adjudicated in this case.

We think AMA attaches unwarranted significance to the actions that it undertook prior to issuance of the complaint and apparently without knowledge of the Commission's investigation. Minutes of the Judicial Council meeting of September 12, 1975, almost three months after *Goldfarb* was decided, state that the Council considered the issue of advertising and solicitation to be "a matter which would require its continued attention and concern with the possibility of updating prior Opinions and Reports in the future to clarify the important ethical considerations involved." (CX 504C) The scope of this possible "updating" is indicated by other minutes of the meeting. These show that the Council continued at this time to consider solicitation and advertising by doctors to be improper. (CX 504A, C) And, according to its Secretary, the Judicial Council felt at its September meeting that a major revision of the profession's position on advertising was unnecessary and inadvisable. (RX 627(a), (b))[71] **[46]**

The Judicial Council was no more specific with regard to its plans at the time of its meeting of November 29 and 30, 1975. The minutes reveal that the Judicial Council decided to prepare an updated report on advertising for the upcoming Annual Convention "indicating the profession's responsibility to the public to circumvent deceptive trade practices by reasonable restrictions and the importance of state statutes in this area." (CX 503I) While this minute indicates that the Judicial Council intended the updated report to focus on deception, another minute reports that the Council's

[71] With respect to community professional directories, prepaid health plans, and HMOs, Mr. Nortell noted that "certain information may be disseminated, if it is not used in a self-aggrandizing manner or to make qualitative judgment about physicians." (RX 627(a)) He also referred to letters printed in the *ABA Journal* emphasizing "the anticompetitive impact that advertising could have on a profession as well as the difficulty of distinguishing between deceptive and nondeceptive advertising." (RX 627(b))

restrictive Guidelines on Telephone Directory Listings were transmitted to an official of the Hartford County Medical Association.[72]

All we can learn from the record, therefore, is that prior to issuance of the complaint, the Judicial Council was sensitive to legal questions regarding professional advertising and solicitation but had formed no clear idea, nor analyzed in any detail, the extent to which existing guidelines should be modified. Thus, the first official statement of AMA's post-*Goldfarb* position on advertising and solicitation is found in the Statement of the Judicial Council on Advertising and Solicitation, ("Statement"), which was discussed and approved by the Council at its meeting of April 9, 1976, nearly four months after initiation of this proceeding. The minutes of this meeting make clear that the Council did not consider the Statement to be a departure from past position.[73] [47]

Before examining the precise language of the 1977 edition, it is instructive to point out that respondent has not modified the *Principles of Medical Ethics* at all since their adoption in 1957. Section 4 of the *Principles* continues to state that "[p]hysicians should . . . uphold the dignity and honor of the profession and accept its self-imposed disciplines." (RX 1, p.4) Section 5 still cautions that physicians "should not solicit patients." (RX 1, p.5) Since these statements have been the subject of extensive AMA explication in the past, they carry important connotations in a medical ethics context. For example, the 1971 edition of *Opinions and Reports* sets forth what the "dignity . . . of the profession" mandates with respect to advertising:

> Respecting the dignity of their calling, physicians should resort only to the most limited form of advertising and then only to the extent necessary to serve the common good and improve the health of mankind.[74]

[48] This statement has been repeated without modification since 1955. (CX 463R, 464R, 465R, 466V, 467Z–3) Hence, republication of the unchanged *Principles* inherently meant that anything more than

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[72] (CX 503H) The Guidelines on Telephone Directory Listings apparently were not superceded by the 1976 Statement on Advertising and Solicitation since the Judicial Council authorized its Secretary to send both documents in response to a telephone listing inquiry. (CX 501D)

[73] The minutes state that "the Council unanimously voted to issue a statement to reaffirm the long-standing policy of the Judicial Council on Advertising and solicitation by physicians. . . ." (CX 502A) At its June 26, 1976 meeting, the Judicial Council approved a new edition of *Opinions and Reports*, incorporating the Statement. (CX 501F) Up until that point, the Judicial Council was apparently still distributing copies of the 1971 edition. (Tr. 4361) The new edition was published in March 1977. (Tr. 4335)

[74] The 1971 edition also uses the words "dignity," "dignified," or "honor" in connection with physician announcements, open houses, and statements of professional qualifications. (CX 462Z–6, –7, –9) With respect to the use of signs, the 1971 edition states that "the physician . . . and his component society should fully observe the precept of the Principles: "A physician is expected to uphold the dignity and honor of his vocation." (CX 462Z–10) "Professional dignity" is also used in the context of purveyal of medical services to the direct profit of lay organizations. (CX 462Z–13) Similar references are sprinkled throughout the 1958, 1960, 1964, 1965, and 1966 editions of *Opinions and Reports* (CX [illegible])

the "most limited form of advertising" was contrary to professional dignity.[75] [49]

AMA asserts that the Judicial Council's 1977 *Opinions and Reports* reflect a reinterpretation of the *Principles.* However, respondent has never unequivocally indicated to its members that the purportedly "archaic" interpretations of the *Principles* contained in the 1971 *Opinions and Reports* have been superceded or rescinded.[76] (ID 230–31) The preface to the 1977 edition did note that some items in past editions of *Opinions and Reports* were withdrawn "because they did not adequately reflect current conditions of medical practice or legal requirements." (RX 1, p.1) But those items found to be inconsistent with prevailing legal requirements were never specified. Such vagueness stands in stark contrast to past occasions in which AMA specifically notified its members that it was toughening its stance on advertising. (CX 463P, 465P) More importantly, the 1977 edition expressly "reaffirms the long-standing policy of the Judicial Council on advertising and solicitation by physicians." (App.A, p.1) Such a statement implicitly invites members of the AMA and its constituent and component societies to retain and to rely upon the more detailed ethical pronouncements included in the 1971 edition.[77] Likewise, AMA's characterization of the 1977 edition as an "updating" of the *Opinions and Reports* is susceptible to the interpretation

[75] The term "solicit" also comes encumbered with meaning acquired over the years. Based on a 1957 opinion, the 1958 and 1960 editions take an approach to advertising and solicitation remarkably similar to the approach taken in the 1977 edition:

The Principles of Medical Ethics do not proscribe advertising as such; they proscribe the solicitation of patients. Advertising, in its broad sense, means the act of making information, fact, or intention known to the public. Solicitation, as used in the Principles, means the attempt to obtain patients by persuasion or influence. Advertising, as distinguished from solicitation, is not in itself unethical. (CX 466W, 467Z–4, App. A, p. 1)

However, this statement was expressly superceded in the 1964 edition which states:

The Principles of Medical Ethics proscribe the solicitation of patients or patronage. Solicitation, as used in the Principles, means the attempt to obtain patients or patronage by persuasion or influence. However, the public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours and the like. The doctor may ethically furnish this information through the accepted local media of communication, which are open to all physicians on like condition. Telephone listings, office signs, professional cards, dignified announcements, all are acceptable media of making factual information available to the public. The particular use to be made of any medium of communication and the extent of that use are, however, matters to be determined according to local ideals. What constitutes an excess, what is not in keeping with the ideals of medicine and what amounts to solicitation are questions of fact. The application of this principle is to be made locally. (CX 465P, Q)

The latter position, in which solicitation swallows up any prior distinction with advertising, was repeated in the 1966 and 1971 editions. (CX 464P, 463P, 462Z–6) AMA's resurrection of the 1955 opinion thus suggests that, despite some semantic variations, nothing has really changed.

