

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 philosophical 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 commissioner—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 department; 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 department 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 ophthalmologists, 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 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 ophthalmologist'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 nation-wide 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 geographic 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 subtle [sic] and indirect form of solicitation[.]" that "[T]here might be some question as to whether [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 Thoracic-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 breach [*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 reinstated 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 pre-clearance 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 physical 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 Cavatron 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