information requested in the questionnaire, including basic fee (Tr. 8617-20; RNHX 109).

In the fall of 1977, Dr. Neumann and the city of New Haven Mayor's Committee on the Elderly decided to publish a new edition of the directory. Thereafter, the city health department staff contacted the city medical association which again agreed to cosponsor the project. Health department staff used the same form questionnaire that had been used for the earlier directory. The staff drafted a cover letter, similar to the one used in 1976, which was sent along with the questionnaire to physicians whose names had not appeared in the first directory. The staff sent a letter noting that a revision was occurring to physicians whose names had been included in the first directory. Followup letters were sent if physicians did not respond to the first letter (Tr. 8622-27; RNHX 146, 147, 148).

Dr. Neumann's staff sent out approximately 100 to 120 questionnaires and received about a 90 percent response rate. None of the physicians objected that participation in the [186] directory would be unethical. At the time of Dr. Neumann's testimony at trial, the directory had been compiled and typed, and was ready for photocopying and distribution to social agencies. The revised directory had the same format and information as the 1976 edition (Tr. 8627-29; RNHX 149A-Z15). There were no objections to the publication or distribution of the directories from any medical societies (Tr. 8622, 8629).

b. Medical Society Opposition to Business and Consumer Directories

131. AMA and its members societies have limited the publication of information on physicians in business and consumer directories. Opinion 18 of Section 5 of the 1971 *Opinions and Reports* declares that, "[m]ost, if not all, listings of physicians by specialty in directories published by commercial concerns, are but subtle ways of avoiding the pronouncement of the Principles of Medical Ethics concerning solicitation of patients" (CX 462Z9). Opinion 18 of Section 5 of the 1971 *Opinions and Reports* also states that if a physician permits the use of his name in a commercial directory that does not include on like terms the names of all licensed physicians in the directory area, he "has the burden of proving that his action is in keeping with the Principles" (CX 462Z9).

The 1971 *Opinions and Reports* recommends that local medical societies enforce an ethical policy that "the listing of physicians in directories of participating members [in bank credit card programs] is contrary to the ethics of the medical profession" (CX 462Z22 [Sec.

7, Op. 13]). In an August 1976 compilation of ethics interpretations, the state medical society in Maryland endorsed this AMA Judicial Council ethical standard and recommended its implementation and application by county medical societies (RX 308, p. 61).

In 1966, the King County (Washington) Medical Society sought the advice of the AMA Department of Medical Ethics on the ethical propriety of listing physicians in a directory of services and businesses participating in a bank credit card plan (CX 99). AMA's reply, which cited provisions of its *Opinions and Reports* (CX 100), assisted the county society in resolving the issue (CX 101A) and the society ruled that "any physician who allowed the use of his name in such a directory would be in violation of the Code of Ethics" (CX 101A). [187]

Payne Avenue Business Directory

132. D. Patrick McCullough, an attorney in St. Paul, Minnesota, who testified in this proceeding, is a member of the Board of Directors of the Payne Avenue Business Association, a group of business and professional people located on Payne Avenue in St. Paul (Tr. 359–60). In 1972, the Association's Board of Directors discussed the possibility of promoting its annual "Harvest Festival" by placing various paid advertisements in a community newsletter. The newsletter was to include a listing of Payne Avenue area businesses and services, including physicians (CX 34B). The list was to contain only the name, address, telephone number and business or profession of each of the association's members (CX 34B), and was to serve as an alternative to the phone book for consumers interested in obtaining services specifically in the Payne Avenue neighborhood (Tr. 367). The business association hoped that distribution of the list would help maintain the viability of the aging Payne Avenue area as an in-town shopping district (Tr. 367–68, 360–61).

Attorney McCullough, working on the project, contacted the Minnesota State Medical Society concerning "possible ethical considerations" about the proposed list (CX 34B). The state society then sought the opinion of the AMA Department of Medical Ethics (CX 34A). The Director of the AMA Department of Medical Ethics replied that, under the applicable Judicial Council ruling, the list would be unethical if it included only those physicians who were members of the business association and was not open "to all physicians on like terms" (CX 33). Even if all the doctors in the neighborhood were to be included, the AMA letter questioned whether the list would be "in keeping with the ideals of the medical profession" (CX 33). The letter stated that "the wishes of all the physicians in Ramsey County

should be taken into consideration" (CX 33). Inclusion, in the directory, of all the physicians in the county would have defeated the purpose of the plan, which was to serve the Payne Avenue neighborhood in particular (Tr. 381–82). As a result of the AMA letter, the proposed directory of businesses and services was dropped (Tr. 378, 380–82).

Prince George's County, Maryland, Directory

133. In the summer of 1973, Public Citizen's Health Research Group of Washington, D.C. [a Ralph Nader-affiliated organization, Tr. 2126], undertook the compilation of a directory of physicians in Prince George's County, Maryland (Tr. 2126, 2136). Approximately 80 percent of the practicing [188] physicians in Prince George's County belong to the Prince George's County Medical Society. All members of the local society belong to the state society, the Medical and Chirurgical Faculty of the State of Maryland (Tr. 7405–06), and 95 percent of all physicians practicing in Maryland are members of the state society (CX 679C).

In Maryland, advertising by physicians is illegal, except as provided by the regulations of the Board of Medical Examiners (Tr. 7412–13; RX 400B). The Maryland state medical society elects all eight members of the Board of Medical Examiners which has the authority to adopt regulations governing advertising by physicians in Maryland. All members of the Board must be physicians practicing in Maryland (CX 2047A, B, D). The regulations provide that a physician may advertise only by use of a personal professional card, a removal notice, an announcement concerning his practice or identification signs, all of a specified size and restricted to certain information (RX 308, p. 3, 309, p. 3, 689, p. 3).

The Health Research Group did not notify the county medical society or the state medical society of its plan to compile a directory prior to initiating its survey of physicians (Tr. 2203–04, 7467, 7479). In mid-July, the consumer group undertook its own questionnaire survey of Prince George's County physicians after its preliminary search for information on physicians practicing in the county had produced only the names, addresses, telephone numbers, specialty certifications, local medical society memberships and some information on physicians' educations (Tr. 2128–29, 2132–38, 2141; CX 679D–H, 2032). The questionnaire, developed without consulting with the medical societies (Tr. 2203, 7407; CX 2032), included questions on specialty, type of practice, teaching or staff appointments, medical education, Board certification, hospitals used, office hours, after-hours coverage, support personnel, average waiting time for appoint-

ments, acceptance of new and walk-in patients, treatment of Medicaid and Medicare patients, time for examination, languages spoken, house calls, fee and billing information, tests available, prescription of birth control and various specific drugs, immunizations and handling of complaints (CX 2032). Physicians were then contacted in a telephone survey (Tr. 2138). Where no response was given by the physician to a particular question, a space was provided labeled, "would not answer." If the physician declined to participate at all, the questioner was directed to inform him or her that the [189] survey was a consumer effort and that "refusal to cooperate" would be published in the directory (CX 2032; Tr. 2218–19). Many physicians phoned the local medical society for information about the survey and the organization sponsoring it, and were disturbed by the Group's threats to list physicians as uncooperative (Tr. 7406–11).

Since the Health Research Group had not contacted the local society in advance, the society had no knowledge about the project or the Group. Moreover, the local society was concerned that questions relating to fees and other specific medical practices were being asked that might be prohibited and constitute unethical advertising by physicians (Tr. 7411–12). Because of the local society's concerns about the proposed directory, it circulated a warning note to its member physicians (CX 680).

The Health Research Group contacted the local society after the first week of the telephone survey (Tr. 2148), informing them of the identity of the organization and the nature of the survey (Tr. 7423). In a letter to the Health Research Group, the society enclosed the relevant ethical and legal regulations and referred the Group to the Board of Medical Examiners or the Commission on Medical Discipline for consultation (CX 681). A copy of the questionnaire was subsequently sent to the society (CX 682). Upon reviewing the questionnaire, the society had further concerns with the questions asked (Tr. 7430–31). The questionnaire was sent to each physician with a cover letter which demanded that the questionnaire be completed, verified and returned within a week, or else the original response would be deemed correct and published in that form. Physicians were again told that if any questions remained incomplete, the directory would note that the physician "would not answer" (CX 683).

The local society thereupon circulated another message to its members (CX 684), which stated that the legal and ethical considerations raised by the questionnaire had not been resolved. Member physicians were advised that if they declined to participate in the directory, they should do so by stating "the information returned for

review is incomplete and inaccurate and that the physician does not consent to publication" (Tr. 7442–43; CX 684).

At the suggestion of the local society, the consumer group contacted the state medical society (Tr. 2148, 2150). The state medical society advised the consumer group by [**190**] letter that: "Other than to indicate his [a physician's] identity in such directory and specialty, if any, which he has and perhaps indicate his office hours, any other publications pertaining to the physician would constitute advertising" (CX 2035A). The state society, an AMA constituent organization (CX 2050J, Z22) that has adopted AMA's Principles of Medical Ethics as its ethical standards (RX 308, p. iii), also stated that a physician who answered any of the other questions in the questionnaire would be acting unethically (CX 2032, 2035). The letter specifically disapproved of a physician publicizing either his fees, that he is available to walk-in or non-English speaking patients or that he makes house calls (CX 2035A).

Many physicians declined to participate in the Health Research Group's directory project (Tr. 2036–43; CX 679N, O, 2031B). The questionnaires which were returned were compiled and the directory was published in January 1974 (Tr. 2166–67). About half of the doctors who had cooperated in the consumer group's initial telephone survey declined to complete the written questionnaire they were sent (Tr. 2158), and only 25 percent of the physicians in the county agreed to inclusion of their names in the directory (CX 2031B, 679 O; Tr. 2166). Only 500 copies of the directory were published by the Health Research Group (Tr. 2233–35).

The directory as published (RX 294) contains not only the responses to the questionnaires but a lengthy introduction. The introduction contains assertions about the alleged prevalence of unnecessary prescriptions and surgical procedures and the widespread physical or mental incompetence of physicians (Tr. 2240–43; RX 294H, S). The introduction also states that the state and local medical societies engaged in a systematic "intimidation of doctors" (RX 294W), and attempted to block publication apparently because the directory would reveal differences between doctors (RX 294J). It also states that "medical society resistance is to be expected in any consumer sponsored survey" (RX 294X). Emphasis was placed on the lack of cooperation of nonresponding physicians, and the names of those physicians were placed in a special list (Tr. 2250–51). The introduction also suggests that better medicine is practiced in group practices than by sole practitioners (RX 294A, A–1, A–2).

On the day of the directory's publication, the Health Research Group filed suit in federal court against the local and state medical

societies, the Commission on Medical [191] Discipline and their officers. The lawsuit challenged the constitutionality of the Maryland advertising statute (Tr. 2167). The federal district court stayed proceedings to allow the parties to engage in settlement negotiations (Tr. 2262; CX 679K) and, subsequently, invoked the abstention doctrine until such time as the Maryland Commission on Medical Discipline had ruled as to whether publication of the directory was prohibited under Maryland law (Tr. 2176, 7487). At the time of the hearing in this case, the decision to abstain was on appeal to the Fourth Circuit Court of Appeals (Tr. 2176).

Health Research Group also filed a request for a declaratory ruling with the Maryland Commission on Medical Discipline pursuant to Article 41, Section 250 of Maryland law (RX 401). The Commission ruled that the directory constituted "advertising" within the meaning of the Maryland statute and was, therefore, illegal (CX 2031). It noted that consumer directories, as such, are not necessarily advertising, although "particular directories, because of the method of compilation, the interpretive gloss, or other factors, may violate Maryland law" (CX 2031P). The Commission held that a physician who participated in the Health Research Group directory would violate Maryland law, but declined to prosecute any participating physicians on the grounds that they were probably unaware of the introduction and commentary and would likely not have participated had they been aware of the endorsement and ratings suggested by those sections (CX 2031E–F).

134. In June 1974, the AMA Judicial Council issued an opinion on consumer directories of physicians stating it would not be unprofessional for a physician to be listed in a directory which is intended to list all physicians in the community on a uniform and nondiscriminatory basis and did not include any "self-aggrandizing" statement or qualitative judgment about physicians (CX 509A–B, N). In December 1974, the AMA House of Delegates adopted the Judicial Council report, with only minor word changes as follows:

> It is not unethical for a physician to authorize the listing of his name and practice in a directory for professional or lay use which is intended to list all physicians in the community on a uniform and non-discriminatory basis. The listing shall not include any self-aggrandizing statement or [192] qualitative judgment regarding the physician's skills or competence. The *American Medical Directory* provides an example of the kind of information that may be properly listed in national as well as community directories for health service personnel. Likewise, specialties or specialty practices used in the *American Medical Directory* should set the pattern for specialty designations (RX 5).

This statement was in effect as of November 1977 (Tr. 3998).

The *American Medical Directory* lists only each physician's name, address, year of birth and licensure, specialty, board certifications, type of practice, educational background and AMA membership status (RX 11, 12, 13, 14).

In 1975, the Illinois State Medical Society was considering issuance of guidelines permitting descriptions in consumer directories of a physician's education, hospital, and medical school affiliations, type of practice, office hours, house call policy, acceptance of Medicare assignments policy, second language spoken, billing practices and in-office allied health personnel (CX 718A, F–I). AMA advised the state medical society that "any such detailed directory . . . could not help but be self-aggrandizing for certain physicians, contrary to AMA principles," and informed the state medical society that the ethics "difficulty" of a directory is "compounded" by widespread distribution (CX 717A–B). AMA noted that the Judicial Council's opinion on consumer directories (RX 5) "is more negative than positive," and that "AMA is *not* on record as positively favoring directories" (CX 717A–B) (emphasis in original).

Catawba County, North Carolina, Directory

135. In the fall of 1974, a sociology class at Lenoir Rhyne College decided to prepare a directory of physicians in Catawba County, North Carolina (Tr. 2366). The course instructor, Professor Daniel C. Bruch, who testified in this proceeding, assigned one student to contact the president of the Catawba County Medical Society ("CCMS") to determine whether the society would endorse the project. Another student was asked to write to the AMA to determine its position on the question of physician directories (Tr. 2371; CX 1835). Sometime in late September 1974, several students met with J. Thomas Foster, M.D., president of CCMS. Dr. Foster also testified in this proceeding. The students sought Dr. Foster's reaction to the preparation of a consumer directory of [193] physicians in Catawba County, North Carolina. Dr. Foster stated that, in his opinion, the general idea of a physician's directory was a good one (Tr. 2372–73, 7363). Shortly thereafter, the class sent a questionnaire to each of the physicians practicing in Catawba County (CX 698A–G; Tr. 2374, 7364). The questionnaire requested such information as the physician's name, address, specialty, fee-for-service or prepaid group practice status, number and type of support personnel in office, medical education and post-graduate training, board certification, hospital and teaching appointments, standard fees for phone consultations and office visits, billing procedures, willingness to make house calls, average waiting room time, acceptance of the Medicare

reimbursements schedule as payment in full and willingness to show patients their medical records on request (CX 698).

At the October 11, 1974, meeting of the CCMS, the subject of the directory was again discussed (Tr. 7364; RX 884A–B). The members expressed concern with several aspects of the questionnaire, such as whether the directory would be periodically updated (Tr. 7365) and whether the question regarding fees might prove to be misleading to consumers (Tr. 7366). Finally, some members felt that the question concerning a physician's prescribing of generic drugs might be misleading to consumers (Tr. 7367–68). The society discussed the AMA's position on the question of physician directories and decided that it would be all right for member physicians to respond "the way the Judicial Committee [sic] of the AMA states that it could be done, or otherwise, it would be unethical and considered to be advertising" (RX 884B).

Sometime during the next week, the Executive Committee of CCMS met with Professor Bruch's class to discuss the question of the physician's directory. When the society representatives raised their concerns about the updating of the directory and the possibility of misleading information, the students were unfriendly (Tr. 2407, 7373). The college class was told that the "self-aggrandizing" clause in the AMA Judicial Council opinion applied "when you list fees" (Tr. 2383, 2410). The CCMS official also stated:

> [S]omebody who reads the directory may choose a physician on the basis of fees, and get the cheapest doctor for example, and therefore it might become a point of competition between physicians to stress the fees and to work out a fee schedule that would be more advantageous than somebody else's (Tr. 2383–84). [194]

On November 11, 1974, the class received a letter from the AMA (CX 1834A–B) in response to their request for the AMA's position on the subject of physician directories (CX 1835). The letter noted that the AMA Judicial Council had adopted a report stating in part:

> It is not unprofessional for a physician to authorize the listing of his name and practice in a directory for professional or lay use. Which [sic] is intended to list all physicians in the community on a uniform and nondiscriminatory basis; providing that the listing shall not include any self-aggrandizing statement or qualitative judgment regarding the physician's skill or competence (CX 1834A. *See also* RX 5).

There is no evidence of any other communication with AMA. By letter of November 14, Dr. Foster informed Professor Bruch of the society's decision. The letter stated, in part: "the Catawba County Medical Society declines to ask its members to answer the questionnaire on the basis that the answers could be considered to be construed as unprofessional self-aggrandizement. The answers that

might be considered ethical would be of no value in a Consumers' Directory" (CX 890). Following the society's action, the college class received only one additional completed questionnaire from a physician, the family pediatrician of the professor directing the project (Tr. 2396). Overall, the class received completed questionnaires from only approximately one-fourth of the physicians surveyed (Tr. 2397).

7. *Direct Contact with Institutions and Physicians*

Dr. Harry G. Browne

136. In mid-1973, Jerry K. Crowell, the administrator of the Lewis County Hospital in Hohenwald, Tennessee, asked Dr. Harry Browne to conduct a pre-survey of the hospital's laboratory and pathology services to determine what upgrading would be needed to bring the services into compliance with the standards of the Joint Commission on Accreditation of Hospitals ("JCAH") (Tr. 281–82, 292–93). Dr. Browne testified in this proceeding (Tr. 1905, *et seq.*) as did Mr. Crowell (Tr. 281, *et seq.*) Dr. Browne is a board certified pathologist in Nashville, and holds a clinical assistant professorship of pathology at Vanderbilt University (Tr. 1905–07). He practices in association with a large pathology group and laboratory company which provides services to hospitals, physicians and others throughout Tennessee and western Kentucky (Tr. 1908–10, 1944). [195]

Dr. Browne is in active competition with Dr. Jack Freeman and other pathologists for the pathology and laboratory business of hospitals in western Tennessee (CX 5A–B, 1B; Tr. 1928, 1930). Dr. Freeman has serviced Lewis County Hospital since 1971 (Tr. 291–92, 296). Dr. Browne visited Lewis County Hospital in the early fall of 1973 to conduct a pre-survey (Tr. 292–93). The hospital had asked Dr. Browne to make a proposal of the services which his pathology group and laboratory company could provide the hospital to give it better coverage than it was getting from Dr. Freeman and to bring it into compliance with the JCAH requirements (Tr. 293–94, 304–05). In October, Dr. Browne submitted a written proposal to the hospital (CX 4). Several months later, Dr. Browne sent Mr. Crowell a more detailed proposal which compared his proposed services and fees with those of Dr. Freeman (CX 1866). Prior to submitting his written proposal, Dr. Browne and his staff had been in direct contact with the hospital personnel, partly in the hope of obtaining their pathology and laboratory business (Tr. 1911–13; CX 4A).

Before acting on Dr. Browne's proposal, the hospital administrator gave Dr. Freeman a copy of it (Tr. 305–06). Dr. Freeman submitted a counter-proposal to the hospital which was almost identical to Dr.

Browne's offer (Tr. 306). The hospital thereafter decided to renew Dr. Freeman's contract, and Dr. Freeman immediately began providing the hospital with significantly improved services (Tr. 306-07, 312-14; CX 1864-65). Prior to Dr. Browne's proposal, Dr. Freeman had never discussed with the hospital administrator possible improvements in his services to the hospital (Tr. 313); furthermore, until Dr. Browne made his pre-survey, Mr. Crowell was unaware that improvements could be made in the hospital's laboratory and pathology services (Tr. 314).

In early 1974, Dr. Freeman sent a copy of Dr. Browne's proposal (CX 4) to the Chairman of the Ethics Committee of the Nashville Academy of Medicine (CX 3, 12), the local AMA component society (CX 1825B, E). Dr. Freeman objected that Dr. Browne's proposal was unethical (CX 3), and indicated that he would also start soliciting business if Dr. Browne's conduct were considered proper (CX 3). The Nashville Academy wrote to the Director of the AMA Department of Medical Ethics for advice (CX 12). The AMA official responded that solicitation of patients or patronage was forbidden, and that Opinions 6, 9, 11 and 20 of Section 5 of the 1971 *Opinions and Reports* (CX 462Z5-Z6, Z9) governed the matter (CX 11). The Nashville Academy then informed Dr. Browne that it had received a [**196**] complaint about his proposal to Lewis County Hospital (CX 7). The Academy stated that it had obtained an ethics opinion from AMA and recommended that Dr. Browne read the *Opinions and Reports* provisions cited by AMA (CX 7, 11). The Academy also stated that it had referred the matter to the Tennessee Medical Association's ("TMA") Judicial Council for its further review (CX 7).

Sometime in late June or early July 1974, the chairman of the TMA Judicial Council requested that Dr. Browne furnish the details surrounding his association with the Lewis County Hospital (Tr. 1922). Dr. Browne complied by sending a detailed description of the situation (CX 1A-C). The TMA Judicial Council then wrote to AMA for additional advice (CX 10). The state society specifically asked whether it was ethical for a physician to solicit, not patients, but referrals from another doctor or from the medical staff of a hospital (CX 10A). It stated that some physicians in the area viewed Dr. Browne's activities as "overly aggressive competition" (CX 10B). It also noted that the complaining pathologist merely wished "the same privileges of solicitation . . . as the other man" (CX 10B). In response, AMA noted that the Principles of Medical Ethics proscribe solicitation of patients or patronage, and stated:

> If a pathologist asks a hospital for the opportunity of providing pathological services and laboratory services, I would think this is solicitation. It is solicitation of

patronage—of business. . . . I do not believe it is acceptable, usual or customary for any physician to solicit referrals or to solicit or offer *consultative* services to fellow physicians . . . . (CX 9)(emphasis in original).

The TMA then wrote to Dr. Browne, informing him that its Judicial Council considered his method of offering services to hospitals to be in conflict with the Principles of Medical Ethics, as interpreted by the AMA Judicial Council (CX 8C). The state society official's letter urged Dr. Browne to exercise greater care in bringing his conduct into line with AMA's and the state society's ethics interpretations (CX 8C). Dr. Browne agreed to abide by the advice and recommendations in every way (CX 2), and has since abided by them (Tr. 1929). **[197]**

Upon receiving the medical association advice, Dr. Browne resolved to modify his behavior so that it would not be considered distasteful (Tr. 1925). He became less personally involved in presenting proposals for the provision of the services of his pathology group and laboratory, particularly in offering services to Dr. Freeman's clients (Tr. 1925, 1928). Specifically, Dr. Browne instructed his laboratory company's marketing representative, in his discussions with potential clients, not to volunteer the names or fees of Dr. Browne and his pathology associates or to offer their services (Tr. 1927-28). He required hospitals to request proposals in writing as well as to request Dr. Browne's help, instead of Dr. Browne seeking proposals (Tr. 1925-27). He became less aggressive in marketing out of concern for his reputation, stating: "If I was to be criticized by my fellow physicians for being aggressive, it would denigrate my reputation and I did not want that to happen to make my position less effective as a physician and more humiliating as a human being" (Tr. 1927).

Other Incidents Involving Direct Contacts with Potential Users of Medical Services

137. A pathologist in San Antonio, Texas, wrote to the Board of Censors of the Bexar County Medical Society in early 1972 to request an ethics investigation of the solicitation activities of a clinical laboratory and its two associated pathologists (CX 2062D). The inquiring pathologist stated that the laboratory and its two pathologists had already obtained as clients a hospital and several physicians whom he had been serving (CX 2062D). The executive director of the Medical Society referred the pathologist's complaint to the Society's attorney for an opinion as to the legality and ethics of the alleged solicitation (CX 2062A). The attorney replied that, because the Medical Practice Act did not prohibit solicitation by physicians

unless it was misleading to the public, the laboratory's solicitations really raised questions of ethics (CX 2063).

The Medical Society's Board of Censors then called the two accused pathologists to its April 1972 meeting (CX 2064A). The Board decided to inform the pathologists that they were in violation of the AMA ethics provision on solicitation of patients by groups and that they should immediately stop soliciting physicians' business through the laboratory's use of their names (CX 2064A). Shortly thereafter, the chairman of the Board of Censors sent a letter to the two pathologists quoting Opinion 8 of [198] Section 5 of AMA's 1971 *Opinions and Reports,* entitled "Solicitation of Patients by Groups" (CX 2065A, 462Z5). A few days after their meeting with the Board of Censors, and again following their receipt of the Board Chairman's letter, the pathologists wrote to the director of the laboratory with which they were associated and requested that their names not be used in contacts with hospitals or other prospective customers (CX 2066A–B).

The Santa Clara County (California) Medical Society has severely restricted the direct solicitation efforts of an industrial medical clinic headed by Dr. Joseph LaDou. The Medical Society has based its actions, which it took in response to complaints from competing medical clinics, on provisions of AMA's 1971 *Opinions and Reports* (F. 98, pp. 124–29).

In August 1976, the state medical society in Maryland published an ethics interpretation prohibiting physicians from the active advertising or direct solicitation of new contracts for delivery of industrial health care services (RX 308, p. 33).

In 1972, a San Francisco physician sent a letter to a local insurance company describing his office facilities and offering to perform physical examinations on its behalf. AMA, which reviewed the letter at the request of an insurance company employee, enclosed a copy of the Principles of Medical Ethics and declared that the conduct of the physician constituted solicitation in violation of Section 5 of the AMA Principles of Medical Ethics. The AMA also recommended that a copy of the physician's letter be sent to the local medical society (F. 96, pp. 122–23).

AMA has condemned as unethical solicitation of patients a number of physicians' form letters and other communications to fellow physicians seeking referrals (*See, e.g.,* F. 110, p. 145; 112, pp. 146–27).

8. *Open Houses*

138. Opinion 13 of Section 5 in AMA's 1971 *Opinions and Reports*

states that if a physician holds an "open house" with the intent of directly or indirectly soliciting patients, he is acting contrary to the Principles of Medical Ethics. The opinion makes it incumbent on physicians to discuss their plans for open houses with their component medical societies before implementing them (CX 462Z7). [199]

In 1973, the Columbia County (Pennsylvania) Medical Society requested advice from the Pennsylvania Medical Society about several physicians who had advertised and held an "open house." The Pennsylvania Medical Society sent AMA a copy of the newspaper advertisement for the open house (CX 95B–G) and asked for AMA's ethics advice (CX 95A). In response, AMA referred the Pennsylvania Medical Society to Section 5 of the AMA Principles and advised that, since the open house had already been held, the medical society was to obtain an apology from the physicians involved (CX 94).