[76] To withdraw from a conspiracy one must take affirmative action to disavow or defeat the purpose of the conspiracy. *Hyde* v. *United States,* 225 U.S. 347, 369 (1912). *See also United States* v. *Parke, Davis & Co.,* 362 U.S. 29, 47–48 (1960). ("It does not appear even that Parke Davis has announced to the trade that it will abandon the practices we have condemned.")

[77] AMA's assertion in a caveat to the 1977 edition that distribution of the previous edition of *Opinions and Reports* had been suspended is not equivalent to a rescission of the earlier edition. A reasonable construction of this announcement is that additional copies of the earlier edition were no longer available. Had AMA wished to advise its members not to rely upon copies of the 1971 edition in their possession, a straightforward, cautionary statement to this effect would have been simple to make.

that additional guidelines have been included only to address new issues of medical ethics, and that most existing precepts retain their currency. (RX 4, p.52)

Exegesis of AMA's 1977 *Opinions and Reports* reveals an important discrepancy between these guidelines and the position of AMA described at oral argument, a discrepancy that brings into sharp focus the extent to which AMA has attempted to comply with the law.[78] Counsel for respondent [50] stated that the 1977 edition would permit physicians to advertise in newspapers the price of routine services. (TROA 8) A physician would have great difficulty, in our view, reaching the same conclusion from a reading of the 1977 edition. That publication mentions fee advertising only in the context of a "reputable directory." (App. A, p.1) Fee information might be included within the class of "other useful information that the public is entitled to know." However, "other useful information" is to be furnished through the "accepted local media," which includes "office signs, professional cards, dignified announcements, telephone directory listings and reputable directories." (App. A, p.1) Newspapers are notably omitted from this enumeration. Since the 1977 edition was published eight months before the Supreme Court decision in *Bates, supra,* 433 U.S. 350, we cannot fault respondent for failing to anticipate the disposition of that case.[79] Nevertheless, AMA's professed "good faith" efforts to comply with the developing law in the area of professional restraints must be measured against the fact that its position on physician advertising has not changed to any significant degree.

Further examination of the 1977 *Opinions and Reports* in light of the 1971 edition demonstrates the extent to which physician advertising and solicitation continues to be circumscribed by AMA. As noted earlier, the *Principles* continue to proscribe, without exception, any solicitation of patients. However, the meaning of "solicitation" has been narrowed somewhat. "Solicitation" is defined in the 1971 *Opinions and Reports* as an "attempt to obtain patients or patronage by persuasion or influence," and it is clear that

[78] Counsel for AMA conceded that there were "problems" with the 1977 edition and that "it could have been phrased differently." (TROA 26)

[79] In defending the reasonableness of its advertising and solicitation revisions, AMA claims that the Court in *Bates* cited with approval AMA's new advertising code. To be sure, the Court in that case contrasted the restrictions imposed by the State Bar of Arizona with those adopted by respondent, observing that "it appears that even the medical profession now views the alleged adverse effect of advertising in a somewhat different light from the appellee." 433 U.S. at 369, n. 20. It is obvious, however, that the Court was simply illustrating, by way of comparison, the extremely rigid position of the Arizona Bar. Clearly, the Court was not attempting to pass judgment on the constitutional or antitrust merits of respondent's advertising restrictions.

traditional advertising as well as personal solicitation of patients is prohibited by that language.[80] By contrast, the 1977 edition redefines "solicitation" in terms of statements or claims that: [51]

> (1) contain testimonials,
> (2) are intended or likely to create inflated or unjustified expectations of favorable results,
> (3) are self-laudatory and imply that the physician has skills superior to other physicians engaged in his field or specialty of practice, or
> (4) contain incorrect or incomplete facts, or representations or implications that are likely to cause the average person to misunderstand or be deceived. (App. A, p.2)

"Advertising," although never fully defined, is technically permitted under the new guidelines, and "solicitation," which is defined to cover various forms of advertising, including any self-laudatory claims as well as deceptive representations, is forbidden.

Since all advertising is to some degree self-laudatory, the 1977 edition suggests that beneath respondent's rhetoric, ethical precepts with respect to advertising haven't changed very much. This view finds support in AMA's argument to the Commission.[81] Respondent's counsel defended the ban on self-laudatory and superiority claims on grounds that such claims convey no useful information and can only be misleading, since they are not susceptible to any kind of measurement. (TROA 22–23) This characterization of claims as misleading on the basis of their utility to consumers or ease of measurement illustrates the potential scope of respondent's ban on "solicitation."

Similarly, the 1977 edition ban on superiority claims could have far-reaching implications. Such a ban proscribes all forms of comparative advertising, no matter how truthful. More importantly, because any advertisement of a doctor's skills or experience may imply superiority, the 1977 edition confirms that AMA wishes to interdict a vast spectrum of advertising practices based on its view that such practices are inherently deceptive.

The overbreadth with respect to other claims encompassed by the "solicitation" definition exacerbates the difficulty of discerning

[80] The 1971 edition states:

> Solicitation of patients, directly or indirectly, by a physician, or by groups of physicians, is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. (CX 462Z–5; *see also* CX 778A)

[81] It should also be noted that the Judicial Council's 1974 Report on Community Professional Directories, which is still in effect (Tr. 3998), states that directory listings shall not include any "self-aggrandizing statement." (RX 5)

precisely what representations, if any, will be tolerated under the new rules. The first category makes clear that any and all testimonials regarding physician services are inherently misleading. (TROA 24) Clearly, a testimonial pertaining to medical care could well present the potential for deception if, for example, the experience of the endorser did not represent the typical experience of other patients, or if, due to the infrequency and complexity of such care, results could not be predicted with any degree of accuracy in other cases. However, AMA's ban would also cover nondeceptive testimonials. For example, testimonials directed toward aspects [52] of a physician's practice other than quality or efficacy, such as accessibility or courteous service, would be prohibited.[82]

The phrase "incomplete facts" is also troublesome. Such facts must be supplemented in order to prevent a claim from being considered "solicitation." Inasmuch as there is no requirement that these facts be material to a patient's decision to utilize a physician's services, or that the absence of such facts would be deceptive, the spectre of lengthy, burdensome disclosures is raised for any doctor who contemplates advertising. Indeed, the danger here is enhanced by the apparent overlap of claims identified by the second and fourth categories. Finally, we note that the fourth category implies that representations directed to a sophisticated group of consumers might nonetheless be unethical if "they are likely to cause the average person to misunderstand or be deceived." This overbreadth is worrisome in view of the fact that AMA and its local societies have taken action to restrict physician advertising to other physicians or otherwise sophisticated recipients. (ID 146–47)

The Judicial Council's discussion of medical directories represents a marked improvement over the 1971 edition.[83] Unfortunately, respondent has imposed new and unnecessary conditions upon the use of such directories. Fee information may not be included in a directory unless "disclosure is made of the variable and other pertinent factors affecting the amount of the fee specified." Again, the ambiguity concerning what will be considered "pertinent factors" at the local level could lead to the imposition of onerous disclosure requirements or chill the exercise of individual discretion.