In August 1976, the state medical society in Maryland published an interpretation, citing the AMA Judicial Council as authority, which declared unethical the holding of an open house for the purpose of solicitation of professional patronage (RX 308, p. 31).

In 1974, the Maricopa County Medical Society in Phoenix adopted guidelines for HMO marketing activities which state that an open house for prospects at the management level and for physicians is allowable, but that it is not allowable on a patient level except for invited specific groups of people that are in the decision-making process (CX 898I).

In 1975 and 1976, other AMA member medical societies have adopted ethical standards authorizing physician attendance at open houses held by HMOs only where the guests are personally invited (CX 2121B, 2122B, 751D).

9. *Other Methods of Soliciting Patients*

139. Opinion 27 of Section 5 of AMA's 1971 *Opinions and Reports* prohibits physicians from mailing out reprints of articles they have written where their intent is to solicit patients directly or indirectly (CX 462Z11). In its advice to medical societies, AMA has applied this restriction to the mailing of reprints to other physicians as well (CX 117–19, 140–43).

Opinion 14 of Section 7 in AMA's 1971 *Opinions and Reports* states that it is unethical for physicians to use their participation in bank credit card programs to solicit patients and, in particular, to list themselves in any bank credit card directory of participating members. Physicians are also prohibited from displaying outside

their offices plaques or signs indicating their participation in such credit card plans (CX 462Z22-23). In August 1976, the state medical society in Maryland published a similar ethical rule, citing the AMA Judicial Council as authority (RX 308, p. 61). [200]

E. Advertising by Fringe Medical Practitioners

1. *Health Quackery*

140. James Harvey Young, Professor of History and Chairman of the History Department at Emory University, teaches courses in American social and intellectual history and conducts two colloquial, one on the history of American medicine, the other on the history of American advertising (Tr. 6605-07). Professor Young's major research has been an analysis of health quackery in America. Quackery can be defined as the use of misleading communications to persuade consumers to use products, drugs or devices to improve their health (Tr. 6608-09). Professor Young has lectured on this subject at numerous medical schools and historical association meetings, participated in an international conference on health quackery, received grants or fellowships to study health quackery from various organizations and served on various national bodies related to this field, including the National Food and Drug Advisory Council and the Consumer Task Force of the White House Conference on Food, Nutrition and Health. Professor Young was chairman of the History of Life Science Study Section of the National Institutes of Health, a body which judges applications of scholars who wish to conduct research in the history of medicine or life sciences. Professor Young has written three books and about 50 articles on medical advertising (Tr. 6610-11).

Professor Young, an expert on the history of medical and health advertising in the United States, testified about false and misleading medical advertising in America as far back as the colonial period. He described many fraudulent methods of promoting medicines, devices and medical services which have been utilized over a 200 year period in the United States (Tr. 6627-35). According to Professor Young, passage of various regulatory legislation has not eliminated the continued threat of medical quackery; quacks merely have become more sophisticated (Tr. 6637-39). Quackery has historically included false and misleading medical advertising by physicians (Tr. 6642-49).

Professor Young testified that the misleading advertising of medical products and services remains a serious problem for several reasons. The ignorance of consumers is a major cause of the problem, since most laymen do not have sufficient medical expertise to

recognize the deceptive nature of some medical advertising. Fear also plays a significant role in quackery, particularly with regard to an individual with a disease which medical science cannot cure or control. Individuals who are [201] stricken with a painful, life-threatening disease often do not act rationally regarding health matters. Finally, quacks rely on the fact that many ailments cure themselves. The individual then adopts the quack remedy, and often is "cured," not by accepting the remedy, but through natural causes. Yet, the patient will believe the remedy worked, will rely on it in the future and will refuse accepted medical treatment (Tr. 6652–54). Misleading advertising may thereby operate to disparage orthodox medical treatments and cause an unfavorable separation between reputable health care professionals and the public (Tr. 6650–51). A major social cost of medical quackery is the suffering and death of people who have rejected orthodox treatment methods in favor of quack remedies (Tr. 6649–50).

Professor Young believes that an increase in the amount of medical advertising is likely to result in an increase in the level of quackery and deception (Tr. 6655). Moreover, he testified that a removal of ethical guidelines which have been adopted by medical societies is likely to result in increased consumer deception. While neither ethical guidelines nor governmental regulations are likely to inhibit the unethical practitioner, some physicians who do not now engage in questionable advertising would probably do so were it not for the existence of standards set by medical societies. Professor Young stated that, without such guidelines, misleading advertising by physicians is likely to enhance quackery (Tr. 6656–58).

2. *Cosmetic Surgery Advertising in California*

141. Advertising by physicians has been most prevalent among plastic surgeons in California. AMA introduced extensive evidence of the experiences of physicians' organizations, individual physicians and consumers with advertising by cosmetic surgeons in California (Tr. 6888–7354). AMA contends that California provides a kind of laboratory in which the nature and effects of widespread physician advertising can be studied (RAF, p. 330).

Advertising by cosmetic surgeons in California began two to three years ago in the form of small, infrequent notices in the classified ads (Tr. 7050). In the past two years, the advertisements have become larger and more frequent (Tr. 7050–51). The record contains numerous examples of recent advertisements by plastic surgeons in California (Tr. 6964; RX 268, 269, 680, 682–85, 781, 783–87, 797, 800, 801). Some advertisements contain false promises about the physical

results of surgery (Tr. 6933), inaccurate statements about the surgical procedure (Tr. 6975; RX 269), [202] false claims about the innovative character of an operation (Tr. 6988, 6990; RX 682, 785, 786) or false claims about the physician or his or her staff (Tr. 6986–88, 7108; RX 682, 785, 786, 804, exhibit 2). Some advertisements include "before and after" photographs, with the "after" picture posed in a more favorable angle and lighting (RX 268, 680, 682–83, 786, 800, 916–17; Tr. 6972, 6988–89). Showing the results of one patient's experience, or giving one person's testimonial, may imply to some people that anyone can and should have the same operation with similar results, an assertion that can be misleading (RX 682, 800; Tr. 6933–34, 6970–72, 6986, 7104–05).

Some advertisements utilize truthful information in a manner that may mislead potential patients as to the qualifications of the advertising physician. An example is one physician who included his membership in the AMA as part of his qualifications; membership in the AMA is not a function of professional skill (Tr. 6972–73, 6980; RX 268, 787, 783, 679, 680). More subtle is a claim by a physician asserting his qualification as a "Board certified cosmetic surgeon" (RX 268, 679, 680). In fact, there is no American Board of Cosmetic Surgery and, if cosmetic physicians are certified, they are certified in other specialties which may have nothing at all to do with cosmetic surgery (Tr. 6933, 6973, 6990). Other advertised credentials, perhaps impressive to lay persons but medically meaningless, include authorship of articles published in obscure medical journals (Tr. 6974, 6979; RX 268, 680B), invention or modification of surgical instruments (Tr. 6979–89; RX 787, 783) and false statements about "special residency training and expertise" (Tr. 6980; RX 787). The names of the advertising surgical groups themselves, such as the Academy of Cosmetic Surgery Medical Group (Tr. 6994; RX 684, 801) or Bay Area Woman's Medical Educational Services (RX 797; Tr. 6992–93), could imply that there is a learned organization or nonprofit social institution involved when such is not a fact.

Some advertisements emphasize the modernity of the facilities, and invite visits by patients who wish to make comparisons (RX 269, 787, 785, 683). Potential patients may not have the expertise to judge its adequacy or medical necessity, and may be misled by superficial appearances (Tr. 6981–82). The invitations also may be designed to lure people into the office where "hard-sell" techniques are adopted (Tr. 6981–82), and to divert attention from the qualifications of the surgeon (Tr. 6982). Some advertisements emphasize the reasonableness of the fees and the easy financing which is made available (RX 269, 787, 786, 684, 784, 685). Pictures of attractive models used in

some [203] advertisements, have little relevance to the cosmetic surgery (Tr. 6984, 6990; RX 680, 682, 684, 690, 800-01). The bikini-clad figures may deceptively suggest that plastic surgery can reshape and rejuvenate the whole body (Tr. 6993-94, 6994-95; RX 684, 690, 784, 797, 801). These psychologically-appealing advertisements may minimize the seriousness of surgical operations (Tr. 6976-77; RX 269). Rarely, if ever, is fee information included in the advertising (RX 804, p. 7). Further, the easy financing which is featured may turn out to be quite expensive (Tr. 6977). Notably absent from such advertising is information about the risks involved in the operation, the expense of the surgery, the potential of permanent disfigurement and, sometimes, even the name of the operating surgeon (Tr. 6976-78, 6984-85, 6995, 7109; RX 680, 684, 685, 784, 781, 801, 804, exhibit 2).

Advertisements for cosmetic surgery appear in reputable publications, such as the *Los Angeles Times* (RX 279, 268, 800, 680, 684), and are widespread, appearing daily in newspapers in San Diego, Santa Ana and Los Angeles (Tr. 6997). Yellow Pages listings in the August 1977, edition of the City of Los Angeles telephone directory contain numerous advertisements for cosmetic surgeons. For example, there are a number of advertisements for E. B. Frankel, M.D., who is associated with the following organizations, all using the same location and telephone number: Acne Derm Medical Group, Affiliated Dermatologists' Medical Group and Cosmetic Surgery Center Medical Group; Dr. Frankel also sponsored a listing under his own name (RX 907A-G). Two advertisements appear for the Bosley Medical Group, including one which prominently states, "End Baldness Permanently With Your Own Living Hair" (RX 907B, C). The Yellow Pages also contains an advertisement for the Acupuncture Institute of Stanley Durbin (RX 907C).

3. *Consumer Witnesses in California Who Experienced Cosmetic Surgery*

142. Respondent AMA called consumer witnesses who testified about their experiences with cosmetic surgery in California, either for breast augmentation (Tr. 6995, 6767, 6795, 6824, 6889) or a "tummy tuck" (Tr. 6855). All of the witnesses responded to advertising by cosmetic surgeons which they had observed in the newspapers or on radio and television (Tr. 6696, 6769, 6795, 6825, 6889). Each of the witnesses was also subjected to high pressure sales techniques after responding to the advertisement (Tr. 6699, 6702, 6770-73, 6800-05, 6828-29, 6858-59, 6892-94). Five of the witnesses suffered severe injury to their health and serious emotional difficulties as a consequence of the surgery. The daughter of the remaining witness

died as the apparent result of the surgery performed by the advertising physician. [204]

The advertisement seen by the first witness appeared in the *Los Angeles Times* in August 1976 (Tr. 6697), and was sponsored by the so-called Women's Advisory Council (RX 877). The second witness saw an advertisement in the *San Diego Evening Tribune* in late 1976 (Tr. 6767–68); the sponsoring organization was identified as the Academy of Cosmetic Surgery; and a telephone number also appeared (Tr. 6767–68). The third witness saw advertisements in newspapers and on television and radio sponsored by "Women Who Help Women" (Tr. 6795). The fourth witness also saw and heard newspaper, radio and television ads sponsored by "Women Who Help Women" in July 1974 (Tr. 6825–26). The daughter of the fifth witness saw an advertisement in the *San Jose Mercury* in November 1976 (Tr. 6855–56). The witness's daughter contacted the advertising surgeon to arrange for a "tummy tuck," although she had previously been advised by several non-advertising physicians that the surgery was contraindicated in view of her obesity, diabetes and general physical condition (Tr. 6857). The sixth witness responded to an ad from the *Los Angeles Times* sponsored by "Women Who Help Women" (Tr. 6890).

All of the witnesses testified as to the medical treatment they received and the results of their cosmetic surgery (Tr. 6689–6919). Without going into the elaborate detail present in the witnesses' testimony, it is concluded from that testimony and from pictures of the results of the surgery that the care was unprofessional in every respect. One patient died and the others were permanently disfigured, even after reconstructive surgery performed by other surgeons. The five witnesses who survived the surgery were under medical care for weeks and months, and the total costs of the surgery were substantial.

4. *Advertising by Bariatric Physicians*

143. Bariatric medicine deals with people who have weight problems (Tr. 7137). The purpose of bariatric treatment is not merely to promote a change in weight, but also to help the patient live a longer, healthier and more useful life (Tr. 7145). A decrease in weight may also cure or control such serious physical problems as high blood pressure, hypertension, diabetes and heart disease (Tr. 7145–46). There are about 560 members of the American Society of Bariatric Physicians (Tr. 7140). This organization, which is not related to the American Medical Association, strives to encourage a high level of bariatric medical care through continuing medical

education programs, seminars and scientific publications (Tr. 7140–41). Approximately 60 members of the Society are certified by the American Board of Bariatrics (Tr. 7139). [205]

When a prospective patient presents himself to a reputable bariatric physician, the first stage of treatment normally involves both an in-depth interview and an extensive physical examination (Tr. 7142). A patient's desire to lose weight may be symptomatic of deeper psychological problems which cannot be treated by the bariatric physician. A reputable bariatric physician will not ignore a patient's psychological problems in order to treat only their physical consequences, but will endeavor to promote the patient's mental health as well (Tr. 7147–48). Sound bariatric treatment often involves not only diet and exercise, but consultation with a psychologist who can aid in behavior modification (Tr. 7143–44). Possible problems which a bariatric physician encounters include patients who suffer from diabetes, high blood pressure, glaucoma, cirrhosis, intestinal problems or kidney or liver dysfunctions, all of which require specialized forms of bariatric treatment (Tr. 7152–53). Recidivism in obesity is common, and weight control requires a well-rounded diet program, good exercise program and a change in eating habits and mental attitude (Tr. 7155). The key to bariatric treatment is loss of fat and a reduction in caloric intake (Tr. 7159–60).

Advertising of weight control programs is widespread both in California and across the United States. A large part of this advertising is sponsored by physicians (Tr. 7166; RX 806–09, 811–16). The copy of a bariatric advertisement may be meaningless but eye-catching, such as "Serious About Losing Weight?" (Tr. 7182; RX 812), or "Come in Fat. . .Walk out Thin" (Tr. 7188; RX 809). Other advertisements are more misleading, suggesting that the consumer can lose a certain amount of weight in a specified limited time period without strenuous exercise, side effects or hunger, and claiming that the system is safe for the "entire family" (Tr. 7177–80; RX 806, 807, 809). Bariatric advertisements frequently feature pictures or drawings of attractive men and women. In fact, even patients who manage to lose large amounts of weight will not look like they did before the weight gain because skin has stretched and wrinkled. Few, if any patients, will resemble the attractive bodies pictured in the advertisements (Tr. 7178–79, 7182–83; RX 813). Some advertisements claim they have a special or unique method of weight control (Tr. 7180, 7187; RX 811, 812, 814). In fact, no one clinic or physician has a unique "key" to weight loss; dieting and exercise is the only effective method of bariatric treatment (Tr. 7180–81). Bariatric advertisers often make unsubstantiated claims about the number of

individuals they have successfully [206] treated (Tr. 7183-84; RX 813, 814, 816), and support their claims with patient testimonials (Tr. 7188-89; RX 808). These advertisements contain no information on the number of individuals who failed to lose weight (Tr. 7184).

The weight clinics to which consumers are drawn by these bariatric advertisements often provide inadequate care at a high cost. The patient may be required to pay a certain amount of money immediately or sign a contract, and repeated collection attempts may be employed if he or she defaults (Tr. 7168-69). High pressure sales tactics are also used (Tr. 7170). Some physicians advertise a large number of offices in various locations, although they could not possibly service all of them and although patients are likely to be unable to contact their physician when they need to (Tr. 7185-86; RX 808, 816).

5. *Evaluation of Advertising by Fringe Medical Practitioners*

144. Most of the physicians engaged in the advertising of cosmetic surgery and weight loss programs are fringe practitioners (Tr. 9337, 6655). Moreover, since most of these advertising physicians are not members of state and local medical societies, they are not subject to their disciplinary jurisdiction (CX 2593, 2420, 2576-77, 2579-81; Tr. 6785, 9337; RX 679, 682, 683, 693, 797, 801); thus, AMA and its local medical societies cannot control the advertising of these doctors through their ethical restrictions (Tr. 9512-13, 9339-41). In any event, most of the fringe practitioners involved in the advertising incidents about which AMA has produced evidence are being actively proceeded against by state licensing officials and, in some cases, by local district attorneys in criminal prosecutions (CX 2206-07, 2210-17, 2222-25, 2582-84).

Quacks and borderline practitioners in the medical field have practiced for many years in California (Tr. 7025, 6757-58; RX 804, p. 6); witnesses were unaware of such advertising by doctors in states other than California (Tr. 6920-7026, 7031-7123, 9529). Most physicians are competent (Tr. 9526, 9335, 9367), and the number of physicians who would make false claims is small (Tr. 9333). Medical educational standards, both for qualifications and character, are stringent, and the physicians being turned out today are of exceptionally and uniformly high quality (Tr. 9335).

The essence of the problems raised by AMA's testimony with respect to cosmetic surgeons is not with the advertising but, rather, with the negligent, inept, insensitive and almost ruthless medical care given the patients (*See* RAF, pp. 339-60). [207]

XI. ETHICAL RESTRICTIONS ON PHYSICIANS' CONTRACTUAL ARRANGEMENTS

A. Contract Practice of Medicine

145. Section 6 of the Principles of Medical Ethics states: "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgement and skill or tend to cause a deterioration of the quality of medical care" (CX 462Z12; RX 1, p. 5). AMA has defined "contract practice" as follows:

> Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita (CX 462Z12).

B. The Restrictions and their Background

146. The 1971 AMA Judicial Council's *Opinions and Reports* provide that an organization's contract with a physician to deliver medical services is "unfair or unethical" under any of the following conditions:

(a) When the compensation received is inadequate based on the usual fees paid for the same kind of service and class of people in the same community.

(b) When the compensation is so low as to make it impossible for competent service to be rendered.

(c) When there is underbidding by physicians in order to secure the contract.

(d) When a reasonable degree of free choice of physicians is denied those cared for in a community where other competent physicians are readily available. [208]

(e) When there is solicitation of patients directly or indirectly[5] (CX 462Z12-13).

AMA has also published this five-part ethical guideline in its 1974 *Report on Physician-Hospital Relations* which was in effect as of the issuance of the complaint herein.

AMA's 1971 ethical standards also proscribe the following contractual relationships:

(a) Opinion 5 of Section 6 of the 1971 Judicial Council's *Opinions and Reports* states: "A physician should not dispose of his profession-

[5] "[B]y 'solicitation' is meant to seek professional patronage by oral, written or printed communications either directly or by an agent" (CX 462Z13).

al attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee" (CX 462Z13).

(b) Opinion 8 of Section 6 declares that "[t]he action of a physician in accepting a salaried position offered by the hospital" to provide professional medical care in the emergency room "is not consonant with the policy of the AMA" (CX 462Z14, 959Z62).

(c) Opinion 4 of Section 6 states:

> In increasing numbers, physicians are disposing of their professional attachments to lay organizations under terms which permit a direct profit from the fees or salary paid for their services to accrue to the lay bodies employing them. . . . Certain hospitals are forbidding their staffs of physicians to charge fees for their professional services to 'house cases' but are themselves collecting such fees and absorbing them in hospital income. Some universities, by employing full time hospital staffs and opening their doors to the general public, charging such fees for the professional care of the patients, as to net the university no small profit, are in direct and unethical competition with the profession at large . . . . (CX 462Z13). [209]

(d) AMA's 1974 *Report on Physician-Hospital Relations* states:

> [A] physician should not bargain or enter into a contract whereby any hospital, corporation or lay body by whatever name called or however organized may offer for sale or sell for a fee the physician's professional services . . . . The physician and the medical staff, as principals, should not approve any contract whose terms or conditions are inconsistent with the 'Principles of Medical Ethics' and established policy of the American Medical Association.
>
> Throughout many years, it has clearly been AMA's position that no lay organization should profit from fees received for physicians' services (CX 959Z2).

This ethical restriction closely resembles Opinions 4, 5 and 8 of AMA's 1971 *Opinions and Reports* (CX 462Z13–15).

147. The actions of AMA's House of Delegates and Judicial Council over the years reveal the anticompetitive motivations behind AMA's ethical restrictions on contract practice. The AMA's House of Delegates adopted a resolution, in 1869, recommending "that all contract physicians, as well as those guilty of bidding for practice at less rates than those established by a majority of regular graduates of the same locality, be classed as irregular practitioners" (CX 1435Q). The AMA House of Delegates rescinded the 1869 resolution eight years later. In 1872, the House referred to the state societies a similar recommendation from its Committee on Ethics:

> [T]hat members of the profession hired by the month or year for definite, stipulated wages, by individuals, families, railroad or manufacturing corporation, or any other money-making institution whatever, for ordinary medical and surgical practice

(always excepting benevolent and eleemosynary institutions and medical officers of the Army and Navy), are to be classed as irregular practitioners (CX 1435Q). [210]

In the 1890's, the AMA House of Delegates adopted a report declaring that contract practice had "gone too far" and that "[t]oo much of the spirit of trade has found its way into the profession, and its further encroachment should be resisted—not encouraged" (CX 1435Q, R).

In 1926, the House of Delegates adopted a resolution recommending that "the whole matter of contract practice be investigated under the direction of the Judicial Council" (CX 1435R). In response, the AMA Judicial Council reported to the House of Delegates, in 1927, that "[t]here is no doubt that the [contract] practice is growing in frequency and becoming widespread. In fact, it is entering into so many phases of the practice of medicine as to be a distinct menace to the stability of our organization" (CX 953B). The Judicial Council proposed, and the House of Delegates then approved, language identical to the provisions of Opinion 3 of Section 6 of the Judicial Council's 1971 *Opinions and Reports* as a "formula . . . to pronounce as ethical or unethical, a given contract for medical services" (CX 1435R–S, 953B–C, E, F).

In 1927, the Committee on the Costs of Medical Care, a commission of leaders in medicine, public health and the social sciences funded by the Carnegie Corporation, the Rockefeller Foundation and other private philanthropies, began an extensive five-year study of the country's health care system (CX 2085). In its report, published in 1932, the Committee recommended the expansion of prepaid health care, involving an increase in the amount of contract practice (CX 2085M, V–Y, Z57). Nine physician members of the Committee on the Costs of Medical Care, including the Secretary of AMA, the then Chairman of the AMA Judicial Council and the 1927 Chairman of the Judicial Council (CX 2085R, Z27, 952B, 953B), published a minority report opposing the Committee's recommendations on group prepaid medical practice (CX 2085Q–Z25). Citing provisions of the Opinion 3 language adopted by the AMA House of Delegates in 1927, the minority disapproved the Committee's proposals for expanded group contract practice, stating that "[a]ny method of furnishing medical care which degrades the medical profession through unfair competition or inadequate compensation . . . must be condemned" (CX 2085W–Y). The minority also criticized the group practice contracts recommended by the Committee on the ground that "[w]herever they are established there is solicitation of patients, [211] destructive competition among professional groups . . . and demoralization of the profession" (CX 2085Z6), and that

"able physicians outside of the groups are being pushed to the wall" (CX 2085Z7).

In 1933, the AMA House of Delegates voted to endorse the minority report of the Committee on the Costs of Medical Care as "expressive, in principle, of the collective opinion of the medical profession" (CX 1435Z42). That same year, the AMA House of Delegates amended the Principles of Medical Ethics to incorporate the Opinion 3 language on contract practice (CX 952B, E, 1435S).

In 1934, the AMA House of Delegates further amended the Principles of Medical Ethics to provide further that:

> It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy (CX 1435S–T).

Absent the second sentence, this provision parallels Opinions 5 and 8 of Section 6 in AMA's 1971 *Opinions and Reports* (CX 462Z13–14) and the restriction on contract practice published in AMA's 1974 *Report on Physician-Hospital Relations* (CX 959Z2).

C. Application of the Restrictions

148. AMA and its member societies have utilized the above described ethical restrictions on contract practice (F. 146, pp. 207–09) to proscribe contracts under which hospitals, group prepaid health plans and other lay organizations employ physicians to care for patients, especially where the physicians are employed for a fixed salary. In a number of instances, AMA and its member societies have counseled physicians to refrain from actions contrary to the contract practice ethical restrictions. [212]

In 1936, the Medical Society of Milwaukee County (Wisconsin) expelled several physicians for associating with a prepaid group health plan proposed for the employees of the International Harvester Company (CX 580A–B). On appeal, the State Medical Society of Wisconsin and the AMA Judicial Council affirmed the physicians' expulsion (CX 580C–D). The AMA Judicial Council held that the physicians' relationship with the group plan constituted unethical contract practice and involved unethical solicitation of patients and advertising (CX 580C, E).

Shortly thereafter, the Medical Society of the District of Columbia expelled one physician affiliated with the Group Health Association,

a prepaid group health plan, and succeeded in pressuring another to resign from the plan. The Medical Society charged the physicians with violating the same AMA ethical provisions on contract practice that were subsequently incorporated in Opinion 3 of Section 6 of the 1971 *Opinions and Reports* (*AMA* v. *United States,* 130 F.2d 233, 238–40 n. 23 (D.C. Cir. 1942), *aff'd* 317 U.S. 519 (1943)). In furtherance of the AMA policy of opposing group prepaid medical practice, the Medical Society also threatened disciplinary action against any physician who consulted with, or any hospital which granted staff privileges to, a Group Health physician (*United States* v. *AMA,* 110 F.2d 703, (D.C. Cir. 1940), *cert. denied,* 310 U.S. 644 (1940)). Both respondent AMA and the Medical Society of the District of Columbia were convicted of conspiracy to restrain and obstruct the development of the group health plan, in violation of the Sherman Act. In affirming the convictions, the D.C. Circuit Court stated: "The concern of [AMA and the local medical society] with the effect of Group Health on the economic status of the medical profession, and upon competition in financing and making available medical and hospital services, is abundantly illustrated by articles and statements of officers and members thereof" (*AMA* v. *United States,* 130 F.2d 233, 239 (D.C. Cir. 1942)). The Supreme Court affirmed the convictions in 1943 (*AMA* v. *United States,* 317 U.S. 519 (1943)). The Administrative Law Judge takes official notice of these decisions.

In 1965, AMA responded to an inquiry from the California Medical Association asking whether a physician could ethically compete with other physicians, through competitive bidding, to obtain an employment contract to perform physical examinations (CX 1158A, 539A). In its [213] response, AMA relied on the first three paragraphs of Opinion 3 of Section 6 of the *Opinions and Reports* governing contract practice (F. 146, pp. 2–7–08), including the provision barring "underbidding by physicians" (CX 1158A–C). The AMA letter stated:

> The guidelines as to what would be proper bidding could be indirectly resolved from points 1 and 2 [the first and second subparagraphs of the third paragraph of Opinion 3 of Section 6 of the 1964 *Opinions and Reports* (CX 465V) and later in the 1971 *Opinions and Reports* (CX 462Z12–13)]. That is, when the bid is below what is the usual fee paid for the same kind of medical service in the locality and when the remuneration is so low as to make it impossible to render competent service [it is unethical]. . . .
>
> . . . [As to] whether or not an affirmative response to such a general invitation to bid for use of the physician's professional services would [it] be within keeping of the dignity of the medical profession? Secondly, a doctor, would know by the type of request tendered to him that he probably is going to be competing against many of his associates for a specific contract or employment. Wouldn't this be a competitive force of so great a magnitude that it would cause a deterioration of the quality of medical service rendered? . . .

Thirdly, wouldn't such a request, if answered, make an inroad into the concept of professionalism in that it reduces the profession to a business? (CX 1158C-D).

In the mid 1960's, corporate plantations in Hawaii were contracting with physicians, on salaried and other fixed compensation bases, to provide medical care for their workers and retirees (CX 852A, 850C). When the plantations' retirees began obtaining coverage under the [214] newly instituted Medicare program, the plantations decided to seek Medicare reimbursement for the services rendered by their contract physicians, while continuing to pay the physicians on a salaried basis (CX 852A-B). The plantations also planned to pay the Medicare deductible for those retirees who continued to obtain their care from the plantations' contract physicians (CX 852A-B). The Honolulu County Medical Society's executive secretary, and later the Hawaii Medical Association's attorneys, wrote to AMA in 1967 asking whether the proposed contractual arrangements were ethical (CX 852, 850). The Hawaii Medical Association's attorney stated: "If the Judicial Council deems it unethical, the doctors will pull out of the contract" (CX 848, 850A). The Secretary of the AMA Judicial Council responded to the Honolulu County Medical Society, enclosing contract practice provisions of the Judicial Council's *Opinions and Reports,* and stating:

[T]his matter is a classic example of contract practice . . . . To the extent that the company seeks to derive benefit for itself from the labors of the physician . . . [i]t would be in derogation of basic ethical principles of medicine. . . . [T]he proposal of the plantation does not appear to be in keeping with traditional AMA policy. Were the plantation to accept an assignment of the physician's benefit, the plantation would be selling the services of the physician and would be exploiting him. There would be no assurance that the income of the physician from the plantation would relate in any way to the amount of services he furnished the individual patient . . . . Perhaps the time has come when an educational program is needed to eliminate as far as possible this older form of contract practice, substituting a fee-for-service system . . . . (CX 851).

The Honolulu County Medical Society adopted, as "clear and unequivocal," AMA's position on the plantations' contractual proposal and declared unethical any arrangement violating the policies set forth in the AMA letter (CX 846). The [215] Secretary of the AMA Judicial Council then wrote to the county society, praising it for "using the *Opinions and Reports* of the Judicial Council [to take] a stand" (CX 845). The AMA letter, which quoted a portion of an earlier AMA Judicial Council report, stated:

The Judicial Council believes that the remedy for the evils associated with contract practice resides in the county societies, and that these societies should use their

influence and power . . . to prevent underbidding for these contracts below what would give a fair reward for medical services rendered . . . .

It seems to me that the Honolulu County Medical Society is observing the spirit of ethical principles . . . . (CX 845A–B).

In January 1966, the AMA Department of Medical Ethics wrote to a Utah radiologist that "an agreement under which the hospital employs the radiologist and sells his services . . . is always considered unethical since professional services are being purveyed to the direct benefit of a lay group; namely, the hospital" (CX 807C, 537A).

In February 1966, the AMA Department of Medical Ethics advised a West Virginia physician that it is unethical to contract to provide coverage for a hospital's "walk-in" patients on a fixed salary basis, even when the physician's services are billed separately (CX 813A–B). AMA sent the physician the 1966 *Opinions and Reports* and directed his attention to, among other provisions, Opinion 8 of Section 6 (CX 813A), which proscribed salaried emergency room practice (CX 463V, W).

In May 1966, the Kentucky Medical Association, an AMA constitutent society whose members must subscribe to the AMA Principles of Medical Ethics (CX 1827H, I, J), threatened three physicians with disciplinary action (CX 1823) for permitting a "lay organization to purvey their services to the public and not restricting their method of compensation as nearly as possible to the time-honored 'fee-for-service' concept" (CX 1823A). The state society's Board of Trustees stated that occupancy of offices in hospitals by "a privileged few" physicians "is a form of solicitation which is inimical to high professional standards" (CX 1823A). **[216]**

In June 1966, the AMA House of Delegates "approved for circulation" a model physician-hospital contract for the staffing of hospital emergency rooms (CX 954A–E). It provides:

11. *Professional fees:* The charges for professional services rendered by the Partnership [of physicians] shall be established, billed and collected by the Partnership in the same manner as are the fees of other physicians engaged in the independent practice of medicine. It is intended that the Partnership's schedule of fees shall conform generally with those customarily charged in the locality and nearby localities for comparable services (CX 954C).

The model contract also provides that the physicians "shall organize and operate the Emergency Department or Section and engage in medical practice therein in accordance with the ethical and professional standards of the American Medical Association . . ." (CX 954D). As recently as June 1974, the Secretary of the AMA Judicial

Council sent a copy of the model contract to a hospital which had requested guidance in staffing an emergency room (CX 868, 869A–D).

In 1967, the House of Delegates of the state medical society in Maryland voted to disapprove the closed-panel practice of medicine as an abridgement of "freedom of choice" (RX 308, p. 29). It relied on a similar policy adopted by the AMA House of Delegates in 1959 (RX 308, p. 29). Previously, the AMA Judicial Council had declared that "free choice of physician . . . expressly requires that any qualified licensed physician residing in the area in which the plan operates be allowed to participate" (CX 1435Z57). The Maryland medical society published its "freedom of choice" resolution in its August 1976 compendium of interpretations of the AMA Principles (RX 308, pp. iii, 29).

In April 1968, a New York physician wrote to AMA to ask whether his part-time employment as a salaried physician at a hospital would violate the AMA Principles of Medical Ethics. AMA replied that the opinions of its Judicial Council do not approve of hospitals employing physicians (CX 1753A). [217]

In July 1968, the Secretary of the AMA Judicial Council wrote to a Virginia physician that it is not ethical "for a physician to have a contractual relationship with a hospital in which professional fees for his services are collected by the hospital and he receives a salary not related to those fees" (CX 831).

Also in 1968, the Chairman of the Judicial Council of the Florida Medical Association wrote to the AMA Judicial Council inquiring about the ethical principles that apply to physicians employed on a salary basis by a hospital or medical school (CX 528A, B), AMA learned that the state association, whose own ethical principles are the AMA's Principles of Medical Ethics (CX 2543K), had adopted a statement providing:

> A salary may be paid to a physician for time spent in administration and supervisory capacity but not for patient care.
>
> It is not unethical for a physician to accept a salary for supervisory, or educational and administrative activities or his presence; but it shall be unrelated to how many patients he sees or how much money he collects from the patients for services rendered them; and fees for treatment of patients shall continue to be billed in the physician's name and disposed of by the physician rendering the service (CX 528A).

The AMA Judicial Council carefully considered this statement and unanimously decided that the Florida Medical Association's own ethical policy statement on salaried hospital practice would serve as an acceptable response to the state association's inquiry to AMA (CX 528B).

In December 1969, the Secretary of the AMA Judicial Council

responded to a physician's inquiry by sending a letter to an AMA field representative (CX 812, 459D). The letter stated: "If the salaried physician is being paid by the hospital for medical care given patients the hospital is practicing medicine through a licensed employee . . . . [This activity] is contrary to AMA policy. See opinion 4 and 5 on page 32, Opinions and Reports of the Judicial Council [CX 463V]" (CX 812A). [218]

In October 1972, the State Medical Society of Wisconsin, a constituent society of AMA whose members are governed by the AMA's Principles of Medical Ethics (CX 1906A, G), wrote to the Secretary of AMA's Judicial Council regarding the ethics of a prepaid group health plan's distribution to the public of a list of its staff physicians (CX 1198). In response, the Judicial Council Secretary cited Opinion 3 of Section 6 of the 1971 *Opinions and Reports* as the most applicable opinion of the Judicial Council (CX 1199). Opinion 3 includes a ban on contract practice "[w]hen there is solicitation of patients directly or indirectly" (CX 462Z13).

In 1973, the Washington State Medical Association, an AMA constituent society that requires its members to subscribe to AMA's Principles of Medical Ethics (CX 475H, I, K, O), asked the AMA Judicial Council for ethics advice on a contract plan proposed by Manpower, the large temporary help service. Manpower wanted to hire physicians to cover hospital emergency rooms and adult health clinics and to conduct physical examinations, and pay them based on an established schedule. It had requested the state association's assistance in locating physicians who might be interested (CX 822A-C). The Secretary of the AMA Judicial Council wrote back noting that, under the proposal, Manpower "would hire a physician and tell him where and when to work, determine his salary, and determine its charge for its service in providing him to its subscribers" (CX 823). The AMA letter said the plan "would exploit the physician" and violate "ethical principles" (CX 823B). The AMA official called the state association's attention in particular to Section 6 of the Principles of Medical Ethics and to the opinions found in the 1971 *Opinions and Reports* following that section (CX 823B). The state association then wrote to Manpower, informing it of AMA's judgment that the contract practice plan would violate ethical principles and declining to provide assistance to Manpower (CX 824).

A hospital in Indianapolis paid an internist a fixed stipend to direct an arthritis treatment clinic which collected fees from patients for the services it rendered (CX 799). In 1974, a member of the medical staff of the hospital wrote to the AMA Judicial Council to ask whether the arthritis clinic was "in violation of ethics and

policies of the AMA" (CX 799). In its response, the AMA Judicial Council questioned the propriety of the clinic selling its contract physician's services for a fee, stating that "[t]he policy of the American Medical Association is that the physician should set his own fees and bill his own patients" (CX 798). [219]

In 1974, a physician's attorney asked AMA whether the physician's contemplated employment with a medical clinic licensed by the Chicago Board of Health would be legal and ethical (CX 815). The physician planned to assign the fees he collected from his patients to the clinic, in return for compensation on an hourly basis (CX 815). The Secretary of the AMA Judicial Council responded that the practice was of questionable legality based on cited court cases. He advised that "[f]rom an ethical point of view I would say that it is contrary to the long established policy of the AMA," and enclosed an opinion reflecting that policy (CX 814).

Sometime after issuance of the complaint in this proceeding, the Texas Medical Association sent a letter to the Texas Hospital Association, with copies to the chiefs of staff of Texas hospitals and to the presidents of every county medical society in Texas, stating that "the only acceptable method for [hospital-based] physicians to fulfill their ethical and legal obligations" is for the individual physicians to bill their patients directly or through hospital accounting departments on a fee-for-service basis (CX 859A, B). The letter referred to the Principles of Medical Ethics (CX 859A), which govern the state society's members (CX 1899U, Z5). The letter also paraphrased the first paragraph of Opinion 5 of Section 6 of the *Opinions and Reports,* which states that physicians should not permit the sale of their services by a hospital or lay organization for a fee (CX 462Z13). The letter asked the Texas Hospital Association to cooperate "in circulating this policy to administrators of hospital facilities in Texas in order that physicians seeking to comply with these ethical guidelines may be able to negotiate, and if necessary renegotiate, acceptable contracts for provision of these medical services" (CX 859A). The letter also stated that Texas law prohibited the corporate practice of medicine. An attachment to the letter, containing Texas Medical Association ethical policies issued in November 1975 and May 1976, stated that physicians who practice under circumstances other than separate, direct billing of patients for particular services rendered "may be subject to charges of unethical conduct and previous policy allows no latitude in deciding the ethics of the matter" (CX 859C, D, A). [220]

Florida Health Care Plan

149. In 1968, the Florida Medical Association ("FMA"), adopted a statement, later approved by the AMA Judicial Council, declaring it unethical for a physician to be paid a salary for patient care (CX 528A).

Throughout the 1970's the FMA and the Volusia County Medical Society ("VCMS"), both AMA member societies (CX 2543A, 1961B), have impeded the development of an HMO by restricting its marketing activities and declaring its physician employment contracts to be unethical. In their actions, the societies have relied on AMA ethical standards and other AMA statements.

In 1971, Dr. E. D. Davis, who testified in this proceeding, and others began organizing the Florida Health Care Plan ("FHCP"), an HMO in Daytona Beach, Florida, which has since gained federal certification and begun operations (Tr. 9146–47, 9155–56, 9158). Its staff includes contract physicians who are paid a fixed salary to care for patients (Tr. 9196–97). In late 1971, the VCMS voted unanimously to oppose and disapprove the plan (CX 2575D, E).

In 1972, the FMA published an ethics opinion stating:

> [A]ny physician contemplating providing medical service in an HMO setting should always be aware of Section 6 of the Principles of Medical Ethics and particularly those ethics covering conditions of medical practice, contract practice, purveyal of medical service to direct profit of lay group, practice of medicine by lay corporations, and lay corporations [Opinions 1, 2, 3, 4, 11 and 12, respectively, of Section 6 of the 1971 AMA *Opinions and Reports* (CX 462Z12–13, Z15)] (CX 2572E).

Also in 1972, the state society issued *Criteria for Ethical Contracts Between Physicians and Hospitals* ("Criteria") (CX 825). The Criteria begin with an almost verbatim rendition of the final paragraph of Opinion 5 of Section 6 of AMA's 1971 *Opinions and Reports* (CX 462Z14). The Criteria also declare that ethical contracts must not include a maximum or ceiling on the contract physician's income (CX 825).

In 1973, at the request of FMA, AMA's Department of Field Service supplied VCMS with "anti-HMO's" information "[which] will give you and your physicians all of the necessary information and 'ammunition' to rebut HMO activities in your area" (CX 2101). [221]

In May 1977, two of FHCP's physicians applied for malpractice insurance coverage (CX 2558, 2566) from an insurance carrier established and controlled by FMA (CX 2540C, D, 2539C). The only other source of malpractice insurance in Florida was a program run

by the State of Florida. The rates for this plan were substantially higher than the FMA carrier's rates (Tr. 9198-99, 9202, 9210).

The state society's insurance carrier obtained copies of the FHCP physicians' employment contracts and forwarded them to the FMA's Judicial Council for review (CX 2562, 2565, 2544). The Judicial Council declared the employment contracts unethical (CX 2563-65, 2544). In June 1977, the insurance carrier rejected the physicians' applications for coverage (Tr. 9201-02), stating in letters to the physicians:

> The Judicial Council has disapproved this contract due to the ceiling on the physicians income or the flat salary which you receive from Florida Health Care Plan, Inc. It is the feeling of the Council that this cap or ceiling is not consistent with the ethical principles of the Florida Medical Association. The Council feels that the income of a physician should be based on his production and the ceiling can result in the exploitation of the contract physician (CX 2565, 2544).

FMA's ethical principles consist of AMA's Principles of Medical Ethics, as interpreted by the opinions of the AMA Judicial Council (CX 2543K).

The physicians employed by the FHCP have had to obtain their malpractice insurance from the high cost plan administered by the State of Florida (Tr. 9198, 9210-11). Consequently, FHCP must pay insurance premiums four times higher than the premiums charged by the medical society carrier (Tr. 9210-11).

D. The Connecticut Respondents

150. The AMA House of Delegates has adopted a resolution declaring that no state or local society which has not adopted AMA's Code of Ethics shall be entitled to [222] representation in AMA (CX 1435Z15-16). CSMS has adopted the AMA's Principles of Medical Ethics to govern the conduct of its members (CX 991D, L-M; CX 1404I-J). NHCMA has also adopted the AMA's Principles of Medical Ethics (CX 1404I). NHCMA's bylaws declare that members can be expelled for violating AMA's Principles of Medical Ethics, "as reflected in the [AMA] Judicial Council" (CX 1404I).

CSMS adopted a resolution in 1962 condemning as "corporate practice of medicine" hospitals' receipt of fees from government health programs and other third-party payers for services which the hospitals' staff physicians were providing to certain beneficiaries (CX 1344A, Z9-Z11). The resolution declared that such beneficiaries "shall have the status of private patients of privately practicing physicians" and that "no fees paid by any third party agency for services rendered by such physicians shall be paid directly or

indirectly to any hospital . . ." (CX 1344Z9, Z11). This resolution is similar to Opinion 5 of Section 6 of AMA's *Opinions and Reports* (CX 462Z13). Copies of the resolution were distributed to general community hospitals throughout Connecticut (CX 1344Z10).

The original draft resolution stated that "the practice of payment to hospitals of fees for services to patients is detrimental to the private practice of medicine and should cease" (CX 1344C–D). In the debate on the resolution, one CSMS delegate stated: "The big thing that we are most concerned about is the fact that certain pressures may be brought upon private physicians in the institutions to which these patients are admitted so that the fee will be paid to the hospital for professional services rendered by physicians" (CX 1344G). Another delegate received applause when he stated that "it is the principle behind this thing . . . that third party payments should not get into the hands of people other than the doctors" (CX 1344Z2). Another CSMS delegate also was applauded when he stated: "[W]e want to stop the hospitals from putting their hands out for that particular type of payment . . . . Now, if we get strong on this motion, perhaps in the future we can go to the help of these poor anesthesiologists and radiologists" (CX 1344Z1). Three years later, in 1965, the CSMS House of Delegates adopted resolutions from its Sections on Radiology and Pathology, supporting "the principle that all hospital patients be billed separately for the professional services of doctors of medicine" (CX 1343E, H, A, B–C). The House declared that "[t]his principle is in accordance with the positions adopted by the American Medical Association . . ." (CX 1343E). In some of its advisory letters to physicians regarding contractual arrangements, AMA has linked the [223] separate billing requirement to the ethical proscription regarding salaried medical practice (CX 820, 830, 831, 806C, G, 813A–B, 798, 799).

From 1972 to 1974, NHCMA complained about HMO written solicitations of patronage in letters to CSMS (CX 964), the Connecticut Commissioner of Insurance (CX 962, 963) and the Commissioner of the Connecticut Department of Consumer Protection (CX 965). In its letter to the insurance commissioner, NHCMA questioned the propriety of a "closed panel health service plan without free choice of physician" which was "supplying medical service . . . in direct competition with the rank and file of taxpaying practitioners" (CX 962).

In 1974, NHCMA wrote to the Secretary of HEW to criticize an HMO's application for a federal grant (CX 966). In a December 1976, newspaper interview, the president of NHCMA associated HMOs

with socialized medicine and otherwise disparaged them (CX 2440, 2441).

Earlier, in a September 1971, letter written by one NHCMA official to another, NHCMA questioned whether, in light of its advertising and publicity, a New Haven HMO was "in violation of AMA principles of medical ethics and principle [sic] of *economics*" (CX 960) (emphasis in original). However, NHCMA took no action because a Connecticut statute permitted the HMO's promotional activities (CX 961).

E. Physicians' Arrangements with Nonphysicians

151. The AMA Principles of Medical Ethics and 1971 *Opinions and Reports* prohibit partnerships between physicians and nonphysician health professionals (CX 1189A, 462Z15, Z16, 1154, 1153). AMA's 1971 *Opinions and Reports* permit physicians to join in the formation of professional associations or corporations for the delivery of health care only if ownership of the organization remains solely in the hands of licensed physicians (CX 462Z15, Z16).

In 1970, AMA advised a county medical society that it would not be ethical for a psychiatrist-member of the county society to form a partnership with a psychologist (CX 1189, 52A).

In 1975, AMA sent an advisory letter to Dr. Paul D. Saville, a West Virginia rheumatologist, who testified in this proceeding (Tr. 2705), informing him that it would be neither ethically nor legally acceptable to form a business partnership or income-sharing arrangement with a [224] physician's assistant for the purpose of delivering health care (CX 1196). After receiving the AMA advice, Dr. Saville and the physician's assistant, Helen Kramer, formed an income-sharing arrangement; however, fearing physician hostility, they have kept the arrangement secret from everyone except their spouses (Tr. 2727–30). Physician's assistant Kramer, who also testified in this proceeding, brought administrative and patient-relations skills to the private practice of Dr. Saville, who lacked such skills (Tr. 2758–59, 2717). The result was a maximal effective practice which enabled the physician always to see new patients who came to his office and to treat a large group of people at minimal cost to them (Tr. 2717–19). Explaining the benefits of the income-sharing arrangement, Dr. Saville testified:

[W]e both contribute something, and it is to our mutual advantage that we both do well.

And the better we do, the harder Helen works, the harder I work, the more income

there is, and the more load on Helen's back. It is a better incentive to share in the profits rather than be fixed salary, in my opinion (Tr. 2720-21. *See also* Tr. 2762).

In 1975, the Texas Medical Association advised an orthopedic surgeon that, under AMA's *Opinions and Reports,* it would be unethical for the physician to enter into an income-sharing arrangement with a physical therapist working in his office because the physical therapist would be getting a direct financial interest in the productivity and fees earned by the physician (CX 1150, 1151A-B).

In 1974, Dr. Kenneth Pitts, a psychiatrist residing in Hillsboro Hills, Michigan, first considered the possibility of establishing a psychiatric out-patient center in surburban Detroit. He discussed the matter over a period of months with Dr. Marvin Hyman, a clinical psychologist with whom Dr. Pitts had worked in the past. Dr. Hyman shared Dr. Pitts' enthusiasm for the project and the two men set out to establish a new out-patient center (Tr. 3166-68). Dr. Pitts and Dr. Hyman each invested an initial sum of $10,000 and, in late 1974, the Orchard Hills Psychiatric Center was organized under Michigan law as a professional corporation (Tr. 3167-70; CX 2102). Each of the men received 50 percent of the corporate shares (Tr. 3171). Dr. Pitts is medical director of the Center and Dr. Hyman serves as its [225] administrative director (Tr. 3164, 3170). All medical decisions at the Center are made by staff psychiatrists. Psychologists and social workers do not have authority to prescribe drugs, hospitalize patients or sign patient termination forms (Tr. 3173).

When the Center was created, Dr. Pitts considered establishing the practice on his own and hiring Dr. Hyman as an employee. Dr. Hyman, because of "professional or personal pride," wanted to be an equal "partner" in the practice (Tr. 3174). The doctors decided that the formation of a professional corporation would be the best alternative—it would offer the potential for a profit-sharing and pension plan, and would allow Drs. Pitts and Hyman to have an equal position in terms of profit and control (Tr. 3174).

In April 1975, Dr. Pitts, who testified in this proceeding, wrote to the Michigan State Medical Society concerning the ethical propriety of forming a mixed professional corporation with a psychologist and a social worker (CX 1183B). The Medical Society deferred its decision until it had obtained the opinion of the AMA Judicial Council (CX 1184). The AMA Judicial Council told the Medical Society that Opinions 14 and 15 in Section 6 of AMA's *Opinions and Reports* prohibit a psychiatrist from owning jointly with a psychologist a professional corporation for the delivery of mental health services, notwithstanding the legality of the arrangement under state law (CX 1185, 1183, 2102N). In October 1975, the Medical Society conveyed

the AMA ethics interpretation, which had confirmed its own opinion, to Dr. Pitts, and stated that the prohibition would apply to partnerships of otolaryngologists-audiologists, pathologists-medical technologists, ophthalmologists-opticians, radiologists-physicists, family physicians and paramedical personnel or physician assistants (CX 1186). In May 1976, the Medical Society's Judicial Council reaffirmed that physician-nonphysician partnerships are unethical (CX 1729).

The Medical Society's October 1975, letter led Dr. Pitts to incorporate the AMA ethics opinions in the standards for out-patient psychiatric clinics which he subsequently drafted for the Michigan Psychiatric Society (Tr. 3189–90; CX 2054C). These standards for out-patient psychiatric clinics, published in April 1977, quote Opinions 13 and 15 of Section 6 of AMA's 1971 *Opinions and Reports* (CX 462Z15, Z16), and state that any out-patient psychiatric clinic organized as a professional corporation must be solely owned by physicians (CX 2054A, C). The Michigan Psychiatric Society [226] promulgated these standards to its members, advising them that it would enforce the standards through peer review and ethics committee activities (Tr. 3191; CX 2054C).

Dr. Pitts had already formed his mixed corporation when he was told it was unethical (Tr. 3182–83). It made possible his association with other professionals and created opportunities for teaching and professional development (Tr. 3174–75). The psychologist, Dr. Hyman, brought a special skill in psychological testing and many other special talents to the joint endeavor (Tr. 3175). Dr. Pitts did not dissolve the corporation because he did not believe the corporate arrangement compromised medical practice; he also thought that it would have been "a very complicated thing to dissolve the corporation at that time" and that Dr. Hyman might have grounds for a lawsuit (Tr. 3185). Dr. Pitts was embarrassed by the situation, but apparently suffered no monetary losses, possibly because information about his situation was not generally known (Tr. 3185–88).

Association with nonphysician health personnel such as psychologists, physician's assistants and physicial therapists, can help physicians spend their time where it is most needed and can increase their productivity (CX 959Z24, 197Z27, U.).

XII. ABANDONMENT OR DISCONTINUANCE

152. The Principles of Medical Ethics of the American Medical Association (RX 1) consist of a preamble and 10 short paragraphs setting out basic principles or standards by which a physician may determine the propriety of his or her conduct in relationships with

patients, colleagues, allied health personnel and the public (Tr. 3940–44, 4289; RX 1). The 10 basic sections of the Principles were approved by the AMA's House of Delegates in 1957 (Tr. 3940, 4289; RX 1).

The *Opinions and Reports* of the Judicial Council are a collection of opinions and statements of the Council on a variety of subjects which have come before it (CX 462; RX 1). Some of these opinions and statements involve interpretations of the Principles of Medical Ethics; the opinions, statements and interpretations are modified from time to time to meet changing conditions of medical practice (RX 1, p. 1; Tr. 4290). The Judicial Council's interpretations of the Principles of Medical Ethics are contained in a booklet, entitled *Judicial Council Opinions and Reports* (Tr. 3982; CX 462; RX 1). The *Opinions and Reports* are distributed to anyone requesting a copy (Tr. 3982). The Judicial Council opinions and statements circulated by AMA [227] prior to the issuance of the complaint in this proceeding were the 1971 *Opinions and Reports,* which were published in booklet form and distributed commencing in 1972 (CX 462). Subsequent to issuance of the complaint, the Judicial Council, in 1976, issued revised opinions and statements which were published in booklet form in 1977 (RX 1). The Principles of Medical Ethics remained unchanged (RX 1, pp. 4–5). Some of the activities of AMA officials and the Judicial Council which preceded publication of the 1977 *Opinions and Reports* are described in the following paragraphs.