The uncertainty of the 1977 edition with respect to advertising and

[82] The Commission has issued Guides Concerning Use of Endorsements and Testimonials in Advertising, 16 C.F.R. 255 (1979).

[83] App. A, p.1. The 1971 *Opinions and Reports* stated:

> Most, if not all, listings of physicians by specialty in directories published by commercial concerns, are but subtle ways of avoiding the pronouncement of the Principles of Medical Ethics concerning solicitation . . . . A physician who uses or permits the use of his name in a commercial directory that fails to include on like terms and without discrimination the names of all licensed physicians practicing in the area served by the directory has the burden of proving that his action is in keeping with the Principles. (CX 462Z–8)

solicitation is compounded by the statement that "[l]ocal, state, or specialty medical associations, as autonomous organizations, may have ethical restrictions on advertising, solicitation of patients, or other professional conduct of physicians that exceed the Principles of Medical Ethics." (App. A, p.1) Thus the extremely limited guidance [53] conveyed by the 1977 edition regarding permissible advertising is subject to the caveat that such advertising could nevertheless lead to disciplinary action if it offends local custom or usage. Moreover, this statement creates another clear link with the 1971 edition. That document placed substantial emphasis upon local custom and usage with respect to permissible communications media, announcements, signs, and open houses. (CX 462Z–7, –8, –9, –10) Given this background, the Judicial Council's reaffirmation of AMA's long-standing policy on advertising and solicitation, (App. A, p.1) and the strong inference that local societies cannot have less restrictive ethical guidelines, it is inevitable that many physicians will be deterred from advertising, whether or not local societies take any specific action in this area.

Respondent's negative attitude toward physician advertising is confirmed by other segments of the 1977 edition. Physicians, as distinguished from commercial enterprises, are not free to engage in advertising "puffery" or to be "baldly self-laudatory" in making superiority claims. (App. A, p.2) And they are permitted to have their photographs published only in connection with a meeting of a recognized medical organization, when elected to office, or when quoted by name on matters of general interest, not related to care of a specific patient. (RX 1, p. 35) "Photographs of physicians in connection with social or civic affairs, not related to medical news or the care of patients, may be published unless the frequency of such photographs bespeaks self-exploitation." *Id.* Another section, entitled "Advertising, Solicitation, and HMOs," states that HMO or prepaid health care plan advertising may not identify any particular physician unless the entire roster of physicians is disclosed. (App. A, p.3) Respondent explains that this restriction is necessary to prevent patients from believing that the physician would be routinely available to all subscribers when this is not the fact. However, AMA does not explain why a simple disclaimer regarding the limited availability of named physicians would not suffice.[84]

We do not mean to imply that precise guidance regarding what claims are false and deceptive is feasible for all kinds of physician advertising. The facts and circumstances of each representation will

[84] AMA also defends this language by citation to the language contained in 42 U.S.C. 360e–10(b) (1976). However, that section pertains to state laws and does not immunize private restrictions on advertising by HMOs.

ultimately be determinative. Moreover, what may be false and deceptive for doctors may be permissible for sellers of other products and services. Harmless puffery for a household product may be deceptive in a medical context. But a doctor would have great difficulty distinguishing between innocuous representations and an abridgement of ethical norms. AMA provides no assistance whatsoever in making this distinction, and its studied ambiguity overall is likely, in our view, to deter truthful ads unnecessarily. [54]

The equivocal language of the 1976 Statement and its often antagonistic tone toward advertising and solicitation, taken together with AMA's decision not to amend the *Principles of Medical Ethics,* has sent a clear signal to the medical profession. It is hardly surprising that many constituent and component societies continued to rely upon the 1971 *Opinions and Reports* even after issuance of the 1976 Statement. (ID 227–28) Indeed, there is evidence that AMA's own officials failed to comprehend the alleged change of position urged upon respondent's counsel. The Chairman of AMA's Board of Trustees testified that it is AMA's position that advertising must be tasteful as well as factually correct. (Tr. 9660–61) A member of the House of Delegates testified that a clinic could be disciplined for advertising the services it performs because it is soliciting business and subject to misinterpretation by the patient. (Tr. 9718)

With respect to the contract practice aspect of this case, AMA argues that the "archaic" statements in the 1971 edition of *Opinions and Reports* have either been voluntarily eliminated or substantially revised in the 1977 edition. The Commission recognizes that the discussion of contractual relationships and free choice contained in the 1977 *Opinions and Reports* represents a significant improvement over earlier versions. (App.A, pp.2, 3)[85] For example, the 1977 edition makes clear that "free choice" is not intended to preclude the use of alternative health care delivery systems, including closed panel systems, that limit the patient's choice to those physicians employed by those kinds of plans. (App. A, p.3) However, by contrast to the AMA's position on advertising and solicitation, there is no evidence that AMA or its Judicial Council even reviewed its position on contract practice issues prior to issuance of the complaint. Indeed, counsel for AMA stated in January 1977 that respondent's current

[85] The 1977 edition provides that physicians working for prepaid plans "should not be subjected to lay interference on professional matters . . . ." (App.A, p.3) This represents a laudable change from the 1971 edition, which forbade employment with prepaid plans altogether and required that ownership and management of professional associations and corporations remain in the the hands of licensed physicians. (CX 462Z–15, –16) Nevertheless, the sweep of AMA's past ethical pronouncements creates some uncertainty regarding the scope of "professional matters" under the new guidelines.

policies on contract practice are "best reflected . . . in the 1974 *Report on Physician-Hospital Relations.*"[86] Like the 1971 edition of *Opinions and Reports,* the 1974 *Report on Physician-Hospital Relations* has never been expressly rescinded. Nor has the AMA communicated to its members its current belief that this document contains positions which are now obsolete. [55]

On balance, we are persuaded that the overwhelming weight of the record evidence contradicts respondent's abandonment argument. Further supplementing this evidence is the law judge's decision to render adverse findings against AMA based upon its refusal to comply with a duly authorized subpoena *duces tecum.*[87] AMA's contention that the Commission lacks authority to make adverse findings pursuant to Section 3.38(b)(1) of the Commission's Rules of Practice is without merit. The adverse inference rule has a solid foundation in the common law,[88] is part of the Federal Rules of Civil Procedure,[89] and has been applied in the context of administrative proceedings.[90] The cases cited by respondent deal not with adverse findings but rather with the Commission's authority to seek penalties for noncompliance of compulsory process. Those decisions are inapposite here.

Application of the adverse inference rule may only be made when the party's failure to produce documentary or other evidence is not adequately explained. *Evis Mfg. Co.* v. *FTC,* 287 F.2d 831, 847 (9th Cir. 1961); *cert. denied,* 368 U.S. 824 (1961). Thus, the adverse inference rule makes the conduct of the person withholding the material an evidentiary fact in and of itself. The resulting inference may be strong or weak, depending on the person's conduct and the surrounding circumstances. *See* 2 J. Wigmore, *Evidence* §285 (3d ed. 1940); *McCormick's Handbook of the Law of Evidence* §272 at 659 (2d ed. 1972). For example, an inference drawn against a respondent offering a weak explanation for its refusal to produce relevant evidence will be stronger than an inference drawn against a respondent providing a more plausible explanation.

It is necessary, therefore, to evaluate respondent's contention that its failure to comply with the administrative subpoena was based

[86] Motion to Certify to the Commission the Motion of Respondent American Medical Association to Reconsider Issuance of the Complaint in this Docket at 6-7 (Jan. 14, 1977).

[87] The ALJ found that:

> AMA's conduct with respect to the formal and informal promulgation, distribution and enforcement of the "Principles of Medical Ethics," established by the record as existing prior to 1975, continued thereafter.

Order Ruling on Complaint Counsel's Motion for Adverse Rulings and Other Relief Due to Noncompliance with Subpoena *Duces Tecum* by Respondent the American Medical Association at 10 (Feb. 25, 1977).

[88] *Armory* v. *Delamirie,* 1 Str. 505 (K.B. 1722); 2 J. Wigmore, *Evidence* §285 (3d ed. 1940).

[89] Fed. R. Civ. P. 37(b)(2)(A).

[90] *International Union (UAW)* v. *NLRB,* 459 F.2d 1329, 1338-39 (D.C. Cir. 1972); *Charles of the Ritz Dist. Corp.* v. *FTC,* 143 F.2d 676, 679 (2d Cir. 1944).

upon a "good-faith" attempt to establish a pre-trial test of the jurisdictional issue in this case. [56] The weight of case precedent supports the view that the Commission's jurisdiction should be judicially reviewed only after agency action has been completed and not in a subpoena enforcement action. *E.g., Oklahoma Press Publishing Co.* v. *Walling,* 327 U.S. 186, 211-14 (1946); *FTC* v. *Markin,* 532 F.2d 541 (6th Cir. 1976). The only decision cited by AMA in support of its asserted right to raise the jurisdictional question in the enforcement proceedings is *FTC* v. *Miller,* 549 F.2d 452 (7th Cir. 1977). That case suggests the following exceptions to the *Oklahoma Press* rule:

(1) where the agency has clearly violated a right secured by statute or agency regulation;
(2) where the issue involved is a strictly legal one not involving the agency's expertise or any factual determinations; or
(3) where the issue cannot be raised upon judicial review of a later order of the agency. *Id.* at 460.

Respondent does not disclose the exception upon which it would have relied, but it is clear to us that AMA would have had considerable difficulty relying upon any of these exceptions. First, because the status of AMA is unclear on the facts, it could not establish that the Commission had clearly violated its alleged right to be immune from FTC proceedings. Second, the jurisdictional issue—whether AMA is organized to carry on business for its own profit or that of its members—is not a strictly legal issue but one requiring a factual determination for its resolution. Finally, the Commission's jurisdiction to enter an order against AMA is an issue that may be raised upon judicial review of any such order, as it has been raised in AMA's appeal to the Commission from the initial decision.

Since it therefore seems likely that AMA's contemplated challenge on jurisdictional grounds to enforcement of the subpoena would have failed, respondent's refusal to comply with the subpoena is not sufficiently explained. It is noteworthy that AMA complied with every other subpoena issued in this proceeding save the one directed at its principal defense. In view of this fact and the absence of a strong explanation for noncompliance, we think the most plausible reason for AMA's refusal is that the evidence sought would have been unfavorable to its cause. Accordingly, we believe the law judge properly exercised his discretion under Rule 3.38(b)(1).[91] [57]

The Commission concludes, therefore, that there is no evidence

[91] Whether the inference standing alone would be sufficient to rebut AMA's abandonment claim is an issue we need not decide. Suffice it to say, the inference drawn here is consistent with other evidence, such as AMA's 1977 *Opinions and Reports,* which independently supports the need for a cease and desist order.

that AMA clearly and effectively abandoned the practices at issue here prior to commencement of this proceeding. We also reject AMA's contention that publication of the 1977 *Opinions and Reports* after issuance of the complaint demonstrates that there is no cognizable danger of recurrent violation. Abandonment of illegal practices during trial does not diminish the Commission's discretion to enter an appropriate cease and desist order. *See United States* v. *Parke, Davis & Co.*, 362 U.S. 29, 47–48 (1960); *Giant Food, Inc.* v. *FTC*, 322 F.2d 977, 987 (D.C. Cir. 1963); *Spencer Gifts* v. *FTC*, 302, F.2d 267 (3d Cir. 1962). That is particularly true where the purported abandonment consists of equivocal statements and efforts to reinterpret central principles in a manner contrary to their commonsense and historical meaning, suggesting that the practices, if abandoned at all, may be resumed. [58]

B. Order

The ALJ issued an order which, *inter alia,* prevents respondents from policing the advertising and solicitation activities of their members for a period of two years. At the end of that period, respondents may formulate, adopt and disseminate ethical guidelines governing advertising and solicitation only if these guidelines have been approved by the Commission. Complaint counsel supports this order, contending that the medical atmosphere with respect to advertising is so inflamed at present that a two-year cooling-off period is warranted. (TROA 61–62) AMA argues that the government should not preclude it from dealing with the difficult problem of deception in medical advertising because, as a professional society, AMA has a responsibility to regulate deceptive practices by its members. (RAB 70; TROA 15–16) AMA further argues that the provision requiring the AMA to obtain prior Commission approval before publishing ethical standards on advertising or solicitation constitutes a prior restraint on speech that is beyond the authority of the Commission. (RAB 72–80)[92]

We have modified the order issued by the ALJ in light of our conviction that the AMA has a valuable and unique role to play with respect to deceptive advertising and oppressive forms of solicitation by physicians. As modified, the order will permit AMA to adopt and enforce reasonable ethical guidelines concerning advertising that is false or deceptive within the meaning of Section 5. In view of the