In September 1975, the Secretary of the Judicial Council wrote to a state medical society: "It was not felt that a major revision of the profession's position on advertising was necessary or advisable, but that an updating of the Judicial Council's previous opinions and reports on advertising might be helpful in the near future" (CX 627A–B). He further stated that any updating would uphold, in general, "reasonable restrictions" on advertising (CX 627B). The proposal for a new "updated" edition of the 1971 *Opinions and Reports* was formally sanctioned at a meeting of the Judicial Council in November 1975 (Tr. 4336; RX 621). Thereafter, on April 9, 1976, four months after the complaint in this proceeding was issued, the Judicial Council issued a revised statement on physician advertising and solicitation (CX 502A, H–K). The content and format of a new edition of *Opinions and Reports* was approved by the Judicial Council on June 26, 1976 (CX 501F). This revised statement was included in a revised edition of the *Opinions and Reports* which was published by the Judicial Council in March 1977, well over a year after the complaint herein was issued (RX 1, pp. 30–31; Tr. 4335). The

AMA Judicial Council issued the revised statement on advertising and solicitation and the 1977 edition of *Opinions and Reports* largely because "changing legal considerations," represented by the Supreme Court decision in *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773 (1975) (Tr. 4337), and administrative agencies' consideration of physician advertising and solicitation (CX 502A, E–H) had, in the view of the Judicial Council, rendered some provisions in the earlier [1971] edition of *Opinions and Reports* "legally inappropriate" (Tr. 4338, 4335; CX 503I).

For a number of months following issuance of the complaint in this proceeding, AMA continued to distribute excerpts from the 1971 *Opinions and Reports,* as well as its "Guidelines on Telephone Directory Listings" and the 1974 *Report on Physician-Hospital Relations* (CX 1790A, 1788, 501D–E). Through at least the beginning of the trial [228] in this proceeding, AMA component and constituent medical societies have continued to restrict physician advertising, solicitation and contract practice based on the 1971 *Opinions and Reports* (Tr. 2076–78, 2085–86; RX 1, p. 31, p. 61, F. 95, p. 121; 98, pp. 124–29; 109, p. 144; 114, pp. 150–52; 118, p. 158; 123, pp. 174, 176; 138, p. 199; 139, p. 199; 148, p. 219; 149, pp. 220–21; 151, pp. 224–26). There is no evidence that any of these societies rescinded any existing ethical rulings, or revised existing ethics guidelines or codes on advertising, solicitation and contract practice since 1975, because of changing legal considerations or because of the revised statement of the Judicial Council. For instance, the former president of the Maricopa County Medical Society, a physician who had served as chairman of both the Society's Professional Committee and its Board of Censors (Tr. 7208–09), stated his belief that, as of the date of his testimony in January 1978, physician members would not be allowed to advertise factual nonmisleading information, such as the opening or closing of an office in newspapers under the Code of Ethics of the Maricopa County Medical Society (Tr. 7254). This statement supports the belief that the 1971 *Opinions and Reports* continue to affect the application of ethical principles to physicians' advertising, solicitation and contract practice, as evidenced by their pervading influence on the ethical guidelines promulgated and enforced by local medical societies. A further example of continuing reliance being placed on the 1971 *Opinions and Reports* involves the Michigan Psychiatric Society, which adopted parts of the 1971 *Opinions and Reports.* Although the psychiatric society is not affiliated with AMA, the chairman of the committee who drafted the society's 1977 guidelines relied on the AMA ethical interpretations of 1971 (Tr. 3189–90; CX 2054C; F. 151, pp. 225–26).

153. The 1976 revised statement of the Judicial Council expressly "reaffirms the long-standing policy of the Judicial Council on advertising and solicitation by physicians" (RX 1, p. 30). The revised statement does not rescind or amend the long-time absolute ban on solicitation in the AMA Principles of Medical Ethics; "[The Principles] proscribe the solicitation of patients" (RX 1, p. 30). Dr. Robert S. Stone, who is Dean of the University of Oregon Medical School, a former Director of the National Institute of Health and a member of AMA's House of Delegates as well, was called by AMA to testify in this proceeding "exclusively about the AMA's position on advertising and solicitation by physicians" (Tr. 9683, 9686, 9688, 9711). He testified that it would still be appropriate for a local medical society to reprimand a physician or clinic for truthfully advertising its services because "that is soliciting business" — "The issue is not the truth of the contents [of the advertisement]" (Tr. 9716–18). [229]

While the revised Judicial Council statement permits the physician to provide certain information which the public is entitled to know, such as names of physicians, their types of practice, office location, office hours and "other useful information that will enable people to make a more informed choice of physician," the statement continues the use of catch-words such as "accepted" local media, "dignified" announcements, "reputable" directories, "solicitation" and "self-laudatory" statements (RX 1, p. 30), words which AMA and its local societies have long used to proscribe physician advertising (CX 462Z5 [Sec. 5, Op. 6], Z6 [Sec. 5, Op. 11], Z7 [Sec. 5, Op. 13], Z39 [Sec. 10, Op. 3], Z44 [Sec. 10, Op. 13], 545D, 514B, 512C, 94, 768B, 117). Examples of acceptable media for making information available to the public are stated to be office signs, professional cards, dignified announcements, telephone directory listings and reputable directories. No mention is made of newspapers, periodicals, radio or television (RX 1, p. 30).

Physician publicity and announcements which constituted "infractions of good taste" were disapproved under the 1971 *Opinions and Reports* (CX 462Z5 [Sec. 5, Op. 6], Z7 [Sec. 5, Op. 14]; Tr. 741; F. 99, pp. 130–31). Dr. Robert B. Hunter, the Chairman of AMA's Board of Trustees, called as a witness by AMA, testified that AMA officials have made public utterances that it is AMA's position that physician advertising must not be only factual, but also "tasteful," and that most state and local medical societies also have that policy (Tr. 9660–61. *See also* Tr. 4870–72). Dr. Stephen C. Biering, Dean of the School of Medicine, University of Indiana, called as a witness by AMA regarding its position on physician advertising and solicitation (Respondent American Medical Association's List of Witnesses For

Its Surrebuttal Case, dated April 21, 1978, p. 3), testified that it is appropriate for a medical society to reprimand or expel a member who has advertised in the newspaper in a truthful fashion but in "bad taste" (Tr. 9533–34).

The 1977 *Opinions and Reports* declares that "local, state, specialty medical associations. . .may have ethical restrictions on advertising, solicitation of patients, or other professional conduct of physicians that exceed the Principles of Medical Ethics" (RX 1, p. 30). AMA has made all such supplementary ethical principles binding upon the respective medical societies' members, provided that the principles are not inconsistent or in conflict with AMA's constitution and bylaws (CX 1435Z20). AMA [230] also has declared that when a physician disregards "local custom," as determined by the local society, he has acted unethically and may be subject to disciplinary action (CX 462Z9–10, Z7, I–J, 1349; RX 1, p. 9).

The 1977 *Opinions and Reports* continues to prohibit health plans from placing in their advertisements the names and qualifications of particular physicians, unless the plan's entire physician roster is included (RX 1, p. 31. *See also* CX 951).

The 1977 *Opinions and Reports* continues to prohibit physician publicity in the media if it "bespeaks self-exploitation," and encourages physicians to pre-clear publicity with their local medical society (RX 1, p. 35. *See also* CX 462Z44). AMA's 1974 ethics restriction on physician directories, which prohibits inclusion of "self-aggrandizing" statements (CX 509A–B, N; RX 5), is still in effect (Tr. 3998).

The 1977 *Opinions and Reports* does not enumerate physician prices or fees among the items of information that it says can be advertised; it mentions prices only in discussing the information that may be included in a "reputable" directory (RX 1, p. 30).

The 1977 *Opinions and Reports* continues to provide that physician conduct may be deemed unethical and subject to medical society disciplinary action when it does not conform to the "customs and usages of the medical profession" and may reflect upon the "dignity of and respect for the medical profession" (RX 1, p. 9; CX 462I–J [Preamble, Op. 4]).

AMA has not specifically rescinded the 1971 *Opinions and Reports* or the 1974 *Report on Physician-Hospital Relations* (CX 959, 461Z156). AMA has not specifically rescinded the "Guidelines on Telephone Directory Listings" (CX 673B–I), which were adopted and approved by the AMA House of Delegates (CX 663, 673A). In June 1977, the AMA House of Delegates adopted a resolution commending the Judicial Council for "updating" the *Opinions and Reports* (RX 4, p. 52); however, the resolution did not rescind the House's earlier

adoption of provisions in the 1971 *Opinions and Reports* and of other AMA restrictions on advertising and solicitation (CX 463), and remained silent on the relationship of the 1977 *Opinions and Reports* to those earlier provisions and restrictions (RX 4, p. 52). While the 1977 *Opinions and Reports* does state that the [231] Judicial Council has "suspended the distribution of the previous edition of Opinions and Reports" (RX 1, p. 1), it does not state that the 1971 or other preexisting AMA ethical restrictions on advertising and solicitation have been rescinded or superseded (RX 1, p. 1). There is no evidence that AMA has advised or requested component and constituent societies to revise or update their own codes or guidelines.

Furthermore, AMA's conduct in respect to the formal and informal promulgation, distribution and enforcement of the Principles of Medical Ethics, established by the record as existing prior to 1975, continued after 1975 as well. Since this conclusory finding is somewhat ambiguous as to which ethical standards were enforced subsequent to 1975, some further elaboration is necessary. Accordingly, it is further found that the correspondence in the files of AMA in the possession of Susan Roberts, prepared, dispatched or received from January 1, 1975 to October 11, 1976 (the date the subpoena duces tecum was served on AMA), relating or referring to any alleged breach of any ethical standard of medical practice by any physician, would have revealed instances of AMA's and of component and constituent medical societies', reliance upon the 1971 *Opinions and Reports* of the Judicial Council in the enforcement of the Principles of Medical Ethics, or reliance upon ethical interpretations consistent with positions stated in the 1971 *Opinions and Reports* (Order Ruling on Complaint Counsel's Motion for Adverse Rulings and Other Relief Due to Noncompliance with Subpoena Duces Tecum by Respondent the American Medical Association, dated February 24, 1977, p. 10). The Administrative Law Judge makes this finding based upon Rule 3.38 of the Commission's Rules of Practice providing for sanctions for disobeying the Administrative Law Judge's order (Order Ruling on Motion of Respondent American Medical Association to Quash Subpoena Duces Tecum, dated November 12, 1976; Order Ruling on Complaint Counsel's Motion for Adverse Rulings by Respondent the American Medical Association, dated February 24, 1977). This finding is consistent with other documentary evidence received in the record (*e.g.,* CX 627, 501, 502, 1790, 1788). Accordingly, this is an appropriate adverse finding. [232]

CONCLUSIONS

I. FACTUAL SUMMARY

The complaint issued in this proceeding challenges the ethics restrictions of respondents AMA, CSMS and NHCMA as violative of Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45. These ethics restrictions do not deal with the medical or therapeutic aspects of a physician's practice; at issue are predominantly restrictions on economic activities. The record evidence presents a substantial body of formal and informal actions, initiated, instigated and directly or indirectly influenced by each of the respondents, that have the effect of enhancing the economic positions of the members of each of the respective medical societies. Moreover, this result has not come about through mere chance or coincidence but, rather, through the concerted efforts of each of the respondents and the numerous other constituent (state) and component (local) medical societies located throughout the United States. The end result of their energies has been the placement of a formidable impediment to competition in the delivery of health care services by physicians in this country. That barrier has served to deprive consumers of the free flow of information about the availability of health care services, to deter the offering of innovative forms of health care and to stifle the rise of almost every type of health care delivery that could potentially pose a threat to the income of fee-for-service physicians in private practice. The costs to the public in terms of less expensive or even, perhaps, more improved forms of medical services are great.

The main body of evidence against respondent AMA consists of the Principles of Medical Ethics, official interpretations of the Principles, which AMA has adopted and disseminated, and letter after letter from AMA officials to medical societies and individual physicians explaining the Principles, applying the Principles to specific conduct and urging compliance with the Principles by the constituent and component societies. This body of evidence, consisting principally of documents from the files of AMA and constituent and component societies located throughout the United States, shows the sweeping nature of the challenged restraints, including a total ban on solicitation of patronage, severe restriction of most forms of advertising and unfair interference with physicians' contracts with third parties.

AMA has invited concerted action by its constituent and component medical societies to enforce the challenged restrictions. All of AMA's member societies have accepted [233] this role within the

AMA ethics framework. They have adopted AMA's Principles of Medical Ethics as their own, their members have abided by them and they have formally and informally enforced the Principles. The Connecticut respondents have adopted AMA's ethical principles and, like AMA's other member societies, have engaged in enforcement of the challenged restrictions.

This proceeding has placed several issues in precise focus. At the outset, there is the jurisdictional question, arising out of Section 4 of the Act, as to whether each of the respondents is a "company . . . or association . . . organized to carry on business for its own profit or that of its members", 15 U.S.C. 44. Another aspect of the multi-faceted question of whether respondents are subject to the Commission's jurisdiction arises out of the "in or affecting commerce" requirement of Section 5(a)(1) of the Act, 15 U.S.C. 45. To come within Commission jurisdiction, respondents' acts and practices must be shown to have the requisite interstate commerce nexus.

The record evidence presents a far-ranging and impressive accumulation of the activities of AMA, CSMS and NHCMA from which to focus on the jurisdictional issues. A substantial amount of each respondents' activities are devoted to the betterment of the health care delivery system in the United States through contributions to science, education and the public health. However, a substantial amount of each respondents' activities also inures to the pecuniary advantage of individual physicians. In fact, some of respondents' activities which are clearly beneficial to the general public also operate to directly or indirectly confer economic benefit upon the physician members of the respondent medical societies. Thus, the record evidence establishes that each of the respondents carries on business for the profit of its members. The record also establishes that respondents' acts and practices are in or affecting commerce. Consequently, each of the respondent medical societies is subject to Commission jurisdiction. This jurisdictional issue is discussed hereafter (*See* pp. 236–54, *infra*).

Having resolved the jurisdictional questions against respondents, the substantive issues of respondents' acts and practices must be considered. Complaint counsel contend that respondents and other medical societies have acted to place restraints on physicians' solicitation and advertising activities. Complaint counsel argues that these restraints [234] constitute unfair methods of competition in violation of Section 5. Complaint counsel also contend that respondents and others have acted anticompetitively with respect to physicians' contractual arrangements, also in violation of Section 5.

Essentially, the record evidence demonstrates that the restraints

placed upon physician competition by AMA and state and local medical societies have operated to restrict the dissemination of information about the price, type and availability of medical services, including information concerning industrial medical clinics, preventive medical services and prepaid group practice plans (*i.e.,* HMOs). The methods that can be used to seek patronage, were it not for the adamant opposition of medical societies, have been denied to physicians as have the benefits to the public that would come with increased competition in the health care sector. AMA and its constituent and component medical societies have restricted physicians' use of announcements, form letters and brochures, newspaper advertising, radio and television advertising, publicity in the news media, Yellow Pages listings, business and consumer directories, direct contact with institutions and physicians, open houses and other methods of soliciting patients. Moreover, ethics limitations have hampered the ability of physicians to engage in contractual arrangements for the provision of medical services.

The effects of respondents' ethical restrictions on physicians, and respondents' purported justification for the restrictions, are discussed later in this decision (*See* pp. 254–79, *infra*).

Having laid out a substantial body of evidence detailing the anticompetitive restraints placed upon physicians by the respondent medical societies and other medical societies not named as parties to this proceeding, Commission counsel assert that the existence of a conspiracy to restrain competition among physicians is thereby established. Taken together, the organization of each of the respondents, their interrelationships and the mutuality manifest throughout their application and enforcement of ethics proscriptions attest to the logical conclusion that the respondents and others have acted in concert to restrain competition among physicians.

Each of the respondents is a nonprofit corporation, comprised primarily of physicians engaged in the private practice, fee-for-service delivery of medical care (F. 1, p. 5; 9, p. 8; 12, p. 9). Respondent AMA is a national organization, with its basic make-up that of a federacy of [235] its state medical societies, which are termed constituent societies. The constituent societies, in turn charter local medical societies, which are termed component societies. In most instances, a physician must be a member of a component society to be a member of a constituent society, and a member of a constituent society to be a member of AMA. A

substantial majority of all physicians retain membership in the AMA and in their constituent and component medical societies.[6]

Not only is there a virtually singular identity of membership in the AMA and state and local medical societies, but there are also other indicia of interconnections. Often, dues are centrally collected by the constituent society for the AMA and the component society. There is a true hierarchy in the manner in which physicians are elected to serve as officials of each of the respective medical societies. For instance, members of component societies elect the officials who govern the constituent societies; they, in turn, elect the governing officials of the AMA (*See* F. 6-8, pp. 7-8; 10-11, pp. 8-9; 13, p. 10).

Of even greater significance is the deference paid by the state and local societies to the AMA. This unbending support of the national organization is attested to by the degree to which the constitutions and bylaws of AMA's constituent and component societies provide that AMA's Principles of Medical Ethics shall govern the conduct of their members.[7] The extent to which local and state societies look to AMA for advice and guidance on ethical matters and the quite numerous occasions on which they follow and implement that advice do more than suggest the interrelationships between the national and the state and local societies. Indeed, the abundance of record evidence establishes an interlocking relationship both organizationally and practically with regard to the formal and informal enforcement of ethics policies. This evidence establishes the existence of a conspiracy between AMA and its constituent and component societies (*See* pp. 279-90, *infra*).

There is also little merit to AMA's contention that it abandoned or discontinued any anticompetitive acts or practices by the issuance and publication of its 1977 *Opinions and Reports* (RX 1). There is no policy statement by AMA to the effect that the 1971 or any other preexisting AMA ethical restrictions have been rescinded [236] or superseded; nor is there any evidence that AMA's constituent and component medical societies have revised or otherwise departed from the ethics strictures of their own codes and guidelines. There is only an unbroken continuum of ethical pronouncements, and enforcement of those pronouncements, that will perpetuate the anticompetitive effects amply established in the record absent a remedial order (see discussion on Abandonment or Discontinuance, pp. 290-92, *infra,* and on Remedy, pp. 293-98, *infra*).

[6] F. 3-4, p. 6; 9, p. 8; 12, p. 9. However, a physician need not be a member of a particular medical society in order to be licensed to practice medicine. F. 2, p. 5; 9, p. 8.

[7] See Appendix A, pp. 306-09.

II. JURISDICTION

A. Nonprofit Exemption

In Section 5(a)(2) of the Federal Trade Commission Act, Congress limits the jurisdiction of the Commission to "persons, partnerships, or corporations", 15 U.S.C. 45(a)(2). Section 4 of the Act defines the word "corporation," for purposes of Section 5(a)(2), to include:

> any company, trust . . . or association, incorporated or unincorporated, which is organized to carry on business for its own profit or that of its members, and has shares of capital or capital stock or certificates of interest, and any company, trust . . . or association, incorporated or unincorporated without shares of capital or capital stock or certificates of interest . . . which is organized to carry on business for its own profit or that of its members.[8]

Respondents take the position that they are professional societies committed to the advancement of science, education and the public health, and are not organized for their own pecuniary benefit or that of their members (AMA Conclusions of Law, p. 6).[9]

Respondents are organized as nonprofit corporations; no part of their funds has ever been distributed to their members, the largest single source of funds are dues from [237] their members and each respondent is exempt from the federal income tax. Respondents argue that, under the rationale of the decision in *Community Blood Bank of the Kansas City Area* v. *FTC,* 405 F.2d 1011 (8th Cir. 1969), they are exempt from Federal Trade Commission jurisdiction. It is clear, however, that in reviewing a jurisdictional challenge under Section 4 of the Federal Trade Commission Act, the form of incorporation is not controlling. *Id.* at 1018–19. The crucial consideration is whether each of these respondents is carrying on business "for its own profit or that of its members", 15 U.S.C. 44. This determination must be made on an *ad hoc* basis depending on the facts of each case. *Id.* at 1018.

While this is a case of first impression involving professional associations claiming the nonprofit exemption under Section 4, there are, nevertheless, some guidelines that are helpful in resolving the controlling issue. In *Community Blood Bank,* the court recognized that Congress did not intend to provide a blanket exclusion for all nonprofit corporations, for it was aware that corporations ostensibly organized not-for-profit, such as trade associations, were merely

[8] 15 U.S.C. 44.

[9] Respondent AMA, on March 24, 1976, filed a Motion for Summary Decision Dismissing the Complaint for Lack of Jurisdiction on the basis that AMA is a nonprofit corporation not subject to the jurisdiction of the Commission. Respondents CSMS and NHCMA filed similar motions on April 26, 1976. These motions were subsequently denied as were requests for interlocutory appeals.

vehicles through which a pecuniary profit could be realized. *Id.* at 1017. The court also accepted, as settled law, the principle that the Commission does have jurisdiction over nonprofit organizations engaged in activities that produce a pecuniary profit. *Id.* at 1019.[10]

In *Community Blood Bank,* the court examined the activities of the respondents and found that those activities did not inure to the financial benefit of anyone and at all times were directed towards promoting a community-sponsored program in the public interest. *Id.* at 1020–22. These facts convinced the court that the organization was in law and in fact charitable, and that the Commission lacked jurisdiction over the nonprofit corporation because it was actively engaged in business only for charitable purposes. *Id.* at 1019, 1021. [238]

In *Ohio Christian College,* the Commission pierced the corporate veil of a nonprofit corporation to assert jurisdiction over the corporation where it provided the individual respondents with much of their subsistence and shelter. *Ohio Christian College,* 80 F.T.C. 815, 847 (1972). In a recent decision, the Commission asserted jurisdiction over a nonprofit corporation "existing in substantial part for the pecuniary benefit of the egg industry." *National Commission on Egg Nutrition,* 89 F.T.C. 89, 177 (1976), *aff'd,* 570 F.2d 157 (7th Cir. 1977), *cert. denied,* 47 U.S.L.W. 3218 (October 2, 1978). In determining that the National Commission on Egg Nutrition was subject to Commission jurisdiction, the Commission looked at the record as a whole. This required analysis of a large number of possible indicia of commercial purpose, such as origin, character of membership, source of funding, relationships with profit oriented groups, nature of publications and stated purpose. *Id.* at 177, 178.

The facts determinative of jurisdiction in the present proceeding do not fit into the exact pattern of any previously decided matter. It is therefore incumbent that the entire record be examined to determine if respondents' activities are entirely charitable or if their activities are infected with a commercial purpose. In *National Commission on Egg Nutrition,* a decision rendered several years subsequent to the *Community Blood Bank* decision, the Commission stated that the respondent existed in "substantial part" for the pecuniary benefit of the egg industry. At another point in its decision, the Commission stated that the respondent "exists in principal part" for the benefit of the egg industry. The Commission

[10] The court cited a number of court cases where the Commission has successfully exercised jurisdiction over trade associations, specifically, *FTC* v. *Cement Institute,* 333 U.S. 683 (1948); *Fashion Originators Guild* v. *FTC,* 312 U.S. 457 (1941); *Millinery Creators Guild, Inc.* v. *FTC,* 312 U.S. 469 (1941); *Pacific States Paper Trade Ass'n.* v. *FTC,* 273 U.S. 52 (1927); *California Lumbermen's Council* v. *FTC,* 115 F.2d 178 (9th Cir. 1940), *cert. denied,* 312 U.S. 709 (1941); *Chamber of Commerce* v. *FTC,* 13 F.2d 673 (8th Cir. 1926).

also stated that an organization which engages primarily in noncommercial activity and incidentally performs a function valuable to commercial interests might not be subject to its jurisdiction. Further, the Commission indicated that the presence of only one possible indicia of commercial purpose might be an insufficient basis for asserting jurisdiction. *National Commission on Egg Nutrition,* 89 F.T.C. at 177–79. The conclusion to be drawn from this imprecise language would seem to be that the Commission will assert jurisdiction over nonprofit organizations whose activities engender a pecuniary benefit to its members if that activity is a substantial part of the total activities of the organization, rather than merely incidental to some noncommercial activity.

Respondent AMA contends that the test of whether a corporation is organized for profit within the meaning of Section 4 is whether it *pays* dividends or other pecuniary [239] benefits to its members (AMA Conclusions of Law, pp. 16, 19). The Commission has previously held otherwise: "Profit, for the purpose of Section 4 of the Federal Trade Commission Act, is not limited to dividends, gains or direct reward." *Ohio Christian College,* 80 F.T.C. at 848.[11] The benefits to the egg industry generated by the respondent in the *National Commission on Egg Nutrition* were advertisements creating a favorable business atmosphere promoting the consumption of eggs. *National Commission on Egg Nutrition,* 89 F.T.C. at 178. No direct benefits were paid to the egg industry. The Commission asserted jurisdiction over the respondent and the courts have upheld that determination. Thus, AMA's contention that dividends or other benefits must be paid is rejected. If respondents directly or indirectly promote the pecuniary and economic interests of their members, the statutory test is satisfied.[12]

The respondents contend that for an organization to be subject to the jurisdiction of the Commission, profit-seeking must be the reason that it was organized and must play a dominant role in its activities (AMA Conclusions of Law, p. 20). While admitting that some parts of their budgets are devoted to activities that confer economic advantages upon their members, respondents argue that such activities are incidental or subordinate to the scientific, educational and public

[11] The Commission quoted, with approval, the definition of profit as stated by the Ohio Supreme Court: "Profit does not necessarily mean a direct return by way of dividends, interest, capital account or salaries. A savings of expense which would otherwise be incurred is also a profit to the person benefitted." *Russell* v. *Sweeny,* 153 Ohio St. 66, 68, 91 N.E. 2d 13, 16 (1950).