[92] Counsel for AMA observed at oral argument that "[i]f Hippocrates were alive today, he would have to come here to get your stamp of approval before he wrote the Hippocratic Oath." (TROA 13) We hasten to point out that the Oath of Hippocrates contains no provision dealing with advertising or solicitation. (RX 1, p. 51) Indeed, Thomas Percival's *Medical Ethics,* upon which AMA's first *Code of Ethics* was based (RX 1, p. 2), contains no mention of advertising or solicitation. *Percival, supra.*

potential overreaching that may occur in the absence of professional regulation, the order will also permit AMA to disseminate guidelines proscribing uninvited, in-person solicitation of actual or potential patients, who, because of their particular circumstance, are vulnerable to undue influence. *See Ohralik* v. *Ohio State Bar Ass'n,* 436 U.S. 447 (1978).[93] [59]

The Commission recognizes that the deception standard incorporated into the order does not delineate with absolute precision the latitude which we have given AMA to prescribe new ethical restrictions. If the Commission were capable of such precision, it could draft the new guidelines itself and exclude AMA from any role in their formulation. We are persuaded, however, that AMA is capable of applying general principles of deceptive advertising law in a medical context taking into account the substantial body of law construing Section 5 of the FTC Act. Additionally, our analysis of AMA's 1971 and 1977 *Opinions and Reports* provides considerable guidance regarding the deficiences of past pronouncements. Moreover, pursuant to Section 3.61(d) of the Commission's Rules of Practice, the Commission will be available upon request to provide advice as to whether a proposed course of action, if pursued by respondent, will constitute compliance with the order. *See FTC* v. *Colgate-Palmolive Co.,* 380 U.S. 374, 394 (1965).

We cannot emphasize too strongly that AMA's discretion with respect to solicitation and advertising is limited to "reasonable" ethical guidelines. The list of particular items of information helpful to consumers in choosing a physician, set forth in the Initial Decision (ID 110–11), is illustrative of the kind of information which should be permitted in most cases without additional qualification. It is especially important that price advertising remain as unfettered as possible. Where ads merely state the price of medical services, particularly services that are routine or fairly well standardized, there is little need for restrictions to prevent deception. Where restrictions, such as affirmative disclosures, are justified, they should be reasonably related to the goal of preventing deception. Across-the-board bans on entire categories of representations or general restrictions applicable to any representation made through a specific medium are highly suspect.

At the same time, the order permits AMA to deal effectively with all forms of deceptive advertising, including unsubstantiated representations, affirmative misrepresentations (express or implied), and

[93] We fail to perceive any comparable danger of harassment or duress with respect to solicitation which occurs via written communication or other media. *Contra, Adler, Barish, Daniels, Levin & Creskoff* v. *Epstein,* 393 A.2d 1175 (Pa. 1978), *appeal dismissed and cert. denied,* 99 S. Ct. 2817 (1979).

representations that are deceptive for failure to disclose a material fact. The FTC has held under Section 5, for example, that if health claims are not intended to embrace all interpretations reasonably attributable to them, then they must be specifically limited by express qualifying language. *Grove Laboratories, Inc.*, 71 F.T.C. 822, 835 (1967).[94] **[60]**

The Commission's order allows the AMA no discretion with respect to unfairness other than the authority already mentioned with respect to solicitation. The history of this proceeding, and in particular AMA's 1977 *Opinions and Reports,* underlines the danger of permitting the medical profession broad discretion to proscribe unfair practices. In the event AMA is able to define with specificity unfair acts or practices that should be addressed in ethical guidelines, it may petition the Commission for modification of the order pursuant to Section 3.72(b)(2) of the Commission's Rules of Practice. *See Professional Engineers, supra,* 435 U.S. at 699.

Moreover, in the event that AMA (or a constituent or component society) becomes concerned with an advertising or solicitation practice which is beyond the scope of its power under the terms of the Commission's order, but which the association believes presents a threat to the public, it is of course not entirely without recourse. As we noted earlier, the states are well-equipped to respond to abuses through their medical licensing boards (I.D. 310–12), and the order does not prevent AMA from referring serious incidents to these public authorities when necessary.

We have also included a requirement that AMA afford any member charged with a violation of ethical standards promulgated in conformity with this order due notice and an opportunity for a hearing. *Silver* v. *New York Stock Exchange,* 262 U.S. 341, 361–63 (1963). In fact, this kind of requirement was suggested by AMA as an alternative to the prior approval provision in the ALJ's order, should the Commission issue an order allowing respondent to regulate deceptive advertising. This provision is intended to give members a reasonable chance to contest the charges, including adequate time to prepare and present evidence in their behalf.

The Commission believes that a disaffiliation provision patterned after a similar provision in the ALJ's order is essential to prevent recurrence of the practices documented by the record in this proceeding.[95] AMA's claim that it does not have the power to

[94] We also note that an ad's capacity for deception under Section 5 must be judged in light of the understanding and the corresponding potential for misunderstanding of the audience to which the ad is directed. *ITT Continental Baking Co., Inc.* v. *FTC,* 532 F.2d 207 (2d Cir. 1976); *Aronberg* v. *FTC,* 132 F.2d 165, 167–68 (7th Cir. 1942); *Travel King, Inc.*, 86 F.T.C. 715, 773 (1975).

[95] As modified, the order affords AMA 120 days to determine whether a constituent or component organization

(Continued)

disaffiliate state and local medical societies is without merit. The House of Delegates adopted a resolution in 1855 asserting that no state or local society that had not adopted the *Code of Ethics* would be entitled to representation in AMA. (CX 1435Z–15, –16) [61] In addition, an AMA official has rendered an opinion indicating that there is no legal impediment to a bylaw provision permitting expulsion of a state association under certain circumstances. (CX 1958A, B) The legal arguments in opposition to the disaffiliation provision are equally unconvincing. Similar provisions were imposed in *Professional Engineers, supra*,[96] and in *National Housewares Inc.*, 90 F.T.C. 512 (1977).

We agree with counsel for the Connecticut respondents (TROA 107) that the inclusion of a disaffiliation provision with respect to AMA renders it unnecessary to bind CSMS and NHCMA to a similar order in order to obtain effective relief. Accordingly, the Commission exercises its discretion to omit respondents CSMS and NHCMA from the cease and desist order.

We have modified those order provisions dealing with the contract practice aspects of this case in order to focus more precisely on the restrictions substantiated by the record in this proceeding. With respect to the restrictions relating to underbidding, the adequacy of fees, or compensation on a basis other than the traditional fee-for-service norm, the order prohibits AMA from interfering in any way with the consideration received by physicians in exchange for their services. The order also includes specific prohibitions on ethical pronouncements or representations addressing the propriety of closed panel or other limited choice arrangements as well as physician arrangements with non-physicians.

Finally, we have included in the order a requirement that for five years AMA maintain records sufficient to describe any action taken with respect to conduct covered by the order and provide the Commission with an annual report of such activities. [62]

IV POST-ARGUMENT MOTIONS

A. Motion to Dismiss

In a motion filed subsequent to the oral argument in this case, AMA urges the Commission to dismiss the proceeding on account of

must be disaffiliated. This interval should be sufficient in most cases to evaluate the facts and circumstances surrounding the conduct considered contrary to Part I, II or III of the Order. Again the Commission is available to advise AMA pursuant to Rule 3.61(d) and will consider a request for tolling of the 120 day period where appropriate.

[96] The district court's unreported order is found in the Appendix to Complaint Counsel's Post-Trial Reply Brief, filed August 25, 1978. The disaffiliation provisions of this order were not modified by the court of appeals or by the Supreme Court.

the Commission's acceptance of a consent agreement in *American Dental Association et al. (ADA),* Docket No. 9093.[97] The consent agreement provides that, upon entry of a final adjudicated order in the *AMA* case, the Commission would issue an order against the *ADA* respondents incorporating the relevant provisions of the *AMA* order conformed so as to be applicable to the *ADA* respondents. It also provides that the *ADA* complaint will be dismissed in the event that the final adjudicated order in the *AMA* case results in a dismissal of the complaint on the merits or for lack of jurisdiction. Prior to final resolution of the *AMA* case, the agreement provides interim relief concerning the dental associations' ethical restrictions on advertising and solicitation.

AMA contends that the consent agreement deprives it of a fair proceeding because the existence of the agreement will influence the Commission, preventing it from basing its decision in this case on the facts of record. AMA further believes that the existence of both cases demonstrates the Commission's concern with announcing a general policy on the role of dental and medical societies with respect to advertising and solicitation, and that rulemaking rather than adjudication should be used to announce such a policy.

The mere fact that respondents in the *ADA* matter have reached a settlement with the Commission in which they agree to be bound by the disposition of issues here does not mean that the Commission will abandon its responsibility to decide this case on the record of this proceeding. A similar issue arose in *American Home Products Corporation* v. *FTC,* 420 F.2d 232 (6th Cir. 1968) Respondent there complained that the Commission deprived it of a fair hearing by allowing other sellers of the same type of product to stipulate that their cases should be decided on the basis of the record in respondent's case. The court of appeals held that this [63] assertion of unfairness was unfounded and that the respondent had not been prejudiced by the procedure. *Id.* at 238.[98]

The Commission does not find persuasive AMA's assertion that rulemaking rather than adjudication is required here. Rulemaking is not required simply because the Commission has reason to believe that more than one party has engaged in similar or identical violations of §5 of the Federal Trade Commission Act. The choice

[97] By motion filed on June 18, 1979, CSMS and NHCMA joined in AMA's motion.

[98] It is not unusual for respondents to agree to a consent order that contains provisions that relate to some occurrence outside that case, including provisions that are contingent on the disposition of other litigated matters. *See, e.g., International Paper Company,* 84 F.T.C. 9, 14 (1974) (consent order provides that if a final order is entered against other companies or if the complaint against them is dismissed, settling parties have the option to accept such order as dismissed in lieu of consent order); *Ford Motor Company,* Docket No. 9073 (Decision and Order, March 29, 1979) [93 F.T.C. 402] (consent order provides that if related cases result in adjudicated or consent orders with less restrictive standards, settling parties may petition for conforming modification of order).

between rulemaking and adjudication lies primarily in the informed discretion of the agency. *See NLRB* v. *Bell Aerospace Company,* 416 U.S. 267, 294 (1974); *SEC* v. *Chenery Corporation,* 332 U.S. 194, 202–203 (1947).

Accordingly, respondents' motion to dismiss the proceeding is denied. [64]

B. Connecticut Respondents' Motion To Reopen and Supplement the Record

Respondents CSMS and NHCMA move that the record in this proceeding be reopened to admit into evidence an article printed in the *Waterbury Sunday American* on April 29, 1979, entitled: "Doctor's Methods Stir Controversy." The article relates to Dr. Leon Zucker, a witness for complaint counsel, describes his opthalmology practice, and quotes his patients as well as various physicians familiar with him or the medical techniques he utilizes. Two of the sources quoted in the article, Drs. Jerome Freedman and David W. Parke, filed the complaints regarding Dr. Zucker's publicity which led to NHCMA's investigation. (CX 694B, 695C)[99] Neither man was called as a witness by counsel for the Connecticut respondents.

We decline to grant respondents' motion because it is not at all clear why the Connecticut respondents could not have called as witnesses during trial those persons quoted in the article. Had respondents done so, the testimony of these individuals would have been received subject to the traditional safeguards of the oath, cross-examination, and analysis by the trier of fact. Instead, we are asked to admit what is in essence uncorroborated hearsay evidence highly prejudicial to complaint counsel.

For these reasons, the motion of the Connecticut respondents to reopen and supplement the record is denied.

An appropriate order is attached.

APPENDIX A

EXCERPTS FROM 1977 EDITION OF AMA'S OPINIONS AND REPORTS (RX 1)

Advertising and Solicitation (¶6.00)

This statement reaffirms the long-standing policy of the Judicial Council on advertising and solicitation by physicians. The Principles of Medical Ethics are intended to discourage abusive practices that exploit patients and the public and interfere with freedom in making an informed choice of physicians and free competition among physicians.

[99] Dr. Freedman, now president of CSMS, filed his complaint against Dr. Zucker in his previous capacity as vice president of CSMS. (CX 2006A) Dr. Parke filed his complaint in his former capacity as president of the Connecticut Society of Eye Physicians. (CX 2006B, C)

Advertising. The Principles do not proscribe advertising; they proscribe the solicitation of patients. Advertising means the action of making information or intention known to the public. The public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and other useful information that will enable people to make a more informed choice of physician.

The physician may furnish this information through the accepted local media for advertising or communication, which are open to all physicians on like conditions. Office signs, professional cards, dignified announcements, telephone directory listings, and reputable directories are examples of acceptable media for making information available to the public.

A physician may give biographical and other relevant data for listing in a reputable directory. A directory is not reputable if its contents are false, misleading, or deceptive or if it is promoted through fraud or misrepresentation. If the physician, at his option, chooses to supply fee information, the published data may include his charge for a standard office visit or his fee or range of fees for specific types of services, provided disclosure is made of the variable and other pertinent factors affecting the amount of the fee specified. The published data may include other relevant facts about the physician, but false, misleading, or deceptive statements or claims should be avoided.

Local, state, or specialty medical associations, as autonomous organizations, may have ethical restrictions on advertising, solicitation of patients, or other professional conduct of physicians that exceed the Principles of Medical Ethics. Furthermore, specific legal restrictions on advertising or solicitation of patients exist in the medical licensure laws of at least 34 states. Other states provide regulation through statutory authority to impose penalties for unprofessional conduct.