[12] The Seventh Circuit Court of Appeals, in a separate proceeding involving a request by the Commission for a preliminary injunction, ruled that even though the respondent in National Commission on Egg Nutrition did not earn or distribute profits to its members, it was within the Commission's jurisdiction because it pursued "profit indirectly" by seeking to improve the business environment for them. *FTC* v. *National Commission on Egg Nutrition,* 517 F.2d 485, 488 (7th Cir. 1975), *cert. denied,* 426 U.S. 919 (1976).

health activities in which they are primarily engaged (AMA Conclusions of Law, p. 25; CSMS Conclusions of Law, pp. 11–12, 14; NHCMA Conclusions of Law, pp. 4–6). [240]

There is no such dominant purpose standard elucidated in any previous case. If respondents are engaged solely in scientific, educational and public health matters which might incidentally have some economic benefit for their members, they might well be exempt from Commission jurisdiction under Section 4. That is not the situation in this case, however. An analysis of the whole record in this proceeding reveals that respondents are engaged to a substantial degree in activities which directly and indirectly protect and enhance the economic well being of their members.

It is not disputed that AMA devotes a substantial part of its time and resources to the advancement of medical science, education and the public health. AMA plays an active role and devotes significant amounts of time and resources to the organizations which set standards for and accredit medical schools, internship and residency programs and continuing medical education courses for physicians and allied health services (F. 16(a)–(d), pp. 12–15). Such programs and courses are open to members and non-members of AMA.

The AMA also devotes a sizeable portion of time and resources to scientific activities. It publishes one of the most influential medical journals in the world, *Journal of the American Medical Association ("JAMA")*. It also publishes nine highly regarded specialty journals, such as the *Archives of Dermatology.*[13] (F. 17(h), pp. 23–25). The AMA publishes a variety of important scientific works including AMA Drug Evaluations, for example (F. 17, pp. 16–25). It sponsors a number of conferences and publications in various medical areas, *e.g.*, nutrition (F. 17(f), pp. 19–20). Its publications and conferences are not restricted to AMA members.[14]

In the field of public health, the AMA engages in a wide variety of activities, such as testifying on many legislative bills and administrative regulations, conducting programs to upgrade the quality of health care in jails, assisting United States medical efforts in South Vietnam and later the Vietnamese physicians who fled South Vietnam to this country [241] and instituting a program to reduce the amount of violence on television (F. 16(f), pp. 15–16; 17(c), pp. 17–18; 17(e)–(g), pp. 18–23; 18, pp. 25–29). AMA distributes hundreds of pamphlets and posters on health care matters to the general public (F. 17(c)–(d), pp. 17–18; 17(f), p. 20; 17(g), pp. 21–23). It also responds

[13] The journals are basically self-supporting, since revenues from advertising and subscriptions roughly equals costs of publication and dissemination of the journals (F. 17(h), p. 25; 53, p. 70).

[14] AMA members receive *JAMA* and one specialty journal free as a membership benefit. The non-member subscription price for *JAMA* is $30 per year, and $18 per year for each specialty journal (F. 17(h), pp. 24, 25).

to calls and letters from the public asking general medical questions (F. 17(c), p. 17; 19, p. 32). It gathers and publishes data on physicians and health care; such data is utilized not only by AMA, but also by scholars and governmental units (F. 16(e), p. 15; 17(d), p. 18; 17(g); 19, pp. 29–32).

The Connecticut respondents engaged in activities that are somewhat similar to the activities of AMA, although on a much smaller scale since their memberships are smaller than AMA's membership. CSMS conducts an annual Scientific Assembly on subjects relating to science and medicine. It has a committee on continuing medical education concerned with investigating and evaluating alternatives in continuing medical education programs and in sponsoring continuing medical education programs. Those programs are available to members and nonmembers alike (F. 55, pp. 73–77).

CSMS publishes a monthly journal, *Connecticut Medicine,* which contains articles of educational value, as well as articles of general intellectual interest and information on the society's activities. The journal is furnished free to CSMS members (F. 56, p. 77).

CSMS offers pamphlets on health related matters to the public free of charge, answers requests from members of the public seeking information about locating a physician, sends delegates to organizations concerned with health care and communicates with legislative bodies concerned with issues of health care (F. 57, pp. 78–80). CSMS has published a Relative Value Scale for use by Connecticut physicians in ascertaining fees (F. 60, p. 83). CSMS annually gives an $8,000 grant to Connecticut medical schools to be used as a loan fund for needy students (F. 61, p. 84).

NHCMA has standing committees, some of which are concerned with matters of public health (F. 74, pp. 92–93). NHCMA publishes *Issues and Insight* on a quarterly basis for distribution to its membership. It sends representatives and advisors to various community-oriented health organizations, such as the Cancer Society and the American Heart Association (F. 76–77, p. 95).

While it can be argued that the above described activities of respondents have, at most, indirect or incidental economic benefits to members, a closer examination of many of [242] respondents' activities reveals a clear, direct economic purpose and effect. These activities which have a pecuniary benefit to members have been set forth in detail in the findings of fact herein (*See* F. 23–50, pp. 38–61; 62–73, pp. 84–92; 79–84, pp. 96–101). These activities combined with other characteristics of respondents, leave no doubt that while respondents do engage in educational, scientific and public health

activities, a significant part of their time and resources are devoted to obtaining, protecting and furthering the economic interests of their members.

AMA's membership is limited to physicians, interns and medical students. In 1977, 63.8 percent of AMA's total revenues came from membership dues, with the bulk of the remainder coming from advertising and subscriptions revenue. Most of AMA members are engaged in the profit motivated private practice of medicine, with over 75 percent of office based practitioners and over 80 percent of board certified physicians in this country being members of AMA. AMA has told its membership that it operates to protect and foster their interests and that one of its primary purposes is to serve its membership (F. 3, p. 6; 23, pp. 38–40).

In communications with its members, AMA has detailed some of its most important activities which have a direct economic benefit for physicians. For example, AMA told its membership that it had made substantial progress towards solving the medical liability insurance crisis, won an important legislative battle to prevent Federal control of residencies, fought for and won exemption for current medical students from paying back Federal grants to medical schools and supported a pay increase for V.A. physicians (CX 1522).

AMA told its membership that because of activities undertaken by AMA certain things did not happen to physicians: precertification of hospital admissions; a national health insurance plan which physicians cannot live with; price controls on physicians' fees; sweeping HMO grants; national relicensure of physicians; unrealistic restrictions on physician discretion in prescribing drugs; mandatory government service for all medical school graduates; and, premature HEW establishment of consumer-run program review teams for Medicare and Medicaid. AMA has stated to its [243] membership that other things did happen for physicians because of AMA: modification of the Keogh law; development of a universal health insurance claim form; American Hospital Association acceptance of the concept that the medical staff should be represented on hospital boards; and, model state legislation to safeguard medical information (CX 245D).

AMA has told its members that certain key benefits of membership are insurance programs at a lower cost than is available anywhere else, a membership retirement fund, physician placement service, leading scientific publications, authoritative legal information and guidelines on every aspect of medical practice, professional management information and guides "to increase the productivity

and profitability of medical practice," the resources of the nation's greatest medical library and comprehensive scientific programming at conventions (CX 245D).

Although these membership representations may be somewhat exaggerated as sales materials, there is no reason to doubt that AMA contributed substantially to all the listed accomplishments. In fact, other record evidence supports AMA's representations.

AMA contends that its program of governmental "interface" serves to encourage government to initiate and maintain programs which will best serve the public health, that there is no substantial economic motivation underlying the program and that it is not designed to enhance the economic welfare of physicians (RAF, p. 53).[15] This contention is rejected. While there are public interest aspects to some of AMA's positions on legislation and administrative regulations, it is concluded that AMA's governmental lobbying activities are directed primarily at the interests of its membership - the physicians.[16] [244]

AMA has stated that the most important AMA membership benefit is having AMA as an effective and influential national spokesman to represent the medical profession's views, interests and rights (CX 259Z13).[17] Professor Paul Feldstein, an acknowledged expert in the field of medical economics, believes that political representation of physicians is AMA's most important activity for its membership (CX 2586F). AMA itself has categorized some of its legislative activities as being in behalf of consumers; it acknowledges that other activities are for physicians (CX 246).

AMA lobbying activities which have had substantial economic impact on physicians include the removal of price controls on physicians' fees (F. 25, p. 43); assurance that physicians receive their usual, customary, and reasonable fees under the Medicare program F. 26, pp. 43–44); opposition to national health insurance programs that do not meet AMA's physician reimbursement standards[18] (F. 27, p. 44); opposition to federal funding of HMOs and opposition to liberalization of existing HMO legislation (F. 28, p. 45; 102, p. 134);

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[15] AMA contends that its opposition to federal price controls on physicians' fees arose out of a concern that controls would lead to "a decline in the quality of medical care" (AMA's Reply to Proposed Findings of Fact of Counsel Supporting the Complaint, p. 19). Can one logically conclude that this is the sole motivation of AMA's effort?

[16] Indirect service to the public may result from some of AMA's legislative activities. In most instances, however, it is the physician who directly benefits. AMA has stated: "Activities in the area of quality assurance and promoting the effective delivery of care ultimately benefit the public, but the benefits generally accrue to the public through the physician" (CX 1042Z7).

[17] As part of its effort to achieve this goal, AMA has 10 lobbyists registered with the federal government (Tr. 9886).

[18] In 1950, the AMA spent over $2.5 million in a campaign it mounted against President Truman's national health insurance proposal (F. 27, p. 44; 45, p. 56).

support for passage of the Keogh Act (F. 29, p. 45); work to solve the malpractice insurance crisis facing physicians (F. 24, p. 41; 30, p. 46; 43, p. 54); support for pay increases for physicians in the Armed Forces and the Veterans Administration (F. 38, p. 49); and opposition to legislation requiring relicensure, retraining recertification or continuing medical education of physicians (F. 31, p. 46). In support of its efforts to influence legislation, AMA organized, and now supports and controls, a political organization, American Medical Political Action Committee, which engages in political education activities and provides financial support for political candidates (F. 22, pp. 35–37; 39, p. 50).

There are other AMA activities which provide a direct economic benefit to AMA members. AMA is very active in dealings with third-party payers, having been instrumental [245] in the creation and development of the Blue Shield insurance plans. AMA acts to assure that physicians are reimbursed on an adequate basis by insurance plans, including Medicare. AMA intervenes directly with insurance carriers when disputes are deemed to have national significance. AMA provides support for foundations for medical care which are physician-controlled health care organizations created to counteract the economic impact of HMOs. AMA has attempted to intervene with the Department of Defense in its military dependents medical program to assure that physicians fees are adequate. To assist physicians in billing and collecting from third-party payers, AMA has developed and distributed a uniform claim form and has developed two publications to aid physicians in billing for medical services, *Current Medical Information and Terminology* and *Current Procedural Terminology* (F. 40, pp. 50–52).

AMA has represented physicians' interests when dealing with hospital administrations such as by calling for separate billing by hospital and physician (F. 41, pp. 52–53); has instituted court actions to challenge governmental controls on physicians' fees (F. 42, pp. 53–54); created and funded, at an investment of $2 million, American Medical Assurance Company to help solve the malpractice insurance crisis (F. 43, p. 54); spent approximately $3 million on public relations activities to help boost the public image of physicians (F. 45, pp. 55–56); and provides members with negotiations training, (F. 46, p. 56), practice management assistance (F. 47, p. 57), legal advice (F. 48, p. 58) and scientific journals and a medical newspaper (F. 49, pp. 58–59). AMA also sponsors insurance programs for its members and has established an investment retirement fund (F. 20, p. 34; 49, pp. 58–59).

Lastly, AMA's ethical restrictions on advertising, solicitation and

contract practice insulate physicians from competition and have a substantial economic benefit to AMA members. The economic effects of these restrictions are discussed in a separate section of this decision at pages 254–79, *infra.*

The evidence unquestionably establishes that AMA has engaged in the listed activities and that they do have a substantial pecuniary benefit for AMA members. AMA has, [246] in fact, represented to its members that these are important benefits to the membership; there is no evidentiary basis in this record on which to doubt these statements. Being a membership organization supported by membership dues, it is neither illogical nor derogatory of the organization to conclude that AMA provides substantial economic benefits for its members.[19]

The federal income tax exemption accorded AMA supports the conclusion reached herein. AMA is exempt from payment of federal income tax pursuant to Section 501(c) (6) of the 1954 Internal Revenue Code. Internal Revenue Regulations describe a Section 501(c)(6) organization as a business league, which is an association of persons having some common business interest, the purpose of which is to promote such common interest and not to engage in a regular business of a kind ordinarily carried on for profit. In contrast, the American Medical Association Education and Research Foundation, a subsidiary of AMA, is exempt from federal income tax pursuant to Section 501 (c)(3), which section exempts from federal income tax those organizations organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary or educational purposes (F. 21, p. 35; 50, pp. 60–61).

AMA devotes a substantial portion of its income to the activities which have an economic benefit for its members. While precise percentages of AMA's income devoted to these activities cannot be ascertained, Professor Paul Feldstein estimated that between 35 percent and 43 percent of membership dues income was spent for these purposes (F. 53, p. 70). [247]

In a report to members made in December 1976 (CX 1055), the AMA explained where its dues dollar goes:[20]

[19] In 1946, the Supreme Court of Illinois, in *American Medical Association* v. *Board of Review of Department of Labor,* 392 Ill. 614, 65 N.E. 2d 350 (1946), had to determine whether or not AMA was entitled to exemption from an Illinois state tax. This issue involved a determination of whether AMA's activities were solely scientific, educational or charitable. The court stated: "It is conceded that appellant [AMA] devotes a substantial portion of its efforts and of its income towards protecting and furthering economic benefits to the individual members of the association." 65 N.E. at 354.

[20] In this publication distributed to all members, informing them of the many benefits that come with AMA membership, benefits that assure economic advantages to physicians, AMA stated in bold-faced type, in reference to the group rates available to members in the various insurance and retirement programs offered by AMA: "In many cases, a physician member can save more than the equivalent of his annual AMA dues" (CX 1055R).

1. Assisting the Physician and His Practice	17.7%
2. Strengthening Organized Medicine	13.8
3. Representing the Profession	10.0
4. Serving the Public	8.0
5. Upgrading Care Through Educational Standards	12.3
6. Disseminating Scientific Information	38.2

The total of the first three categories equals 41.5 percent of dues revenue. The 41.5 percentage would appear to directly benefit the physician; it does not include anything from "disseminating scientific information," which would include the distribution of *JAMA* and specialty journals free to members.

Respondent AMA asked several of the physician witnesses who testified in this proceeding whether they felt they received an economic benefit from AMA membership; several said that they did not think so, and that they had dropped their membership in AMA because the dues were getting larger and it was no longer worth the price (Tr. 1153, 2665, 4203). This fact, however, reveals little about the nature of the organization of AMA and the purposes of its various programs. Whether an institution has failed in its profit-making endeavors or is perceived as having failed is irrelevant. The witnesses' abandonment of membership reveals, if anything, that members expected something personal in return for the monies given respondent AMA, and when the expected return was not forthcoming, they stopped giving — hardly the typical attitude of the charitable contributor. [248]

The Connecticut respondents engage in substantial activities which have a pecuniary benefit for their members. In the first instance, one must be a member of a local and state society before being eligible to become an AMA member (F. 4, p. 6). The pecuniary benefits which AMA provides its members are key benefits which are available to CSMS and NHCMA members upon joining AMA through their local and state societies. In 1975, 81.6 percent of the physicians registered in Connecticut were members of CSMS; over 50 percent of CSMS members were also members of AMA (F. 9, p. 8).

Approximately 71 percent of all physicians registered in New Haven County are members of NHCMA; over 90 percent of NHCMA members are also members of CSMS, and approximately 40 percent are also members of AMA (Tr. 8439). Membership in NHCMA provides an opportunity for a physician to become a member of CSMS and receive the pecuniary benefits offered by that society.

CSMS as an organization represents the professional interests of physicians in Connecticut in a manner that would be impossible for individual physicians to act on their own behalf. A guiding principle of CSMS is that physicians should always have the right to charge their usual, customary and reasonable fees (F. 62, pp. 84–85). CSMS has published a *Relative Value Guide* and strongly recommended that physicians use it to determine usual, customary and reasonable fees. Third-party payers in Connecticut also use the *Guide* to determine physician fees (F. 63, pp. 85–86). CSMS has opposed policies of insurance carriers and governmental agencies to prevent physician fees from being reduced or becoming substandard. CSMS opposed a contract adopted by the Connecticut Blue Shield Plan because payments to physicians were lower than the usual and customary fees being received by CSMS members. CSMS strenuously opposed a payment policy adopted by Aetna Life and Casualty Company that paid fees only up to a level determined by Aetna (F. 64, pp. 86–87).

CSMS has urged its component societies to form foundations for medical care to protect the interests of practicing physicians. CSMS issued an interest-free loan, repayable when feasible (RCX 68, p. 17), in an amount of $4,999, to the New Haven County Foundation for Medical Care (F. 65, pp. 87–88).

CSMS has lobbied for legislation having significant economic benefits for physicians. CSMS opposed price controls on physicians' fees. CSMS pressed for repeal of the Connecticut law requiring physicians to pay a $150 [249] annual registration fee. CSMS has lobbied for adoption of malpractice insurance legislation that would forestall premium increases as well as make it more difficult for plaintiffs to prevail in malpractice litigation and reduce the size of possible malpractice liability awards against physicians. CSMS has supported increases in and faster payment of physicians' claims under Medicaid, and has opposed the charging of fees by the State Health Laboratory and legislation expanding the practice of podiatrists and chiropractors (F. 66, pp. 88–89).

In support of its legislative activity, CSMS has organized and financially supported Connecticut Medical Political Action Commit-

tee to serve as the political "arm" and "tool" of the medical profession in Connecticut (F. 58, pp. 80–82; 67, p. 89).

CSMS operates a physician placement service, gives estate planning and settlement advice, operates a public relations program and sponsors a variety of group insurance programs at a savings to CSMS members, the most significant of which is the malpractice insurance policy available to CSMS members at a substantial savings (F. 68–70, pp. 90–91). CSMS also publishes a monthly journal, *Connecticut Medicine,* made available to members free of charge (F. 56, p. 77; 71, p. 91).

CSMS's principal source of funds is membership dues (F. 72, p. 91). It is exempt from federal income tax under Section 501(c) (6) of the 1954 Internal Revenue Code (F. 73, p. 92. *See also* F. 50, pp. 60–61).

NHCMA also defends and supports the maintenance of usual, customary and reasonable physicians fees, and is an advocate for better working conditions for its local physicians (F. 79, p. 96). NHCMA has engaged in lobbying activities on behalf of physicians, protesting federal controls on physicians' fees, opposing the special treatment given HMOs and the annual $150 registration fee for physicians practicing in Connecticut. NHCMA maintained an active legislative program to resolve the malpractice insurance crisis. NHCMA urged CSMS to press the Connecticut Welfare Department to bring the Medicaid program fees up to the usual, customary and reasonable level. NHCMA protested to the Connecticut Commissioner of Insurance about the marketing efforts of an HMO operating "in direct competition" with private practitioners, and it urged the Department of HEW to deny extension of grant money to an HMO (F. 82, pp. 99–100). [250]

The New Haven County Foundation for Medical Care was organized by NHCMA to promote the economic interests of its members and has loaned the Foundation $4,999 on an interest-free basis. The Foundation is an organization of fee-for-service practitioners which is controlled by NHCMA with fees based on the usual, customary and reasonable concept (F. 80, pp. 96–98).

NHCMA operates an active Board of Censors and Third Party Payments Committee, which together comprise the Peer Review Committee. The Peer Review Committee assists NHCMA members in their disputes with third-party payers and patients about fee-related matters. The Committee has relied upon the CSMS *Relative Value Guide* and a conversion factor geared to the usual, customary and reasonable fee concept in their resolution of fee disputes (F. 81, pp. 98–99).

NHCMA also operates a public relations program, sponsors

insurance programs for members and intervenes with local hospitals on behalf of physicians to assist them in obtaining hospital privileges (F. 83, p. 101).

NHCMA's principal source of funds is membership dues, and it is exempt from federal income tax under Section 501 (c)(6) of the 1954 Internal Revenue Code (F. 79, p. 96; 84, p. 101. *See also* F. 50, pp. 60–61).

CSMS and NHCMA have adopted, disseminated and enforced ethical restrictions on physician advertising, solicitation and contract practice which have restrained and eliminated competition between and among physicians (*see* pp. 254–79, *infra*). These activities have rebounded to the economic benefit of their members.

The record clearly establishes that respondents are engaged in a substantial number of activities that have a direct economic benefit for their members. It is equally clear from the record that respondents are engaged in a substantial number of activities of an educational, scientific or charitable nature which benefit their members, if at all, in an indirect manner. It is virtually impossible to precisely measure which activities predominate in respondents' overall operations. Such a determination is unnecessary, however. Neither the courts nor the Commission has ever held that Commission jurisdiction is limited to nonprofit organizations whose sole *raison d'etre* is to [251] serve as a conduit for the commercial interests of members. Nor is there any precedent for the proposition that business activity conducted by a nonprofit organization *for economic objectives* as distinguished from charitable objectives, is exempt. To the contrary, the legislative history of the Federal Trade Commission Act discloses that, in 1914, Joseph E. Davies, Commissioner of the Bureau of Corporations (predecessor to the Federal Trade Commission) informed Senator Newlands, the Senate manager of the Federal Trade Commission Act, that trade associations should be covered notwithstanding the fact that "[a]s to some of the things done by these associations, no question as to their propriety can be raised." *Community Blood Bank,* v. *FTC,* 405 F.2d 1011, 1017 (8th Cir. 1969).

Since respondents are engaged continuously and substantially, as contrasted to incidentally or sporadically, in activities which have a pecuniary benefit for their members, it is concluded that they are subject to the jurisdiction of the Federal Trade Commission. The eleemosynary results of many of respondents' programs cannot provide a shield for the restraint of trade resulting from its other programs. *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773, 787 (1975). The public service aspect of professional practice is not controlling in

determining whether respondents are within the Commission's jurisdiction.

B. Commerce

AMA has stipulated that its acts and practices are in or affect interstate commerce (F. 14, p. 10; Tr. 2120, 2124). CSMS and NHCMA, however, claim that complaint counsel did not meet the burden of proving that their conduct is in or affecting interstate commerce (CSMS Conclusions of Law, pp. 14–19; NHCMA Conclusions of Law, pp. 6–8). The Connecticut respondents admit that substantial dollar amounts of Medicare, Medicaid and insurance payments are made to their members for medical services and that such payments derive from sources outside Connecticut. It is argued, however, that these facts relate to the practice of medicine by CSMS and NHCMA members and not to the challenged acts and practices of respondents. Thus, respondents insist there is no nexus between the acts and practices being challenged and interstate commerce (CSMS Conclusions of Law, p. 15; NHCMA Conclusions of Law, p. 6).

The Connecticut respondents also argue that the fact that some members may occasionally treat patients who reside in other states and the fact that some medications are [252] manufactured outside Connecticut and dispensed from pharmacies pursuant to prescription by physicians, some of whom are CSMS and NHCMA members, does not establish the required nexus with interstate commerce (CSMS Conclusions of Law, p. 17; NHCMA Conclusions of Law, p. 7). These respondents further argue that their ethical restrictions were concerned with Connecticut physicians in Connecticut and that occasional travel outside Connecticut to attend AMA conventions and occasional use of the interstate mails or interstate telephones are insufficient to establish that the challenged conduct is in or affecting interstate commerce (CSMS Conclusions of Law, p. 19; NHCMA Conclusions of Law, p. 7).

The restrictions on physician advertising and solicitation adopted, disseminated and enforced by the Connecticut respondents are in or affect interstate commerce in several respects. The restrictions affect the volume and destination of millions of dollars coming into Connecticut from out-of-state government and private health insurance sources in payment for medical care and related services rendered in the state; they have been undertaken as part of a nationwide conspiracy which restrains competition and commerce in every state; they are furthered through use of the United States mail and other interstate communications media and transportation facilities; they restrain advertisements by Connecticut physicians in

newspapers with interstate circulation and in out-of-state telephone directories; and, they affect the flow of patients into Connecticut from other states and countries.

The great majority of licensed physicians in Connecticut and New Haven County, respectively, belong to CSMS and NHCMA and have agreed to abide by the AMA ethical code. Because this code of ethics restrains, hinders and deters these Connecticut physicians from advertising, soliciting patients and engaging in the proscribed forms of contractual relationships, it necessarily affects the volume, destination and amounts of interstate payments into Connecticut for medical services. A physician who does not seek new patients by advertising must obviously forego the reimbursements he would receive if he attracted such new patients. Similarly, the ultimate destination of interstate insurance payments is necessarily affected when physicians [253] are restrained from competing with one another through advertising. For example, a physician in New Haven restrained by respondents' ethical restrictions from advertising physical examinations is likely to receive less patronage than if he had been able to advertise his prices and services. Accordingly, the physician will automatically receive a lesser volume of interstate Medicare, Medicaid and private insurance payments for his services. If the physical examinations are performed by other doctors, then the destination of the interstate payments has been affected. In *Hospital Building Co.* v. *Trustees of Rex Hospital,* 425 U.S. 738 (1976), the Supreme Court held that interference with revenue received by a hospital from out-of-state insurance companies affects interstate commerce. Whether the conduct affecting interstate commerce was directed at, or intended to affect, interstate commerce, is irrelevant. It is sufficient that interstate commerce has been affected. *Hospital Building Co., Id.* at 744–45.

Further, there need be no showing of the magnitude of the effect on interstate commerce. In *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773 (1975), the Court stated:

> The fact that there was no showing that home buyers were discouraged by the challenged activities does not mean that interstate commerce was not affected. Otherwise, the magnitude of the effect would control, and our cases have shown that, once an effect is shown, no specific magnitude need be proved . . . *Id.* at 785.

Use by the Connecticut respondents of the United States mails and other interstate transportation and communications facilities in transmitting and receiving interpretations of the challenged ethical restrictions and copies thereof and in attending AMA conventions where many of the challenged ethical restrictions have been

discussed and approved, provide "an adequate basis for Commission jurisdiction." *Tysons Corner Regional Shopping Center,* 85 F.T.C. 970, 988, 1015 (1975).

The Connecticut respondents have joined together with other state and local medical societies to form AMA and have adopted, as have these other societies, the AMA Principles of Medical Ethics to govern the conduct of their members. By [254] participating in concerted activities which restrain commerce throughout the country, CSMS and NHCMA have subjected themselves to Commission jurisdiction. As the Supreme Court has observed: "The Commission would be rendered helpless to stop unfair methods of competition in the form of interstate combinations and conspiracies if its jurisdiction could be defeated on a mere showing that each conspirator had carefully confined his illegal activities within the borders of a single state." *FTC* v. *Cement Institute,* 333 U.S. 683 696 (1948). *See also United States* v. *Wilshire Oil Co.,* 427 F.2d 969, 974–75 (10th Cir.), *cert. denied,* 400 U.S. 829 (1970).

The substantial volume of commerce involved, including direct federal government funding of Medicare and Medicaid, the participation of out-of-state third-party insurers, interstate laboratory testing and diagnostic evaluations, commercial flow of drugs and medical equipment and the inseparability of particular physician services from the interstate aspects of health care generally, together with the use of interstate communications and transportation facilities, provides a satisfactory basis for concluding that the acts and practices of respondents CSMS and NHCMA are in or affect interstate commerce and that these respondents are subject to Federal Trade Commission jurisdiction. *See* discussion at *Doctors Inc.* v. *Blue Cross of Greater Philadelphia,* 490 F.2d 48, 50–54 (1973).

III. RESTRICTIONS ON PHYSICIANS' ADVERTISING, SOLICITATION AND CONTRACTUAL RELATIONS

A. The Restrictions and their Anticompetitive Effects

It is not disputed that the AMA has made a significant public contribution through its health related activities from the date of its first meeting in 1847 to the present. Furthermore, it is not possible to give the AMA its just credit by a mere listing of the tremendous inroads it has made in the areas of medical education, medical licensure standards and public health programs, to name but a few. However, the history of the AMA is largely irrelevant for the purposes of this proceeding, which deals not with whether the AMA is deserving of public admiration but, rather, with what effects AMA

ethics policies have had on physician competition in recent years. Moreover, the AMA's history is not untainted, as evidenced by the criminal conviction over 30 years ago of the AMA and the [255] Medical Society of the District of Columbia for conspiring to restrain and obstruct the development of a group prepaid health plan. *American Medical Association* v. *United States,* 317 U.S. 519 (1943), *aff'd* 130 F.2d 233 (D.C. Cir. 1942).

Respondent medical societies exercise complete control over physicians' advertising, solicitation and contractual relations. Their control has effectively thwarted competition by physicians in the health care sector. To accomplish these ends, the AMA, CSMS, NHCMA, numerous other constituent and component societies and individual physician members have engaged in a persistent pattern of formal and informal enforcement of broadly based ethics rulings. The means utilized by medical societies in their efforts to perpetuate the fee-for-service physician in private practice and the "usual, customary and reasonable" method of fee reimbursement as the driving forces in medical care in the United States have been the AMA's Principles of Medical Ethics, the AMA's *Judicial Council Opinions and Reports* and sundry interpretations of each. Reliance by the AMA and by constituent and component medical societies upon these sources of ethics pronouncements has been extensive and cannot be disputed in view of the extensive evidence in this record.

Complaints about physician advertising and solicitation often have been submitted to local medical societies, including respondent NHCMA, by individual physicians in the same specialties as the accused doctors. Some of the complaining physicians have expressed concern about the competitive implications of the offending doctors' activities. In response to these complaints, the medical societies have taken restrictive ethics actions regarding the accused physicians.[21] On occasion, they have gone so far as to openly refer to and take into account the competitive concerns expressed by the complaining physicians.[22]

Complaints about health maintenance organizations' advertising and solicitation activities have been registered with local medical societies by physicians openly concerned about HMO competition with their fee-for-service practices. [256] Complaints about HMOs have also been made by competing health plans, including foundation health plans sponsored by local medical societies. (F. 104, pp. 137, 138). In response to these complaints, the medical societies have

[21] F. 98, pp. 124-29; 100, pp. 131-32; 112, pp. 147, 148; 113, pp. 148-50; 120-22, pp. 160-71; 136-37, pp. 194-98; CX 136, 137; Tr. 1739, 1743, 1745-47.

[22] F. 98, pp. 124-29; 100, pp. 131-32; 120, p. 162; 136, p. 196; CX 759, 764B, 10B, 2062A.

taken restrictive ethics actions regarding the accused HMOs and their physicians.[23]

Statements by officials of AMA and its constituent and component medical societies reveal their opposition to doctors competing with each other. In 1973, Edwin J. Holman, Director of the Department of Medical Ethics of AMA, stated to an AMA constituent society: "[I]f the day should ever come when physicians or groups of physicians would regularly utilize professional public relations staffs, then medicine would find its members competing *against* each other for selfish, personal reasons" (CX 272B) (emphasis in original). In 1974, the president of the Allegheny County Medical Society in Pittsburgh, Pennsylvania stated: "[A]s you may know, it is considered unethical for doctors to advertise or to compete for patients, as soap companies compete for buyers, in the marketplace" (CX 2182B). Dr. Stephen Biering, called by AMA to testify in this proceeding about the role medical societies should play in regulating physician advertising, believed it inappropriate for physicians to compete on the basis of price, quality and service in the delivery of medical care (Tr. 9544–45, 9547–48).

An official of the Catawba County [North Carolina] Medical Society stated to a class at Lenoir Rhyne College, in opposition to a medical directory the class was proposing:

> [S]omebody who reads the directory may choose a physician on the basis of fees, and get the cheapest doctor for example, and therefore it might become a point of competition between physicians to stress the fees and to work out a fee schedule that would be more advantageous than somebody else's (Tr. 2383–84. See also F. 135, pp. 192–94).

Other AMA and medical society documents and officials have indicated their opposition to competition among physicians in connection with advertising, solicitation and contract practice.[24] [257]

Respondents' ethical restrictions on advertising and solicitation seek to prevent any doctor from presenting his name or information about his practice to the public in any way that sets him apart from other physicians. AMA's 1971 *Opinions and Reports* allows the limited publication of information on physicians only in media which are open to all physicians on like condition (CX 462Z6 [Sec. 5, Op. 11]). AMA has declared that it is not unethical for a physician to authorize the listing of his or her name in a physician directory which is intended to list all physicians in the community on a uniform and nondiscriminatory basis. AMA's Guidelines for Tele-

[23] F. 102–07, pp. 134–43.

[24] *See* F. 123, p. 174; 148, pp. 212–13; CX 759, 764B, 2119B.

phone Directory Listings prohibit box advertisements by physicians in the Yellow Pages and require uniformity of size and face of type among the physician listings. AMA's position on listing physician's names in credit card plans is that the plan must be available to all physicians in an area (CX 98C, 100A). In 1973, AMA wrote to the Bergen County [New Jersey] Medical Society about the ethics of a preventive medicine clinic's magazine article describing its services. AMA stated:

> Aren't there many physicians in Bergen County engaged in preventive medicine in one way or another? . . . Isn't the description of medical facilities best left to the medical society, which speaks for all physicians . . .? If one physician extols his own services, facilities, competence, etc., what is to prevent another physician from doing likewise and then what is the need for a medical society at all? (CX 1747; F. 119, pp. 159-60).

AMA's ethical restrictions affect all facets of competition among physicians, from the sole practitioner desiring to announce the opening of a new office to the group practitioners wishing to disseminate information regarding preventive medical services. While the Findings of Fact detail numerous incidents of restrictive practices adversely affecting physicians' abilities to compete, several of the more aggravated and pronounced instances deserve individual mention as illustrative of the serious consequences that the restraints have had and continue to have upon the delivery of health care in the United States. [258]

Dr. Joseph LaDou formed the Peninsula Industrial Medical Clinic ("PIMC"), located in Sunnyvale, California, to offer a package of occupational health and safety services to local industry on a large scale. Santa Clara County, which encompasses Sunnyvale, is an industrial community that would benefit by receiving the type of services being offered by Dr. LaDou and PIMC. The only feasible way in which Dr. LaDou could make PIMC's services known would be by solicitation. However, the Santa Clara County Medical Society informed Dr. LaDou that he and other industrial physicians, as well as their sales agents, would be prohibited from making any direct contacts with companies through personnel officers and other executives, such as by a general promotional mailing. This ruling came about as a consequence of complaints about PIMC made to the medical society by a competing medical clinic. As a result of the medical society's ruling, Dr. LaDou and PIMC have had to curtail the services they were intending to offer to local industry, to the

detriment of consumers of occupational medical services in Santa Clara County.[25]

In 1973, Dr. Richard Hansen, director of a private rural hospital near Chattanooga, Tennessee, instituted a program called "Operation Heartbeat." The program planned to offer a package of tests to assess a patient's risk of heart attack or other coronary disease. The cost to each patient would be $25, which was about half of what would otherwise be charged for similar services in the area. In response, the Chattanooga and Hamilton County (Tennessee) Medical Society advised Dr. Hansen, both at a meeting to which he was summoned and in a letter sent to him by the Medical Society, that any future announcements for the program should avoid the appearance of advertising which, it was stated, is unethical. Dr. Hansen promptly dropped the Operation Heartbeat program.[26] The direct impediment to a service that would not only promote competition but also serve a vital public health need in a rural area is manifest. [259]

The Volunteer Medical Clinic, staffed by Drs. Ralph Robinson and Catherine Gilreath, performs abortions in Knoxville, Tennessee. An abortion at the Clinic costs $175, as compared with the $450–600 cost at Knoxville hospitals. To promote its services, the Clinic was advertising in local newspapers in 1975. In response to abortion clinic advertising, the Knoxville Academy of Medicine, an AMA component society, forbade members from affiliating with organizations that advertised in the public media. Consequently, Dr. Gilreath, the only physician on the Clinic staff with admitting privileges at any Knoxville hospital, resigned from the Clinic. Dr. Robinson, a board certified obstetrician-gynecologist and the twice elected president of his own Bell County (Kentucky) Medical Society, found himself unable to obtain staff privileges at a local hospital due to the furor over his advertising; this hampered the Clinic's functioning. In 1977, the Clinic ceased all advertising.[27] Its ability to secure patronage was demonstrably affected.

In 1973, Medi-Call, Inc., a firm located in Johnson County, Kansas, near Kansas City, Missouri, began offering a commercial physician house-call service. For a $50 annual charge, subscribers would receive two night house-calls by a physician; subsequent visits would cost $25 each. At the time, physicians were reluctant to make house-calls in the area Medi-Call planned to serve. Medi-Call began

[25] F. 98, pp. 124–29.

[26] F. 100, pp. 131–32. While Dr. Hansen later reinstituted the program, he did not resort to any advertising owing to the above-described encounter with the Medical Society. As a result, the program attracted minimal attention.

[27] F. 114, pp. 150–52.

advertising its services through radio, television newspapers and billboards; without such advertising, the firm could not hope to attract clients. Subsequently, the Area Medical Council, composed of the top officers of four AMA component medical societies in the area, informed Medi-Call that its advertising was unethical. The firm ceased promoting its services. The action of the medical societies led to the financial failure and termination of Medi-Call's physician house-call service.[28]

Dr. Edward Diethrich, an eminent cardiovascular surgeon, established the Arizona Heart Institute in 1971, in Phoenix. The Institute offered the latest methods for the study and treatment of cardiovascular problems, and charged fees which were often lower than similarly situated cardiovascular surgeons. Dr. Diethrich began promoting the Institute through various public media in order to get it off the ground. Dr. Diethrich received adverse reactions from the Maricopa County Medical Society, the AMA, the [260] American College of Surgeons and the Society of Thoracic Surgeons (the latter two are specialty societies). He was denied membership in both the MCMS and the AMA, and was placed on three years' probation by the two specialty societies. Dr. Diethrich and the Institute have since become less visible and have experienced difficulty in raising funds.[29]

Dr. Leon Zucker, an ophthalmologist in Waterbury, Connecticut, participated in a newspaper interview in 1976, regarding an operation he had performed in order to better inform the public about medical advances. Both CSMS and NHCMA, in response to complaints from other ophthalmologists who viewed the newspaper article as publicity, declared that Dr. Zucker's action constituted self-aggrandizement and unethical behavior. Fearful of medical society reprisal, which could have deprived him of his source of malpractice insurance, Dr. Zucker immediately acceded to requests to refrain from such behavior in the future. Dr. Zucker testified that he felt stigmatized by the matter and has since been reticent with regard to communicating information to anyone.[30] The economic motivation behind the informal use of medical society power, and the resultant harm to competition and the flow of innocent information are apparent.

In 1973, Public Citizen's Health Research Group of Washington, D.C. (a Ralph Nader-affiliated organization) undertook the compilation of a physician directory in Prince George's County, Maryland. The project was begun in light of the dearth of accessible consumer

[28] F. 117, pp. 154–56.
[29] F. 120, pp. 160–66.
[30] F. 121, pp. 167–68.

information regarding physician providers of medical care in the area. The response from the local and state medical societies was one of noncooperation and opposition; the consumer group was advised that a physician who supplied more than his identity, specialty and office hours would be acting unethically. As a result, the Health Research Group obtained a minimal response rate from physicians, thereby depriving consumers of worthwhile and beneficial information that would aid them in choosing a physician.[31]

In 1973, Dr. Harry Browne, a Nashville, Tennessee, pathologist, submitted a written proposal to Lewis County (Tennessee) Hospital. The proposal detailed how [261] the hospital's laboratory and pathology services could be improved; Dr. Browne also compared his proposed services and fees to those of the hospital's current pathologist, Dr. Jack Freeman. Upon seeing Dr. Browne's proposal, Dr. Freeman submitted an almost identical counter-proposal to the hospital which was accepted. The hospital experienced lower costs and a significant improvement in its laboratory and pathology services. The Nashville Academy of Medicine, Tennessee Medical Association and AMA all viewed Dr. Browne's action as in conflict with the AMA's Principles of Medical Ethics and advised him so. Dr. Browne deferred to the ethical guidance of the medical societies, and has since restricted his marketing activities.[32] Ironically, it was Dr. Freeman who initiated the complaint against Dr. Browne; and it was Dr. Freeman who upgraded the medical services being provided, although only in response to the competition presented by Dr. Browne.

In 1971, Dr. E.D. Davis and others began organizing the Florida Health Care Plan, Inc. ("FHCP"), an HMO in Daytona Beach, Florida. Earlier, in 1968, the Florida Medical Association adopted a statement, later approved by the AMA Judicial Council, declaring it unethical for a physician to be paid a salary for services provided. The FHCP includes contract physicians on fixed salaries. FHCP met with opposition from the state society and the Volusia County Medical Society. In 1977, two of FHCP's physicians applied for malpractice insurance from an insurance carrier controlled by the state medical society; the only other insurance carrier had substantially higher rates. The applications for insurance were rejected for the explicit reason that the two physicians were on fixed salaries. The physicians were forced to pay the higher rates of the other carrier.[33] The financial burden to the FHCP is indicative of the

[31] F. 133, pp. 187-91.

[32] F. 136, pp. 194-97.

[33] F. 103, pp. 135-37; 149, pp. 220-21.

obstacles placed in the path of health maintenance organizations, which pose a direct economic threat to the fee-for-service private practitioner.

Dr. James Warren is head of the Department of Obstetrics and Gynecology at Washington University Medical School in St. Louis. He is also medical director of the Washington University Center for Outpatient Gynecological Surgery. [262] In 1975, Dr. Warren prepared and distributed to St. Louis area physicians a brochure describing the Center's abortion services, including information on fees and facilities. The Center was ideally located adjacent to the hospital center which would be available for emergency treatments. The brochures, sent only to area physicians, met with opposition from several sources, including the state and local medical societies. Dr. Warren, fearful of disapprobation by the medical community, sent a letter of apology to two-thirds of the physicians on the St. Louis Medical Society's mailing list before action could be taken by any medical society. Shortly thereafter, the Ethics Committee of the St. Louis Medical Society recommended that Dr. Warren be censured. The Medical Society resolved the situation by getting Dr. Warren to write a second letter of apology, which was distributed to all Medical Society members along with a Medical Society report of the incident. Since this incident, Dr. Warren's medical clinic has never issued another brochure describing its activities.[34]

The Harvard Community Health Plan, an HMO in the Boston area affiliated with Harvard University, began operating in 1969. In order to familiarize the public with its method of financing medical services and, thereby, attract subscribers, the Plan began advertising in the news media. Physicians complained to the Massachusetts Medical Society that the Plan's advertising was attracting patients away from private practitioners and was unethical; in other words, the fee-for-service private practitioners were fearful of the economic competition posed by the plan. In response to discussions with the medical society, the Plan agreed to refrain from advertising. The motivating factor behind the refusal of the Plan's physicians to authorize advertising was fear of medical society reprisal. In late 1976, the Plan's physicians authorized limited advertising in light of the instant FTC proceeding among other things.[35] Were it not for their overriding belief that more expansive forms of advertising would prompt ethical objections by the Medical Society, the Plan's physicians could be expected to authorize the dissemination of more

[34] F. 99, pp. 130–31.
[35] F. 106, pp. 140–41.

extensive information in the media, with concomitant benefits to the public. [263]

An organization in Bergen County, New Jersey sought approval from the local medical society of a proposal to send a form letter to the Mayors and Councils of 72 communities offering physical examinations for the communities' firemen, police and volunteer ambulance corpsmen at $50 each. The AMA advised the local society that the proposal "is out and out solicitation" proscribed by the Principles of Medical Ethics (F. 95, pp. 118–19). A physician in Minnesota wrote to AMA about a pap smear clinic he was proposing to run for one week during which he would reduce his fee for a pap smear and pelvic examination by one-fourth. He requested an opinion as to whether he could alert the public through newspaper and radio announcements. The AMA advised that public announcements of the kind that was proposed should not be made by individual physicians (F. 95, p. 119).

The above examples demonstrate the extent to which the AMA, CSMS, NHCMA, countless other constituent and component societies and their physician members have gone to deprive the public of any semblance of meaningful competition among physicians. Respondents AMA, CSMS, NHCMA and other medical societies did not engage in these efforts independently of each other. To the contrary, they actively consulted with each other and followed the state of affairs in jurisdictions other than their own. Needing guidance, advice or merely assurance as to ethical positions already or soon to be taken, constituent and component medical societies repeatedly solicited and acted upon the advice of the AMA. The Principles of Medical Ethics, the 1971 *Opinions and Reports* and autocratic interpretations of each provided the beacon that guided each medical society initiative to its goal. The respondents and numerous other medical societies acted in concert with each other in the formal and informal promulgation and enforcement of ethical pronouncements that suppressed physician competition.[36] [264]

B. Justifications for the Restrictions

Several expert witnesses testified about the nature of health care delivery in the United States, the information available to assist consumers in making an informed choice of a physician, the information necessary to enable consumers to make such an informed choice, the probable effect of physician advertising and related activities upon the cost and availability of medical care, the

[36] *See* pp. 279–90, *infra*, for a more detailed discussion of the evidence which demonstrates the conspiracy that existed between AMA and its constituent and component societies.

probable effect of such advertising upon the physician-patient relationship and the practice of medicine, and the public interest in medical society regulation of physician advertising.

Witnesses called by AMA[37] testified that lack of knowledge does not usually inhibit patients from entering the health care system. Most consumers currently have access to sufficient information to allow them to make an intelligent choice of a physician. Information concerning physicians and their practices is available through the mass media, telephone directories, physician directories, medical societies and individual physicians' offices. People gain information about physicians from other doctors, relatives, friends, coworkers, employers, hospitals, departments of health and medical societies. People who do not have a regular physician often wait until they are sick and, then, present themselves at an emergency room. They will typically inquire about obtaining a physician at that time. AMA's witnesses concluded that widespread advertising by physicians is not likely to substantially enhance the quality or usefulness of this information, since advertising by its very nature conveys only the selected information the advertiser chooses to disclose (Tr. 9690–91, 7703–09, 9498–99, 9517, 6094–95). [265]

In the case of patients without financial resources, or in the event there is a large dollar difference between two comparable medical procedures, the cost of a physician's service is a factor in the choice of physician. Where, for example, there is a $25 difference in two medical procedures and third-party payment is involved, the difference in cost usually does not have a significant impact upon the consumer's decision. In emergency situations, price is rarely a factor. Dr. Halberstam stated that it is reasonable to assume that the cost of physician advertising will be passed along to patients in the form of higher fees. In addition, physician advertising can be expected to increase the demand for medical services, with the majority of this increased demand being for potentially unnecessary services (Tr. 7701–03).

AMA's experts testified that widespread advertising by physicians would have a deleterious effect upon the practice of medicine. For example, if physicians were allowed or encouraged to disseminate "objective" information concerning the number of cases of a particular disease which they have treated, inexperienced or unqualified physicians might well be encouraged to treat more cases of the

[37] AMA called the following witnesses to testify about physician advertising and its effects upon medical care: Dr. Robert S. Stone, Dean of the School of Medicine at the University of Oregon; Dr. Stephen Biering, Dean of the School of Medicine at Indiana University; Dr. Franz J. Ingelfinger, former editor of the *New England Journal of Medicine;* Dr. Michael Halberstam, a practitioner in Washington, D.C.; and Dr. Theodore Cooper, Dean of the Cornell University Medical College and a former top government health official.

disease. Similarly, allowing physicians to advertise the mortality or complication rates of their patients might discourage them from treating more difficult cases. Such advertising might also encourage overutilization of medical care, since physicians might tend to perform more and more relatively easy procedures or treatments on patients who did not necessarily require them. A physician might also choose to advertise the number of operations which he or she has performed. If the physician is being judged publicly on such a criterion, he might tend to "accummulate" a large string of operations. This motivation could also result in overutilization of medical services (Tr. 7695–97, 5332, 6089).

Further, fee advertising could cause a physician to alter his best medical judgment in order to stay with the fee which he advertised. Widespread physician advertising may lead the patient to believe that his or her physician is "selling" the recommended treatment, thus undermining the traditional relationship of trust and confidence and interfering with the quality of medical care (Tr. 5328, 5347, 5353–56, 7700, 9702).

Dr. Cooper testified that advertising of physicians' services also has the potential for consumer deception. Consumers are more vulnerable to deceptive advertising when they are sick than when they are well. A misleading [266] advertisement on behalf of a physician may lure a patient away from a source of responsible, continuing care to someone who may be less responsible (Tr. 6083–84, 6089). A physician's advertising of his medical credentials may result in consumer deception.

AMA's witnesses testified that a physician's advertising of prices generally will not enable a consumer to predict the cost of his or her specific medical care, since there is great diversity in the extent of care required by any individual. Price advertising is also unlikely to assist a consumer in making an informed choice of a physician, since price information alone cannot convey the quality of care which will be provided (Tr. 9504–05, 9692–94).

Dr. Ingelfinger testified that fee advertising has the potential for bait and switch tactics because the initial fee will often not cover further tests necessitated by complications or the need to confirm inconclusive results. He stated that advertising of the fee for a physical examination is misleading unless disclosure is made of the amount of time the physician spends with the patient, the thoroughness of the examination, whether the fee includes the taking of a history and what other tests and procedures are included in the fee (Tr. 5340–42, 5346). Advertising of new techniques which have not been generally accepted in the medical community can be deceptive

and hazardous. An example of such a situation is the Wagenstein method of treating ulcers by freezing the stomach, which was highly touted at first but which subsequently proved to be harmful (Tr. 5336–38).

Claims that one physician is better than another or is the best in a particular group are misleading because superiority cannot be objectively determined. Success depends on the kind of patient treated along with other factors, such as the degree of difficulty of each procedure, the general health of the patient and the kind of patient who is being treated. Thus, advertising of success rates in medicine is potentially misleading. Patient testimonials about physicians' services, even when based on truthful facts, are inherently misleading because of their statistical invalidity. No meaningful predictions about other cases can ever be made on the basis of one individual's medical experience. Anecdotal reports mean nothing unless one studies case histories or two groups of patients in a scientifically controlled setting (Tr. 5332–35, 6082, 9501–02, 9701). [267]

Promises of cures are deceptive because no medical procedure is always successful and all involve some degree of risk. Physician advertising may be deceptive unless it contains disclosure of the risks involved in the procedure being advertised (Tr. 5330–31, 6090).

Complaint counsel's witness, Dr. Robert H. Ebert,[38] testified that physicians should be allowed to advertise. Medicine has become increasingly complex in recent years and patients often are not aware of the choices available to them. It is difficult for patients to know about how to get into the health care "system," or to know about primary care physicians, specialists, hospitals, physician groups that provide a complete range of services, medical foundations, HMOs and prepaid medical plans. Dr. Ebert was of the opinion that most information available to patients today is communicated by word of mouth, rather than on a more orderly basis. He believes that advertising should supplement whatever information is already available. Dr. Ebert stated that the public is entitled to know what services are available in the health care system and that advertising can educate the public in this respect. Fee information is something the public is entitled to know and price advertising would provide access to it (Tr. 9318–21, 9354, 9409).

In testifying about HMOs, Dr. Ebert stated:

. . .it is very difficult for the general public to appreciate what is available in various kinds of systems. For example, it is now mandatory, I guess, through recent legislation

[38] Complaint counsel called as a witness Dr. Robert H. Ebert, President of the Milbank Memorial Fund and former Dean of Harvard University Medical School.

that there should be [a] choice in any firm of over 25 if an HMO exists in a region, that there should be at least a freedom of choice between that and an ordinary Blue Cross-Blue Shield or whatever commercial carriers may be offering. One of the great difficulties with this is it is not easy to get the best information about that choice. One gets some general descriptions of it [268] but very often it is not considered proper to list the physicians, who they are and what their background is and so on. It does seem to me the kinds of things that can be put into advertising that lists the services, that lists the costs, that lists the people and their qualifications, is valuable in terms of educating the public (Tr. 9321-22).

Dr. Ebert was also of the opinion that there are ways in which the quality of medical services can be utilized in advertising, and that any media is appropriate for medical advertising (Tr. 9322-32). Doctors have always solicited patients through social gatherings, membership in clubs, talks, presentations of papers and participation in church or community activities. Thus, solicitation by specialists in certain areas, for example in industrial medicine, would be in the public interest. Dr. Ebert stated his belief that advertising would not detract from the professionalism which is deeply engrained in physicians, but would tend to open up the "guild" philosophy which exists in medicine today.

Dr. Ebert is opposed to medical society regulation of advertising; in his testimony, he stated: "I say that because, again, I worry about this kind of guild philosophy, that it is too easy in a sense to use that in a way, and sometimes even inadvertently, as a weapon against anything new, any novel approach to the practice of medicine" (Tr. 9332). He believes the majority of physicians would not under any circumstances advertise falsely, and the threat of malpractice would be an enormous deterrent to false advertising. Dr. Ebert testified that restrictions on physician advertising were developed for another time when physicians were less trained and there was more concern about control of fringe people and quacks; today, physicians are well trained and of exceptionally high quality. The problem today is not control of false advertising, but "what more information can patients get and what can they learn about what is available in their community in a much more complex time." (Tr. 9334-35, 9333).

Controlling fringe practitioners through medical society regulation of advertising is, in Dr. Ebert's opinion, "rather indirect" (Tr. 9337), as brought out in his testimony: [269]

[W]ell, I would almost say since usually the people are outside of legitimate medicine and practice outside of the medical society and they don't belong and many of them are moving from one state to another ahead of the law, I would say that how they should be regulated is much more in the substance of what they do.