Solicitation. The term "solicitation" in the Principles means the attempt to obtain patients by persuasion or influence, using statements or claims that (1) contain testimonials, (2) are intended or likely to create inflated or unjustified expectations of favorable results, (3) are self-laudatory and imply that the physician has skills superior to other physicians engaged in his field or specialty of practice, or (4) contain incorrect or incomplete facts, or representations or implications that are likely to cause the average person to misunderstand or be deceived.

Competition. Some competitive practices accepted in ordinary commercial and industrial enterprises—where profit-making is the primary objective—are inappropriate among physicians. Commercial enterprises, for example, are free to solicit business by paying commissions. They have no duty to lower prices to the poor. Commercial enterprises are generally free to engage in advertising "puffery," to be boldly self-laudatory in making claims of superiority, and to emphasize favorable features without disclosing unfavorable information.

Physicians, by contrast, have an ethical duty to subordinate financial reward to social responsibility. A physician should not engage in practices for pecuniary gain that interfere with his medical judgment and skill or cause a deterioration of the quality of medical care. Ability to pay should be considered in reducing fees, and excessive fees are unethical.

Physicians should not pay commissions or rebates or give kickbacks for referral of patients. Likewise, they should not make extravagent claims or proclaim extraordinary skills. Such practices, however, common they may be in the commercial world, are unethical in the practice of medicine because they are injurious to the public.

Freedom of choice of physician and free competition among physicians are prerequisites of optimal medical care. The Principles of Medical Ethics are intended to curtail abusive practices that impinge on these freedoms and exploit patients and the public.

Contractual Relationships (¶4.05)

The contractual relationships that physicians assume when they enter prepaid group practice plans are varied.

Income arrangements may include hourly wages for physicians working part time, annual salaries for those working full time, and share of group income for physicians who are partners in groups that are somewhat autonomous and contract with plans to provide the required medical care. Arrangements also usually include a range of fringe benefits, such as paid vacations, insurance and pension plans.

Physicians may work directly for plans or may be employed by the medical group or the hospital that has contracted with the plan to provide services. The AMA recognizes that under proper legal authority such plans may be established and that a physician may be employed by, or otherwise serve, a medical care plan without violating the Principles of Medical Ethics. It believes that in the operation of such plans physicians should not be subjected to lay interference on professional matters and that their primary responsibility should be to the patients they serve.

Advertising, Solicitation, and HMOs (¶6.01)

It is not unethical for a physician to provide medical services to members of a prepaid medical care plan or to members of a health maintenance organization which seeks members (or subscribers) through advertising its services, facilities, charges, or other non-professional aspects of its operation as long as such advertising does not identify, refer to, or make any qualitative judgment concerning any physician who provides service to the members or subscribers.

The foregoing qualification is intended to discourage deceptive advertising which would lead prospective members (or subscribers) to believe that the services of a named physician who has a reputation for outstanding skill would be routinely available to all members (or subscribers) having need for his kind of services if in fact this is not so. However, the publication by name of the roster of physicians who provide services to members, the type of practice in which each is engaged, biographical and other relevant information as outlined in "Advertising and Solicitation" above is not a deceptive practice.

Free Choice (¶6.28)

Free choice of physicians is the right of every individual. The individual may select and change at will the physicians who serve him, or he may choose a medical care plan such as that provided by a closed panel or group practice, or he may choose to obtain medical care by becoming a subscriber of a health maintenance or service organization. The freedom of the individual to select his preferred system of medical care and free competition among physicians and alternative systems of medical care are prerequisites of ethical practice and optimal medical care.

FINAL ORDER

This matter having been heard by the Commission upon the appeals of respondents from the Initial Decision, and upon briefs and oral argument in support thereof and opposition thereto, and the Commission for the reasons stated in the accompanying Opinion having determined to deny the appeal of respondent American Medical Association and to grant the appeal in part of respondents

Connecticut State Medical Society and New Haven County Medical Association, Inc.,

It is ordered, That the Initial Decision of the administrative law judge be adopted as the Findings of Fact and Conclusions of Law of the Commission, except to the extent inconsistent with the accompanying Opinion.

Other Findings of Fact and Conclusions of Law of the Commission are contained in the accompanying Opinion.

It is further ordered, That the following Order to Cease and Desist be, and it hereby is entered. [2]

I.

It is ordered, That respondent American Medical Association, and its delegates, trustees, councils, committees, officers, representatives, agents, employees, successors and assigns, directly or indirectly, or through any corporate or other device, in or in connection with respondent's activities as a professional association in or affecting commerce, as "commerce" is defined in the Federal Trade Commission Act, do forthwith cease and desist from:

A. Restricting, regulating, impeding, declaring unethical, interfering with, or advising against the advertising or publishing by any person of the prices, terms or conditions of sale of physicians' services, or of information about physicians' services, facilities or equipment which are offered for sale or made available by physicians or by any organization with which physicians are affiliated;

B. Restricting, regulating, impeding, declaring unethical, interfering with, or advising against the solicitation, through advertising or by any other means, including but not limited to bidding practices, of patients, patronage, or contracts to supply physicians' services, by any physician or by any organization with which physicians are affiliated; and

C. Inducing, urging, encouraging, or assisting any physician, or any medical association, group of physicians, hospital, insurance carrier or any other non-governmental organization to take any of the actions prohibited by this part.

Nothing contained in this part shall prohibit respondent from formulating, adopting, disseminating to its constituent and component medical organizations and to its members, and enforcing reasonable ethical guidelines governing the conduct of its members with respect to representations, including unsubstantiated representations, that would be false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act, or with respect to uninvited, in-person solicitation of actual or potential patients, who,

because of their particular circumstances, are vulnerable to undue influence. [3]

II.

It is further ordered, That respondent American Medical Association, and its delegates, trustees, councils, committees, officers, representatives, agents, employees, successors and assigns, directly or indirectly, or through any corporate or other device, in or in connection with respondent's activities as a professional association in or affecting commerce, as "commerce" is defined in the Federal Trade Commission Act, do forthwith cease and desist from:

A. Restricting, regulating, impeding, advising on the ethical propriety of, or interfering with the consideration offered or provided to any physician in return for the sale, purchase or distribution of his or her professional services;

B. Restricting, interfering with, or impeding the growth, development or operations of any entity that offers physicians' services to the public, by means of any statement or other representation concerning the ethical propriety of medical service arrangements that limit the patient's choice of a physician;

C. Restricting, interfering with, or impeding the growth, development or operations of any entity that offers physicians' services to the public, by means of any statement or other representation concerning the ethical propriety of participation by non-physicians in the ownership or management of said organization; and

D. Inducing, urging, encouraging, or assisting any physician, or any medical association, group of physicians, hospital, insurance carrier or any other non-governmental organization to take any of the actions prohibited by this part.