* * * * *

And it would seem to me that the medical society, in its concern, which is a legitimate concern for the welfare of the legitimate public, would be much more advised to go immediately where this practice is being carried out to see whether there is not a way of controlling it quite directly, because usually there is. I would have said quite honestly that the advertising by these fringe people might also be an advantage in the sense that it gives you evidence that it is going on. . . . I would be almost more worried if it was all underground and there was no way to know that this kind of thing was being kind of promulgated by word of mouth.

So I really think that one can clearly attempt to control, you are never going to control completely this sort of thing but one can follow up on it and do it rapidly enough so it simply makes it very uncomfortable for people to do that kind of practice or anything illegal. (Tr. 9337–38. *See also* Tr. 9395, 9400, 9403).

Dr. Ebert further believes that the public is capable of evaluating and utilizing physician advertising, physicians are not going to engage in making exaggerated claims in advertisements, advertising will not adversely affect the physician-patient relationship or affect a patient's confidence in a physician, advertising will not lead to overutilization of those medical facilities that are under the control of the physician, price advertising by physicians will not lead them to cut corners in the treatment or [270] diagnosis of patients, advertising may or may not cut medical costs, and advertising by legitimate physicians may actually dilute the effect of advertising by fringe practitioners (Tr. 9333, 9341–58, 9409–10. *See also* Tr. 7001–02, 5361–62). He stated that directories of physicians are helpful, but there is need to advertise that such directories are available to patients (Tr. 9354–55). Dr. Ebert believes that the majority of physician advertising will center around systems of health care rather than the sole practitioner (Tr. 9377, 9409).

Dr. Ebert supports the principle that medical societies should not exercise any control over physician advertising:

JUDGE BARNES: The issue here is whether to take all control away from the medical society as to advertising?

THE WITNESS: Yes.

JUDGE BARNES: That is the basic issue and I think that is what Mr. Costilo is seeking an answer to. The question is do you support that view?

THE WITNESS: Yes, I do. I support the view not (sic) to take away overall advertising because I think it now is ineffective in controlling a group of physicians who are operating outside of the framework of organized medicine anyway and it is limiting the information that can be given to the public by perfectly legitimate groups of physicians, therefore I do think the relief sought is proper and it should be taken away.

* * * * *

A. I think that what is important here is not the advertising per se, but what the physician does. I would think that untruthful advertising would certainly be the signal to find out whether his behavior as a physician was unethical in terms of his practice. Certainly, if it were, he should be expelled.

Q. But with respect to his advertising, should the local medical society regulate his advertising as advertising? [271]

A. No. I don't think they should. I think, and the reason for that, Your Honor, is not that in the blatant cases (pointing) it might not be useful there, but what is difficult is the gray areas. There is unfortunately the tendency to regulate rather more severely those things you don't happen to like personally, so I think the principle is a dangerous one. As I say, not in these blatant kinds of ads (pointing), but the principle, when applied to the grayer kind of area, I think the consequences could be such as to prevent perfectly responsible things from developing.

* * * * *

Q. . . .Should a medical society be able to expel a doctor if, in making an advertisement, the advertisement is concluded by the medical society to be likely to create inflated or unjustified expectations of favorable results?

A. I think my answer, Your Honor, is the same as I have given earlier, that I don't think that using the criteria of advertising is the appropriate criteria for expelling a member. I think an appropriate criteria would be what has actually happened to the patients of the doctor rather than the ad. As I indicated, I said that because of the potential that it could be misused.

Q. When you say "It can be misused," what do you mean?

A. The potential that it could be misused in those areas in which some question might be raised where the bias of an individual in the medical society might be such that they would tend to be more severe on a system they were less familiar with or didn't like or was more competitive with them, whereas, I think, on the basis of what the results are, where the medical society then does have that prerogative. (Tr. 9339-40, 9416-17, 9419-20). [272]

C. The Justifications are Without Merit

The arguments presented by respondents need not be looked at in isolation from similar arguments raised in other settings. The Supreme Court has already addressed itself on several occasions to the legality of ethical restrictions enacted by a "learned profession." *National Society of Professional Engineers* v. *United States,* 98 S. Ct. 1355 (1978); *Bates* v. *State Bar of Arizona,* 433 U.S. 350 (1977); *Virginia State Board of Pharmacy* v. *Virginia Citizens Consumer Council, Inc.* 425 U.S. 748 (1976); *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773 (1975). These cases, then, provide the contours within which

the restraints upon physician competition imposed by the AMA, CSMS, NHCMA and other medical societies must be analyzed.

The importance of advertising as the prime means by which information about the nature, price and availability of products and services is conveyed to the public is a well recognized fact. "Advertising is the traditional mechanism in a free-market economy for a supplier to inform a potential purchaser of the availability and terms of exchange." *Bates,* 433 U.S. at 376. As such, advertising "performs an indispensable role in the allocation of resources in a free enterprise system . . . [and] serves individual and societal interests in assuring informed and reliable decisionmaking." *Id.* at 364. Price advertising places pressure on sellers to reduce prices, instills cost consciousness in providers of services and informs the public about price alternatives. *Advertising of Ophthalmic Goods and Services,* 43 Fed. Reg. 23992, 23994-95 (FTC June 2, 1978). Advertising facilitates the entry of new and alternative providers of services into the marketplace; in the absence of advertising, such providers would be hard pressed to make their very existence known to the public. Through advertising, the public is presented with a wider array of choices and is better equipped to comparison shop among providers of the same services.

The record in this proceeding demonstrates the substantial anticompetitive effects of respondents' restrictions on physician advertising and the free flow of commercial information to the public. Physicians have been prevented from seeking customers by advertising or offering to provide services at a particular price, or by advertising their [273] services, availability or qualifications. As a result, it is more difficult for consumers to comparison shop for physicians' services, to locate physicians upon first arriving in a community, to change physicians, to find physicians who will accept the Medicare reimbursement schedule as payment in full, to become informed about group practices and HMOs and to benefit in many other ways from competition among the providers of health care services. The challenged restrictions have hindered the entry of new providers into the physicians' services market, including private practitioners, prepaid health care plans such as HMOs and other organizations and programs using innovative or alternative approaches in the delivery of health care. Physicians, prepaid health care plans and other medical organizations and programs that have been prevented and deterred from advertising and soliciting patronage have been injured economically, and the restrictions have made it more difficult for these physicians and organizations to continue to offer their services to the public and to compete effectively.

The Supreme Court has declared that there is no longer any automatic immunity from the antitrust laws based on the mere fact that a group constitutes a "learned profession." The Court stated: "[T]he cautionary footnote in *Goldfarb,* 421 U.S. at 788–89, n. 17 . . . cannot be read as fashioning a broad exemption under the Rule of Reason for learned professions." *Professional Engineers,* 98 S. Ct. at 1367. *See also Goldfarb,* 421 U.S. at 787–88.

There is also no merit to the contention that the ethical restrictions on advertising are necessary to guard against adverse effects on professionalism. The record evidence has clearly demonstrated that respondents' ethical strictures were motivated by economic objectives rather than by a need to maintain professionalism among physicians. Physicians are, perhaps, the most highly regarded profession, as a whole, in this country today (RX 915). To say that advertising would destroy that degree of public respect and tear into the physicians' self-image would be to deny the great skills and talent and the life-or-death judgmental abilities possessed by many physicians. "[T]he postulated connection between advertising and the erosion of true professionalism [is] severely strained." *Bates,* 433 U.S. at 368. *See also Virginia State Board of Pharmacy,* 425 U.S. at 768–770. [274]

Allowing advertising by physicians will not open the floodgates to widespread abuses with resultant detriment to the public. The overwhelming majority of physicians are honest, competent and dedicated and will not engage in false, misleading or deceptive advertising or other truly unethical forms of behavior. Respondents' arguments that because of advertising physicians will cut corners in their professional services, perform unnecessary treatments, or select out the easy procedures in order to compile an impressive success record, unduly denigrates a highly trained professional group. The Supreme Court has observed of other professions that advertising will not have such adverse effects: "We suspect that, with advertising, most lawyers will behave as they always have: They will abide by their solemn oaths to uphold the integrity and honor of their profession and of the legal system." *Bates,* 433 U.S. at 379. Nothing less should be said about physicians.

Further, high professional standards, including standards against dereliction in performance, are assured by state medical licensing boards[39] and state statutes regulating physician conduct, including advertising and solicitation.[40] Moreover, false or deceptive advertising is already prohibited in every state and the District of Columbia

[39] See F. 88, pp. 108–10.

[40] See Appendix B, pp. 310–12, *infra.*

in enacted laws preventing deceptive and unfair trade practices. *Ophthalmic Rule,* 43 Fed. Reg. at 23997, n. 89. The substantial penalties provided for under the Federal Trade Commission Act are a substantial deterrent to false or deceptive advertising. (15 U.S.C. 45(1).) Since not all physicians are members of medical societies, and therefore not subject to medical society ethical rules, those fringe practitioners who might be more likely to commit abuses remain unaffected by present ethical restrictions.[41] "Restraints on advertising . . . are an ineffective way of deterring shoddy work. An attorney who is inclined to cut quality will do so regardless of the rule on advertising." *Bates,* 433 U.S. at 378 "The advertising ban does not directly affect professional standards one way or the other." *Virginia State Board of Pharmacy,* 425 U.S. at 769. The same reasoning holds true for physicians. [275]

With regard to advertising by attorneys, the Supreme Court stated in *Bates:*

> We are not persuaded that restrained professional advertising by lawyers inevitably will be misleading. Although many services performed by attorneys are indeed unique, it is doubtful that any attorney would or could advertise fixed prices for services of that type. The only services that lend themselves to advertising are the routine ones: the uncontested divorce, the simple adoption, the uncontested personal bankruptcy, the change of name, and the like-the very services advertised by appellants. Although the precise service demanded in each task may vary slightly, and although legal services are not fungible, these facts do not make advertising misleading so long as the attorney does the necessary work at the advertised price. The argument that legal services are so unique that fixed rates cannot meaningfully be established is refuted by the record in this case: The appellee State Bar itself sponsors a Legal Services Program in which the participating attorneys agree to perform services like those advertised by the appellants at standarized rates. Indeed, until the decision of this Court in *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773 (1975), the Maricopa County Bar Association apparently had a schedule of suggested minimum fees for standard legal tasks. . . . We thus find of little force the assertion that advertising is misleading because of an inherent lack of standardization in legal services. Bates, 433 U.S. at 372–73.

The Court's response applies with equal force to the case of physician advertising. Services such as routine examinations, laboratory and diagnostic tests, immunizations and other short, simple procedures do lend themselves to meaningful advertising. The Relative Value Guides[42] promulgated by many medical societies indicate that there are base fees that can serve [276] as standards for even complex procedures.[43] More importantly, price advertising is only one of

[41] See discussion at F. 144, p. 206.

[42] *See* F. 33, p. 46; 60, p. 83; 63, pp. 85–86.

[43] During the period of federal price controls in the 1970's, federal regulation required all medical practitioners to post a sign in their facilities announcing the availability for public inspection of a schedule showing their

(Continued)

many types of information that could be disseminated once the ethical ban on advertising were lifted. Consumer directories, information about health maintenance organizations and medical clinics, more informative telephone listings, in person solicitation of corporate clients and other professionals and open houses are some of the means by which physicians could apprise the public of the range of available forms of health care delivery. The Supreme Court recognized that a well informed public represents, perhaps, the best means to the rational choice and utilization of services, for only a well informed public will perceive their own best interests. *Virginia State Board of Pharmacy,* 425 U.S. at 769–70. In *Bates,* the Court stated:

> [I]t seems peculiar to deny the consumer, on the ground that the information is incomplete, at least some of the relevant information needed to reach an informed decision. The alternative - the prohibition of advertising - serves only to restrict the information that flows to consumers. Moreover, the argument assumes that the public is not sophisticated enough to realize the limitations of advertising, and that the public is better kept in ignorance than trusted with correct but incomplete information. We suspect the argument rests on an underestimation of the public. In any event, we view as dubious any justification that is based on the benefits of public ignorance. *Bates,* 433 U.S. at 374–75.

To say that physicians are above "trade," and to assert that they are entitled to preserve their basic ethical values despite deleterious effects on [277] competition, would be to completely remove physicians from a marketplace setting, rather than admit that the services they offer, the delivery of which are both highly necessary and equally highly respected, might better comport with the public's needs were they subject to appropriate competitive factors, *i.e.,* advertising, solicitation and contract practice.

Respondents also argue that they do not proscribe advertising *per se,* but only that advertising which is misleading or deceptive.[44] The actual occasions on which medical societies interceded and effectively curtailed various forms of physician advertising show the fallacy of this argument. Dr. LaDou desired to acquaint the public with the advantages of preventive medicine and industrial medical services; he intended for his advertising to accomplish this objective.[45] He had hoped to bring his services to the attention of business executives, a

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customary prices for those services which accounted for 90 percent of their aggregate annual revenues (CX 2602). From this evidence, it can be inferred that physicians' fees are readily capable of being publicized in a nondeceptive manner.

[44] There is a real danger here, as Dr. Ebert has pointed out. Having your competitor determine whether your advertisement is false or deceptive has inherent risks. This power can be used as an anticompetitive weapon. One is more likely to closely regulate that which he dislikes or is unfamiliar with. Restrictions aimed at fringe practitioners are ineffective and prohibit legitimate advertising.

[45] See discussion at p. 258, *supra,* and at F. 98, pp. 124–29.

knowledgeable consumer group. Dr. Browne's proposal, stating the nature of and price for the laboratory and pathology services that he could offer, was intended to show that improved services did not require any increase in price.[46] Dr. Browne was dealing with hospital executives, again a knowledgeable group. These physicians, Dr. LaDou and Dr. Browne, and others posed obvious economic threats to medical societies and their members, who viewed the fee-for-service, private practice physician, in a noncompetitive setting, as the only viable means for delivering medical services. Neither Dr. LaDou, Dr. Browne nor the greater majority of physicians who engaged in advertising or who proposed to engage in some form of advertising, as recounted in the record evidence, misled or deceived the public. The information they hoped to [278] disseminate would only contribute to the pool of information on medical services available to the public, and thereby add to the breadth of the system of health care delivery in this country.

In considering the justifications for the ethical restrictions presented by respondents and the benefits to society engendered in competition among physicians, there are two modes of antitrust analysis. One category consists of agreements that are so "plainly anticompetitive" that they are "illegal per se;" the other category consists of agreements that must be subjected to the Rule of Reason analysis, which determines "whether the challenged agreement is one that promotes competition or one that suppresses competition." *Professional Engineers,* 98 S. Ct. at 1365. "Under [the Rule of Reason], the fact finder weighs all of the circumstances of a case in deciding whether a restrictive practice should be prohibited as imposing an unreasonable restraint on competition." *Continental T.V., Inc.* v. *GTE Sylvania, Inc.,* 433 U.S. 36, 49 (1977). In *Professional Engineers,* the Court held that a canon of ethics prohibiting the submission of competitive bids and refusing to discuss price until after an engineer was selected operated as an absolute ban on competitive bidding and violated Section 1 of the Sherman Act on its face. *Professional Engineers,* 98 S. Ct. at 1365–66.

The record evidence in this proceeding is overwhelming in establishing the anticompetitive effects of respondents' ethical restrictions, their economic motivations and their consequent harm to the public interest. The unreasonableness of the restraints on competition imposed by respondents AMA, CSMS, NHCMA and other AMA constituent and component medical societies needs no further elucidation. The ethical restrictions which the medical

[46] See discussion at pp. 260–61, *supra,* and at F. 136, pp. 194–97.

societies have imposed heavily tip the balancing scales against the needs of the public and in favor of the maintenance of the financial security of physicians. In such instance, the Rule of Reason is clearly violated. Since a record has been made that clearly demonstrates the unreasonableness of respondents' ethical restrictions, it is unnecessary to consider whether such activities also fall within a *per se* ban.

Respondents' ethical restrictions on advertising, solicitation and contract practice are also unfair under Section 5 of the Federal Trade Commission Act. A practice is unfair and violates Section 5 if it results in substantial [279] harm to consumers and offends public policy. *FTC* v. *Sperry & Hutchinson Co.,* 405 U.S. 233, 244–45 n. 5 (1972); *Spiegel, Inc.* v. *FTC,* 540 F.2d 287, 293 (7th Cir. 1976). That public policy supports advertising even where a professional group is involved was recognized by the Supreme Court in *Professional Engineers, Bates, Virginia State Board of Pharmacy, Goldfarb* and *Bigelow* v. *Virginia,* 421 U.S. 809 (1975). The Commission, most recently, has ruled in favor of a policy of providing information about commercial transactions to the public. *Advertising of Ophthalmic Goods and Services.* That respondents ethical practices have caused and continue to cause substantial injury to consumers has been established by the reasoning presented herein. Recent Supreme Court and Commission decisions leave no doubt that public policy strongly favors providing the public with information, not keeping them in ignorance.

The purported justifications for restrictions on advertising, solicitation and contract practice are an insufficient basis to overcome the substantial adverse effects on competition imposed by the restrictions and the strong public policy favoring the free flow of commercial information. As the Supreme Court stated: ". . . [W]e may assume that competition is not entirely conducive to ethical behavior, but that is not a reason, cognizable under the Sherman Act, for doing away with competition." *Professional Engineers,* 98 S. Ct. at 1367. Therefore, respondents' ethical restrictions are unfair and violate Section 5 of the Federal Trade Commission Act.

IV. RESPONDENTS HAVE ENGAGED IN A CONSPIRACY TO RESTRAIN COMPETITION

The record evidence establishes the existence of a conspiracy between the AMA and its constituent and component medical societies, including respondents CSMS and NHCMA. The degree and pattern of reliance by state and local medical societies upon the AMA for statements of official ethics policy, as well as for advice on ethical matters as they arise or are likely to arise, and the

dependence by the AMA upon the state and locals to implement and enforce those ethics policies become manifest in the internal structure and organization of the AMA and its constituent and component societies and in their working interrelationships. The prescriptions and proscriptions of AMA, as set forth in AMA's Principles of Medical Ethics, *Judicial Council Opinions and Reports* and other official pronouncements represent a pervading force in virtually all disciplinary actions undertaken by medical societies. To conclude, from respondents' admissions and from the parallelism between the nature of official policy on ethical issues as articulated by the AMA and as implemented and enforced by AMA member medical societies, that the striking uniformity of medical societies' positions [280] on ethics matters should have come about by mere chance or coincidence, as respondents have argued, rather than based on a common understanding and concerted activity is to adopt the impractical and ignore the reality.

To find otherwise than that the AMA and state and local medical societies were engaged in a conspiracy to restrain competition would be to ignore an abundance of evidence to the contrary. The record contains a more than sufficient quantum of independently admissible evidence to establish the existence of the conspiracy. There is also additional third-party documentary materials that were offered as evidence of the nature of the local medical societies, their actions and statements; these documents were provisionally admitted subject to connection to a conspiracy. Under the coconspirator rule[47] regarding statements that would otherwise be classified as hearsay, such documentary evidence from AMA's constituent and component societies is admissible against all respondents without the necessity of calling witnesses from these nonrespondent societies. The third-party documentary evidence provides further proof that supports and confirms the finding of a conspiracy. Moreover, this third-party evidence may be used as direct proof of the unlawfulness of the conspiracy.

A. The Conspiracies Being Challenged

The complaint alleges that respondents and others have agreed to prevent and hinder competition among physicians (Comp. ¶¶ 6 and 7). Respondents have engaged in two types of unlawful agreements. First, AMA has agreed with all of its constituent and component medical societies, including the Connecticut respondents, to promul-

[47] Rule 801(d)(2)(e) of the Federal Rules of Evidence, states:
"A statement is not hearsay if the statement is offered against a party and is a statement by a co-conspirator of a party during the course and in furtherance of the conspiracy."

gate and enforce ethics restrictions on physicians' advertising, solicitation and contractual relations. Second, each respondent medical society has engaged in concerted activity with its members by adopting the ethics restrictions, disseminating them to its members and agreeing to abide by them. [281]

B. The Legal Standard Governing Respondents' Activities

The core of conspiracy is a mutual understanding or agreement to accomplish an unlawful objective. The agreement is often described by the words, "meeting of the minds," "unity of purpose" or "common design and understanding." *American Tobacco Co.* v. *United States,* 328 U.S. 781, 810 (1946). So long as there is a mutual understanding to follow a common plan, a conspiracy may be found despite the lack of total uniformity among the conspirators. *FTC* v. *Cement Institute,* 333 U.S. 683, 715–16 (1948).

A formal or express agreement is not necessary to constitute an unlawful conspiracy, *American Tobacco,* 328 U.S. at 809, and will rarely be found in antitrust conspiracy cases. "It is elementary that an unlawful conspiracy may be and often is formed without simultaneous action or agreement on the part of the conspirators." *Interstate Circuit, Inc.* v. *United States,* 306 U.S. 208, 227 (1939). *See United States* v. *Masonite Corp.,* 316 U.S. 265, 275 (1942). Instead, the inherent nature of a conspiracy is often marked by a continuous course of conduct. To isolate out and separately analyze the individual components of a conspiracy would be to contradict the very theory that lies behind it. "Acts done to give effect to the conspiracy may be in themselves wholly innocent acts. Yet, if they are part of the sum of the acts which are relied upon to effectuate the conspiracy which the statute [the Sherman Act] forbids, they come within its prohibition." *American Tobacco,* 328 U.S. at 809. The agreement may be inferred from a course of conduct which could include communications among the coconspirators as well as seemingly concerted activities. "The character and effect of a conspiracy are not to be judged by dismembering it and viewing its separate parts, but only by looking at it as a whole." *Continental Ore Co.* v. *Union Carbide & Carbon Corp.* 379 U.S. 690, 699 (1962), quoting *United States* v. *Patten,* 226 U.S. 525, 544 (1913). This represents not only a rational legal and analytical approach to the instant factual situation, but a common sense view of it as well.

In *Interstate Circuit,* 306 U.S. at 226–27, the Supreme Court held that where concerted activity is contemplated and invited by a central, coordinating party and such [282] invitation is accepted by competitors knowing that their participation is essential to achieve

the purposes of the agreement, a conspiracy has been established. The kind and gravity of the conduct entered into that, taken as a whole, comprises the conspiracy may not only vary, but may defy categorization under traditional conspiracy concepts. "If persons devise some subtle, unique form of conspiracy tailored to best serve their own purposes which purposely leaves few tracks or fingerprints, it may violate the law even though it cannot be easily accommodated in the familiar mold of a simple and limited conspiracy." *United States* v. *Consolidated Packaging Corp.*, 575 F.2d 117, 126 (7th Cir. 1978).

It is not necessary to show that *every* constituent and component medical society participated in the agreement in order for a conspiracy to be established; "what is required . . . is substantial evidence from which such an agreement can be inferred." *Northern California Pharmaceutical Association* v. *United States,* 306 F.2d 379 (9th Cir. 1962), *cert. denied,* 371 U.S. 862 (1962). *See also Interstate Circuit,* 306 U.S. 208 (1939). Once a conspiracy has been established, only slight evidence is necessary to connect a particular participant to it; such evidence might be no more than a single act demonstrating, directly or inferentially, the intent to participate. *Consolidated Packaging,* 575 F.2d at 126–27; *United States* v. *Cadillac Overall Supply Co.,* 568 F.2d 1078, 1087 (5th Cir. 1978), *cert. denied,* 46 U.S.L.W. 3776 (June 19 1978). *See also Blumenthal* v. *United States,* 332 U.S. 539, 556–57 (1947).

In *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773 (1975), the Supreme Court decided that § 1 of the Sherman Act was violated by a minimum fee schedule for lawyers that was promulgated by a county bar association following the impetus provided by the state bar association in its fee schedule reports. The Court noted that enforcement of the fee schedule was aided by the prospect of professional discipline from the State Bar - a distinct possibility unmistakably present in the State Bar's ethical opinions - as well as the desire of attorneys to comply with announced professional norms. *Id.* at 781, 791 n. 21. However, there had been no formal disciplinary action to enforce the fee guidelines. *Id.* at 776–77. The Court concluded that "[t]he State Bar, by providing that deviation from County Bar minimum fees may lead to disciplinary action, has voluntarily joined in what is essentially a private [283] anticompetitive activity, and in that posture cannot claim it is beyond the reach of the Sherman Act." *Id.* at 791–92. The parallelism between *Goldfarb* and the instant set of facts is clear.

The second type of conspiracy challenged here, namely a conspiracy between each respondent medical society and its members, has

also been addressed by the Supreme Court. In *National Society of Professional Engineers* v. *United States,* 98 S. Ct. 1355 (1978), the Court held that a learned profession's canon of ethics prohibiting the submission of competitive bids amounted to an unlawful agreement among members of the society to restrain trade. "Petitioner's ban on competitive bidding prevents all customers from making price comparisons in the initial selection of an engineer, and imposes the society's views of the costs and benefits of competition on the entire market place." *Id.* at 1367. These words apply with equal force here. The Court further noted that "the cautionary footnote in *Goldfarb,* 421 U.S. at 788–89, n. 17 . . . cannot be read as fashioning a broad exemption under the Rule of Reason for learned professions." *Id.*

C. The Existence of a Conspiracy Is Established by Independently Admissible Evidence

The record evidence shows that respondent AMA served as the focal point of a plan to restrict physicians' advertising, solicitation and contractual relations. AMA provided the impetus for the Connecticut respondents and other state and local medical societies to act in concert with them in the restrictive practices detailed in the findings of fact, herein. The means by which such restraints were effected include the promulgation and distribution of the Principles of Medical Ethics, the *Opinions and Reports* and interpretations thereof, and communications with medical societies and individual physicians to promote compliance with these and other ethical pronouncements.

The structural hierarchy of the AMA and its member societies and the organizational network that allows them to function in an efficient and integrated manner reveal a close working relationship.[48] AMA is a federation of constituent (state) medical societies which, in turn, charter component (county and district) medical societies. [284] In most instances, a physician must join his or her state medical society to be eligible for AMA membership. Membership in a local society is usually a prerequisite to membership in a state society (F. 4–5, p. 6; 9, p. 8). The state societies usually collect AMA membership dues on behalf of AMA.