III.

It is further ordered, That respondent American Medical Association cease and desist from taking any formal action against a person alleged to have violated any ethical standard promulgated in conformity with this Order without first providing such person with:

A. Reasonable written notice of the allegations against him or her;

B. A hearing wherein such person or a person retained by him or her may seek to rebut such allegations; and

C. The written findings or conclusions of respondent with respect to such allegations. [4]

IV.

It is further ordered, That respondent American Medical Association:

A. Send by first class mail a copy of a letter in the form shown in Appendix A to this Order to each of its present members and to each constituent and component organization of respondent, within sixty (60) days after this Order becomes final.

B. For a period of ten years, provide each new member of respondent and each constituent and component organization of respondent with a copy of this Order at the time the member is accepted into membership.

C. Within ninety (90) days after this Order becomes final, remove from respondent American Medical Association's *Principles of Medical Ethics* and the Judicial Council's *Opinions and Reports,* and from the constitution and bylaws and any other existing policy statement or guideline of respondent, any provision, interpretation or policy statement which is inconsistent with the provisions of Parts I and II of this Order and, within one hundred and twenty (120) days after this Order becomes final, publish in the *Journal of the American Medical Association* and in *American Medical News* the revised versions of such documents, statements, or guidelines.

D. Require as a condition of affiliation with respondent that any constituent or component organization agree by action taken by the constituent or component organization's governing body to adhere to the provisions of Parts I, II, and III of this Order.

E. Terminate for a period of one year their affiliation with any constituent or component organization within one hundred and twenty (120) days after learning or having reason to believe that said constituent or component organization has engaged, after the date this Order becomes final, in any act or practice that if committed by respondent would be prohibited by Parts I, II or III of this Order.

V.

It is further ordered, That respondent American Medical Association: [5]

A. Within sixty (60) days after the Order becomes final publish a copy of this Order with such prominence as feature articles are regularly published in the *Journal of the American Medical Association* and in *American Medical News* or in any successor publications.

B. Within one hundred and twenty (120) days after this Order becomes final, file a written report with the Federal Trade Commis-

sion setting forth in detail the manner and form in which it has complied with this Order.

C. For a period of five (5) years after this Order becomes final, maintain and make available to the Commission staff for inspection and copying upon reasonable notice, records adequate to describe in detail any action taken in connection with the activities covered by Parts I and II of this Order, including but not limited to any advice or interpretations rendered with respect to advertising, solicitation, or contract practice involving any of its members.

D. Within one year after this Order becomes final, and annually thereafter, for a period of five (5) years, file a written report with the Federal Trade Commission setting forth in detail any action taken in connection with the activities covered by Parts I and II of this Order, including but not limited to any advice or interpretations rendered with respect to advertising, solicitation or contract practice involving any of its members.

VI.

It is further ordered, That respondent American Medical Association shall notify the Commission at least thirty (30) days prior to any proposed change in the respondent, such as dissolution, assignment, or sale resulting in the emergence of a successor corporation or association, or any other change in the corporation or association which may affect compliance obligations arising out of this Order.

APPENDIX A

Dear Doctor:

As you know, the Federal Trade Commission issued a complaint against the AMA on December 19, 1975, challenging the AMA's ethical restrictions on the advertising, solicitation, and contractual practices of its members. The complaint also named the Connecticut State Medical Society and the New Haven County Medical Association, Inc. as respondents.

In an opinion issued on [insert issue date], the FTC held that the AMA, the two Connecticut medical societies, and other state and local medical associations have unlawfully restricted the advertising, solicitation, and contractual practices of their members in violation of Section 5 of the Federal Trade Commission Act.

In conjunction with that opinion, the Commission issued an order which has now become final. This order is printed in the [insert issue date] issue of the *Journal of the American Medical Association,* the [insert issue date] issue of *American Medical News* and may be obtained from the AMA headquarters or from your state or local medical society.

Among other things, the order forbids any action by AMA that would:

- Restrict its members; solicitation of patients by advertising, submission of bids, or other means.

- Interfere with either the amount or the form of compensation provided a member in exchange for his or her professional services.

- Characterize as unethical the use of closed panel or other health care delivery plans that limit the patient's choice of a physician.

- Characterize as unethical the participation of non-physicians in the ownership or management of health care organizations that provide physician services to the public.

However, the order does not prohibit the AMA from formulating and enforcing reasonable ethical guidelines governing deceptive advertising and solicitation (including unsubstantiated representations). The AMA may also issue guidelines concerning uninvited, in-person solicitation of patients who, because of their particular circumstances, are vulnerable to undue influence.

Finally, the order requires the AMA to amend the *Principles of Medical Ethics* and the Judicial Council's *Opinions and Reports* and to sever all ties for one year with any state or local medical society that engages in conduct of the type prohibited under the order.

Thank you for your cooperation.

Sincerely,

_____

President

IN THE MATTER OF

FORBES HEALTH SYSTEM MEDICAL STAFF

CONSENT ORDER, ETC., IN REGARD TO ALLEGED VIOLATION OF THE FEDERAL TRADE COMMISSION ACT

Docket C-2994. Complaint, Oct. 15, 1979 — Decision, Oct. 15, 1979

This consent order, among other things, requires a Pittsburgh, Pa. medical association (Medical Staff), to cease engaging in actions having the purpose or effect of excluding from appointment to Medical Staff applicants who are associated with a Health Maintenance Organization (HMO), or who practice on an other than fee-for-service basis. The association is further prohibited from unreasonably delaying final recommendations on staff privilege applications, and from according discriminatory treatment to HMO-associated members, which may prevent them from providing effective patient care at Forbes. Additionally, respondent would be required to change its Bylaws to conform with the terms of the order.

Appearances

For the Commission; *Barbara K. Shapiro* and *James E. McCarty.*

For the respondent: *Eric F. Stoer* and *Daniel Masur,* Pittsburgh, Pa.

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act, as amended, 15 U.S.C. 41, *et seq.,* and by virtue of the authority vested in it by said Act, the Federal Trade Commission, having reason to believe that the Forbes Health System Medical Staff has violated the provisions of Section 5 of said Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the interest of the public, hereby issues its complaint stating its charges as follows:

PARAGRAPH 1. The Forbes Health System Medical Staff (hereinafter "Medical Staff") is an unincorporated association, organized and existing under the laws of the Commonwealth of Pennsylvania, and located at 500 Finley St., Pittsburgh, Pennsylvania. It is composed of the more than 300 medical physicians, osteopathic physicians, dentists, and podiatrists who have been granted privileges by the Forbes Health System to attend patients in the Forbes Health System.

PAR. 2. The Forbes Health System (hereinafter "Forbes") is a corporation organized and existing under the laws of the Commonwealth of Pennsylvania. The physical facilities of Forbes consist of