The local societies select the members of the state societies' governing bodies, and the state societies select the members of the AMA ruling body, the House of Delegates. The House of Delegates, representing the medical societies in the AMA federation, has adopted the Principles of Medical Ethics and has made adherence to

[48] See discussion at pp. 234–35, *supra.*

them a condition of membership in AMA. The House has approved and specifically adopted many of the ethical restrictions on physicians' advertising, solicitation and contractual relations that are contained in the *Opinions and Reports.* The House has declared it a prime purpose of AMA to maintain "ethical" standards among all members of the medical profession (CX 990Z10). Promulgation and enforcement of its code of ethics has been a principal function of AMA since its founding (CX 959Z28). The House of Delegates elects the members of the AMA Judicial Council. The Judicial Council issues interpretations of the Principles *(Judicial Council Opinions and Reports),* is empowered to institute disciplinary proceedings at the request of state societies against physicians who violate the Principles and has appellate jurisdiction over cases originated by constituent and component societies in ethical matters (F. 6, p. 7; 8, pp. 7–8; 85, p. 102; 86, pp. 105–06).

Often, the constitutions and bylaws[49] of constituent and component medical societies expressly state that a primary purpose of existence is to form and maintain, along with other medical societies, the AMA (F. 5, p. 6). The bylaws of these medical societies provide that AMA's Principles of Medical Ethics shall govern the conduct of their members (*See* Appendix A, *infra*). The AMA House of Delegates has adopted a resolution making state medical societies' own ethical principles binding upon the respective societies' members, provided that the principles are not inconsistent or in conflict with the Constitution and Bylaws of AMA (CX 1435Z20). AMA has also declared that when a physician disregards "local custom," as determined by the local medical society, he has acted unethically (F. 86, p. 104; CX 1349). Furthermore, AMA has declared it the duty and [285] obligation of its local medical societies to insure full compliance with the spirit and intent of the AMA Principles of Medical Ethics (CX 462Z9 [Sec. 5, Op. 20]), and has frequently urged its constituent and component medical societies to fulfill this obligation (CX 462Z1 [Sec. 4, Op. 9], Z2 [Sec. 4 Op. 14], Z5–6 [Sec. 5, Op. 9], Z6, [Sec. 5 Op. 11], Z6–7 [Sec. 5, Op. 12], Z7 [Sec. 5, Op. 13], Z9 [Sec. 5, Op. 20], Z10 [Sec. 5, Op. 23], Z40 [Sec. 10 Op. 4], Z45 [Sec. 10, Op. 13]; 26B, 54, 488B–C, 662B–C, 673A, E, 845, 1392C, 1810). AMA has also stated that the application of all of the opinions in the *Opinions and Reports* is the obligation of county medical societies (CX 489).

AMA has distributed thousands of copies of the Principles and the *Opinions and Reports,* which interpret the Principles to its state and local societies; these AMA member medical societies have, in turn,

[49] AMA has not challenged these documents on the grounds of authenticity or hearsay. Therefore, they are adjudged independently admissible evidence.

distributed copies throughout their organizational network (F.85, p.103), thus assuring that the Principles and the *Opinions and Reports* filter down to all physician members. By these actions, AMA has openly encouraged medical societies and consequently, member physicians to take part in the restrictive practices and thereby to participate in a conspiracy to restrain competition.

The hierarchy of the medical societies, their common members, the bylaws of the state and local societies, combined with AMA's Principles and its *Opinions and Reports,* constitute a prima facie showing of the conspiracy between AMA and its constituent and component societies, including the Connecticut respondents. Moreover, the actual restrictive practices, including the constant flow of communications between AMA, its member medical societies and individual physicians concerning ethics policy and ethics enforcement, further demonstrate the existence and extent of the conspiracy. AMA has prompted its constituent and component medical societies to apply its restrictions on physician advertising, solicitation and contractual arrangements to particular physicians and medical care organizations, has offered guidance to its member societies in interpreting and applying the restrictions and has expressed after-the-fact approval of specific restrictive actions taken by its member societies.[50] State medical societies including CSMS, [286] have prompted and participated with their local medical societies including NHCMA, in specific actions to interpret and enforce AMA's ethical restrictions on solicitation, advertising and contractual arrangements. Apparently feeling less qualified and less expert in the application of ethical pronouncements than the AMA, local societies have written to AMA to solicit its advice and opinions on numerous occasions. AMA's responses often take the form of advisory opinions, ethical policy statements and, where appropriate, have usually resulted in the informal enforcement by the local societies of the restrictions on physicians' advertising, solicitation and contractual relations contained in the Principles. Where the AMA receives communications from sources other than member medical societies, it often responds by referring ethical complaints and inquiries to the appropriate component medical society for action.

In sum, AMA acts as a clearinghouse for the dissemination of policy on ethic matters and, frequently, for the resolution of ethics complaints. AMA field officials, under the direction and guidance of

[50] AMA's Department of Medical Ethics, in internal reports, has stated that it "works closely" with the officers and staff of state and county medical societies on ethical matters, including those relating to advertising (CX 1766A, 1767A).

the AMA Judicial Council and its staff, act as intermediaries on matters of medical ethics between AMA and its constituent and component medical societies and others. In so doing, AMA field officials engage in many of the same activities as the AMA Judicial Council and its staff and routinely, in formal and informal ways, interpret and enforce, and assist and advise AMA's constituent and component medical societies and others in the interpretation and enforcement of, AMA's Principles of Medical Ethics and AMA's Judicial Council interpretations thereof.[51] The incessant obedience of the locals and their members to AMA's ethical dictates belies the possibility of mere coincidence. Instead, such concerted actions bespeak of a common conspiratorial undertaking.

Evidence independently admissible against the Connecticut respondents establishes their prima facie involvement in a conspiracy with AMA and other constituent and component societies.[52] NHCMA members are directly represented in the CSMS House of Delegates which, in turn, sends delegates to the AMA House of Delegates. Both CSMS and NHCMA have adopted, published and distributed to their members the AMA's Principles of Medical Ethics and interpretations of them; both have made adherence to the [287] Principles a condition of membership. NHCMA has explicitly provided that its members are bound by the AMA Principles as reflected in the opinions of the AMA Judicial Council (F. 86, p. 104). Both Connecticut respondents have communicated with AMA about matters relating to the Principles and, thereby, to the aforementioned restrictions on physicians, and both have engaged in informal enforcement of the AMA Principles (F. 95, pp. 119–20; 112, p. 147; 119, p. 160; 121, pp. 167–68; 123, pp. 172–73; CX 136A–F, 137). This is more than the "slight evidence" that is needed to connect a particular party to an ongoing conspiracy.

The record evidence[53] evinces, beyond any reasonable doubt, a "unity of purpose" and a mutual understanding on the part of the AMA, its constituent and component societies and the individual physicians that comprise the membership of those medical societies to promulgate, disseminate and enforce ethical restrictions on advertising, solicitation and contract practice. The orchestration of

[51] See Order Ruling on Complaint Counsel's Motion for Adverse Rulings and Other Relief Due To Noncompliance With Subpoena Duces Tecum By Respondent The American Medical Association, February 24, 1977, pp. 11–12.

[52] Since it is held that all medical societies and their individual physician members, not named as parties to this proceeding, are participants in the conspiracy, it follows that CSMS and NHCMA are also coconspirators aside from the quantum of evidence that is independently admissible against them.

[53] These specific instances of implementation of AMA ethical pronouncements to restrain competition among physicians are too numerous to repeat again here. Instead, reference is made to pp. 254–63, *supra*, and to Sections X and XI of the findings.

activities that effectively restrain physician competition throughout the United States is too harmonious to be suggestive of anything other than concerted action - a conspiracy - among physicians and their medical societies.

D. Third-Party Medical Society Documents

The third-party evidence admitted provisionally subject to connection to a conspiracy is made up of a large number of documents from the files of AMA's constituent and component societies. The documents consist primarily of communications between constituent and component medical societies and individual physicians, minutes of meetings of the state and local societies and other correspondence generally relating to ethics inquiries and complaints addressed by the state and local medical societies.[54]

Respondents have not challenged the authenticity of these documents. The main objections to them are on the grounds of relevancy and hearsay. There are several alternative evidentiary bases upon which the documents are admissible. [288]

First, the documents are admissible under the well established principle that out-of-court declarations of conconspirators are admissible against all of the conspirators once a *prima facie* showing has been made by independently admissible evidence that the parties were engaged in a combination, partnership or "common plan." This principle is based upon the agency relationship that comes into existence when a conspiracy has been established. It is not necessary to show by independent evidence that the combination was unlawful, for that "element of illegality may be shown by the [hearsay] declarations themselves." *Hitchman Coal & Coke Co.* v. *Mitchell,* 245 U.S. 229, 249 (1917). *See Schine Chain Theatres, Inc.* v. *United States,* 334 U.S. 110, 116–17 (1948); *United States* v. *United States Gypsum Co.* 333 U.S. 364, 388–93 (1948); *Bakers of Washington,* 64 F.T.C. 1079, 1137 (1964), *aff'd sub nom., Safeway Stores, Inc.* v. *FTC,* 366 F.2d 795 (9th Cir. 1966), *cert. denied,* 385 U.S. 932 (1967).

Since a conspiracy has already been established by independently admissible evidence, as described above, the third-party documents become admissible as declarations of the coconspirators in aid of the conspiracy. These documents provide further confirmatory evidence that buttresses the finding of a conspiracy to restrain competition. It is immaterial that the AMA or other parties to the conspiracy may not have known of the commission of the act or the making of the

[54] Most of the documents specifically refer to AMA's Principles of Medical Ethics and *Opinions and Reports* as the authority for ethics actions; almost all of those that do not are from societies which have adopted the Principles to govern their members.

declaration contained in the third-party document. The coconspirator doctrine attributes those acts and declaration to each partner in the conspiracy.

The third-party documents may, however, be used as evidence of the conspiracy itself. To reach this end, the basis for admissibility lies in the fact that the documents constitute nonhearsay and, therefore, are independently admissible.

The documents are not hearsay because they can be viewed as having been offered not for the truth of the matters stated, but rather for the fact that the statements contained in each document were made. *See United States* v. *Mesarosh,* 233 F.2d 449 (3d Cir. 1955); *rev'd on other grounds,* 352 U.S. 1 (1956); *Baush Mach. Tool Co.* v. *Aluminum Co. of America,* 79 F.2d 217 (2d Cir. 1935). Consequently, the third-party documents may be used to establish the conspiracy.

Since many of the third-party documents refer explicitly, as well as implicitly, to the AMA's Principles of Medical Ethics and to the *Opinions and Reports,* they constitute [289] additional direct evidence of a conspiracy. Indeed, the documents attest to the wide-ranging extent of the conspiracy to restrict physicians' advertising, solicitation and contractual relations. Those third-party medical society documents that do not either mention the Principles or directly refer to the AMA as the primary source of ethics pronouncements, form a pattern of advice and policy on ethics matters that is not only consistent with AMA views but unswervingly in line with almost all AMA ethics dictates. Such a pattern inexorably leads to the inference of conspiracy.

This proceeding is governed by the Federal Trade Commission's Rules of Practice, rather than by the Federal Rules of Evidence. *See FTC* v. *Cement Institute,* 333 U.S. 683, 705–06 (1948). A final ground for the admissibility of these documents is based upon Rule 3.43(b) of the Commission's Rules of Practice.[55]

There is no doubt as to the relevancy or materiality of the documents. They point towards the same type of practices that respondents are charged with, and frequently refer to and make mention of AMA's Principles of Medical Ethics, its *Opinions and Reports* and other ethics pronouncements. The third-party medical society documents give rise to an inference of conspiracy that finds full support in the evidence described above.

The only question lies in the reliability of the documents.

[55] Section 3.43(b) reads as follows:

Admissibility. -Relevant, material and reliable evidence shall be admitted. Irrelevant, immaterial, unreliable, and unduly repetitious evidence shall be excluded. Immaterial or irrelevant parts of an admissible document shall be segregated and excluded so far as practicable.

However, the documents largely consist of minutes of official meetings and correspondence generated during the normal course of operations and prepared contemporaneously with the transactions described therein. Documents such as these are akin to business records which are routinely admitted into evidence under an exception to the hearsay rule.[56] Evidence of this nature is traditionally accorded a high degree of reliability arising [290] out of the fact that such documents are among the types of materials that reasonable persons will rely upon in their daily business affairs. The authenticity of these documents has not been challenged. Therefore, they are admissible under Rule 3.43(b) and provide further evidence of conspiracy.

While AMA does not literally control its constituent or component medical societies, it exerts tremendous influence over them and, thus, over individual physicians, especially in the area of ethics complaints and inquiries. It is inappropriate to look at the relationship of AMA to state and local societies in terms of actual control. Medical societies are not corporations; there is no veil to be pierced.

The establishment of a conspiracy rests upon a strong factual showing. As various examples of the interdependence among the AMA and its constitutent and component medical societies along with individual incidents demonstrating the effects of their concerted activities are revealed, the record evidence builds increasingly to the finding of a conspiracy among physicians and medical societies to restrain physician competition in the United States. While there is no magical number denoting the quantum of evidence that is necessary to lead to the conclusion of conspiracy, in certain instances the cumulative import of facts adduced at trial will allow no other conclusion. The present case represents such a situation.

V. ABANDONMENT OR DISCONTINUANCE

Respondent AMA contends that the basis for any decision in this case should be AMA's *current* position on advertising, solicitation and contract practice as reflected in the 1977 *Opinions and Reports* (RX 1), and that there is no need to inquire into the antitrust implications of earlier editions of the *Opinions and Reports* (AMA Conclusions of Law, pp. 72–76, 120–122; AMA Post-Trial Brief, pp. 29–36). AMA contends that the Commission should determine the lawfulness, not of obsolete statements of the AMA, but of the current position of the Association. A ruling based on outdated statements in the 1971 edition would amount to "a sterile exercise of the

[56] *See, e.g.*, Fed. Rules Evid. Rule 803(6), 28 U.S.C.

Commission's power, an exercise engaged in simply to have an order on record" (AMA Post-Trial Brief, p. 34).[57] [291]

It is undisputed that AMA's Judicial Council did publish a 1977 edition of *Opinions and Reports* which differs from the 1971 edition. Complaint counsel contends, however, that AMA has not specifically rescinded the 1971 edition and that many of the restrictions on physician advertising, solicitation and contract practice have not been abandoned (Complaint counsel Brief, pp. 49–51; Complaint counsel Reply Brief, pp. 36–38; CPF pp. 276–281).

The facts of this record reveal complete reliance upon the 1971 *Opinions and Reports* by AMA and its constituent and component societies for interpretations of what is or is not ethical conduct in the areas of advertising, solicitation and contract practice. The 1971 edition has many detailed examples which can be followed in determining the ethical propriety of a physician's conduct; the 1977 edition is of a more summary nature (*Compare* CX 462 *with* RX 1). Based on the 1971 edition, many constituent and component societies promulgated codes and guidelines for their members. The AMA House of Delegates adopted the 1971 *Opinions and Reports* and other promulgations concerning ethical matters which were based on the 1971 edition; *i.e., Report on Physician-Hospital Relations* (CX 959) and "Guidelines on Telephone Directory Listings" (CX 534C–D, 533K, 673B–I). None of these publications has ever been specifically rescinded by the AMA House of Delegates, and the 1977 edition of *Opinions and Reports* has never been adopted by the AMA House of Delegates.

The 1977 edition of *Opinions and Reports* expressly "reaffirms the long-standing policy of the Judicial Council on advertising and solicitation by physicians" (RX 1, p. 30). The 1977 edition also states that, "The [Principles of Medical Ethics] proscribe the solicitation of patients" (RX 1, p. 30). There are other examples of equivocation in the 1977 edition, especially the use of "catch words" of limitation or restriction which were also utilized in the 1971 edition (F. 153, p. 229).

There has never been any communication from AMA to its constituent and component societies to revise or update their own ethical codes or guidelines so as to conform with the 1977 edition of the *Opinions and Reports*. The record is devoid of evidence that constituent and component societies [292] have revised, systematically or otherwise, their ethical codes and guidelines. In fact, the

[57] On January 14, 1977, AMA filed a Motion for Certification to the Commission of AMA's Motion to Reconsider Issuance of the Complaint because of changed circumstances—the issuance of the 1977 *Opinions and Reports*. After certification of the motion, the Commission, on April 26, 1977, denied the motion.

record contains a number of incidents which strongly establish that constituent and component societies are continuing to enforce AMA's ethical interpretations as contained in the 1971 edition of the *Opinions and Reports.* Several witnesses testified that their advertising policy still conformed to the 1971 interpretations (*See* F. 152–53, pp. 226–31, for detailed findings on the issue of discontinuance).

The message that the new *Opinions and Reports* conveys to AMA's component and constituent societies and to individual member physicians is not one of clear and unambiguous abandonment of the prior ethical restrictions. At no time has the AMA House of Delegates or the Judicial Council ever publicly and explicitly declared to its affiliated societies and members that its earlier ethical pronouncements have, in fact, been officially rescinded or superseded by issuance of the 1977 *Opinions and Reports.* The deeply imbedded hostility to advertising, solicitation and contract practice by physicians — apparent in the testimony of respondent AMA's own surrebuttal witnesses and in the recent activities of some of AMA's constituent and component societies[58] — confirms that respondents have not made an unequivocal and effective discontinuance of the challenged practices and cannot show with reasonable certainty that the challenged practices will not recur. Further, AMA's purported discontinuance or abandonment, *i.e.,* the publication of the 1977 *Opinions and Reports,* occurred subsequent to the issuance of the complaint in this matter on December 19, 1975. In November 1975, the AMA Judicial Council formally sanctioned an updated edition of the 1971 *Opinions and Reports.* On April 9, 1976, the Judicial Council issued a revised statement on physician advertising and solicitation. The content and format of the new edition of the *Opinions and Reports* was approved by the Judicial Council on June 25, 1976. The revised statement by the Judicial Council was published in the 1977 *Opinions and Reports* in March 1977 (F. 152, pp. 226–27).

From the above sequence of events it is apparent that any definitive action on revising the 1971 *Opinions and Reports* was taken *after* the complaint herein had issued. Failure of AMA to take more positive steps to ensure that a complete and unequivocal discontinuance of the challenged practices was effected, with the Commission's complaint outstanding, leads to the conclusion that a discontinuance or abandonment was never intended. [293]

[58] See especially the inability of Florida physicians associated with an HMO to obtain low-cost malpractice insurance in 1977, through the Florida Medical Association because of the opposition of that Association and the Volusia County Medical Society to physicians associated in the contract practice of medicine. (F. 149, pp. 220–221).

VI. THE REMEDY

Having found a conspiracy to restrain competition, the effects of which have been to deprive consumers of the free flow of commercial information that is indispensable in making informed economic decisions, and to interfere with the freedom of physicians to make their own decisions as to their employment conditions, it is necessary to devise a remedy that will open the channels of communication and prevent obstruction to physicians and, *inter alia,* HMOs in their contractual arrangements. It is well established that "the Commission has wide discretion in its choice of a remedy deemed adequate to cope with unlawful practices" and that, so long as the remedy selected has a "reasonable relation to the unlawful practices found to exist," the courts will not interfere. *Jacob Seigel Co.* v. *Federal Trade Commission,* 327 U.S. 608, 611 (1946). *See also Federal Trade Commission* v. *Cement Institute,* 333 U.S. 683, 726 (1948); *Federal Trade Commission* v. *Colgate-Palmolive Co.,* 380 U.S. 374, 392 (1965); *L. G. Balfour Co.* v. *Federal Trade Commission,* 442 F.2d 1 (7th Cir. 1971)[59] Having established a violation, the Commission must "be allowed effectively to close all roads to the prohibited goal, so that the order may not be by-passed with impunity." *Federal Trade Commission* v. *Ruberoid Co.,* 343 U.S. 470, 473 (1952). *See also Federal Trade Commission* v. *National Lead Co.,* 352 U.S. 419 431 (1957). As the Supreme Court has explained, "[O]nce the Government has successfully borne the considerable burden of establishing a violation of law, all doubts as to the remedy are to be resolved in its favor." *United States* v. *E. I. duPont de Nemours & Co.,* 366 U.S. 316, 334 (1961).

Recent Supreme Court decisions have emphasized the need for the free flow of commercial information. Commercial speech serves to inform the public of the availability, nature, and prices of products and services, and thus performs an [294] indispensible role in the allocation of resources in a free enterprise system. In short, such speech serves individual and societal interests in assuring informed and reliable decisionmaking. *Bates* v. *State Bar of Arizona,* 433 U.S. 350, 364 (1977); *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.* 425 U.S. 748, 765 (1976).

In acknowledging the significance of commercial speech to the public, the Court has not hesitated to strike down barriers that inhibit the dissemination of commercial information. The Court has also made it abundantly clear that Congress did not intend to

[59] The Supreme Court, in a very recent antitrust decision, stated: "[T]he standard against which the order must be judged is whether the relief represents a reasonable method of elininating the consequences of the illegal conduct." *National Society of Professional Engineers* v. *United States,* 98 S. Ct. 1355, 1368 (1978).

exclude professional associations from antitrust regulation. *Professional Engineers,* 98 S. Ct. at 1362–68; *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773, 787 (1975). *Virginia State Board of Pharmacy* at 766–770.

Purported justifications for withholding commercial information from the public have not been persuasive. The Court's position, clearly articulated in recent decisions, is that people will perceive their own best interests if they are well enough informed. The best way to accomplish this is to open the channels of communication, not close them. Information cannot be foreclosed from the public on the purported bases that the products or services might be harmful, or that the advertising information might be incomplete or some of it deceptive, or that the public might misunderstand the information. The solution is not to keep the public in ignorance, but to insure that opportunities are available to provide the public with more information.

AMA argues that it is not opposed to the dissemination of truthful, objective information about physicians' services that will be helpful to consumers. AMA contends that its position on advertising and solicitation is reasonable in that it combats deception, enhances the physician-patient relationship, and guards against a lowering of the quality of medical care received by patients (AMA Reply Brief, p. 54–55, 66). Even assuming that AMA's intentions are altruistic, the record shows that its restrictions have had the effect of depriving consumers of the information necessary to make an informed choice of health care and insulating physicians from the give and take of the marketplace. New methods of health care have been discouraged, restricted and, in some instances, eliminated. That some of the effects of respondents' ethical restrictions may have been to prevent inferior services or insure ethical behavior is not a sufficient justification for permitting respondents [**295**] to impose continuing restraint on competition. There are other methods to accomplish respondents' purported objectives without the substantial restraints on competition which inherently flow from respondents' ethical restrictions.

In fashioning a remedy, it is observed that the Supreme Court has indicated that there is a role for a professional society to play in the regulation of the ethical standards of its members. *Bates,* 433 U.S. at 369 n. 20, 373 n. 28, 379, 384; *Professional Engineers* at 1367–69. The Order which will be entered in this proceeding will take into account this expression by the Court. Respondents will be permitted to participate in setting ethical guidelines for the conduct of their

members, after first obtaining the permission and approval of the Federal Trade Commission.

AMA has presented certain evidence that state boards of medical examiners and the Federal Trade Commission have neither the resources nor the inclination to regulate physician advertising (AMA Proposed Findings, pp. 440–448). The purpose of this evidence is to bolster the argument that governmental agencies are not adequate to protect the public from deceptive advertising and therefore medical society regulation is necessary to protect the public interest (AMA Conclusions of Law, p. 142; AMA Reply Brief, p. 64). The evidence presented by AMA is not persuasive.

The history of the Federal Trade Commission over the years is replete with proceedings concerning false and deceptive advertising and promotional practices involving drugs, cosmetics, devices and medical services, including such items as bust developers, hair preparations, bedwetting devices, arthritis cures and weight reducing and control devices and remedies.[60] The Wheeler-Lee amendment to the Federal Trade Commission Act,[61] passed in 1938, was enacted to broaden the powers of the Commission so as to provide more effective control over false advertisements of foods, drugs, devices and cosmetics.[62] For the first time, the Commission was given authority to enjoin false and deceptive advertising. Recent actions by the Commission in [**296**] this area of regulation include proceedings entitled *Simeon Management Corporation,* Docket 8996 [87 F.T.C. 1184] (weight reduction clinics), *Travel King Inc., et al.* Docket 8949 [86 F.T.C. 715] (physic surgeons), *Porter & Dietsch, Inc.,* Docket 9047 [90 F.T.C. 770] (weight control products), *American Home Products Corp.,* Docket 8918 [Initial Decision, Administrative Law Judge Hyun, dated September 1, 1978] (headache or pain remedies), and *Karr Preventative Medical Products Inc.,* Docket 9109 [94 F.T.C. 1080] [Complaint issued April 26, 1978] (acne remedy). The penalties provided for in the Federal Trade Commission Act may well be a substantial deterrent to false and deceptive advertising by physicians. As noted by the Commission in the recently issued trade regulation rule on the advertising of ophthalmic goods and services, all of the 50 states have laws prohibiting false and deceptive advertising. *Advertising of Ophthalmic Goods and Services,* 43 Fed. Reg. 23992, 23997 n. 89 (FTC June 2, 1978). Thus, it cannot be concluded in this proceeding or, indeed, in any proceeding that governmental regulation of false and deceptive advertising, although

[60] *See* CCH Trade Reg. Rep. ¶¶ 7739, 7741, 7743, 7745, 7747, 7749, 7751, 7780–85.

[61] 52 Stat. 114, 15 U.S.C. 52, *et seq.*

[62] H.R. Rep. 1613, 75th Cong., 1st Sess.

at times perhaps imperfect, must give way to private regulation to protect the public.

Respondent AMA argues that if any order is entered in this proceeding on the advertising aspect of this case, "it should be limited to prohibiting regulation of advertising when respondents have no reason to believe that such advertising is untruthful, deceptive, or otherwise lacking in information which would help consumers make an informed choice of physician" (AMA Conclusions of Law, pp. 8, 146–147). If an order is entered on contract practice issues, AMA contends that it should be limited to "remedying any specific violations that have been established" (AMA Conclusions of Law, p. 150). Respondents CSMS and NHCMA suggest that such respondents could be ordered not to restrict their members from publishing in the print media truthful, objective and verifiable information relating to physicians and their practices, or relating to routine services and procedures performed by the physicians (CSMS Conclusions of Law, pp. 36–37).

Respondents have contended throughout this proceeding that the only restrictions they have imposed on their members were intended to prevent deception of the public and to protect the quality of medical care, and that they have not opposed the dissemination of truthful information which will assist consumers in making an informed choice of a physician. The record evidence is otherwise, however, it establishes with clear conviction that respondents have prevented the dissemination of truthful, objective information that could provide substantial benefits to the public. These restrictions have been carried out over a long period [297] of time as a common understanding between AMA, CSMS and NHCMA and over 2,000 other medical societies throughout this country and their members. These restrictions must be completely eliminated and physicians must be given the unfettered opportunity to present to the public information which the public needs and is entitled to receive, subject only to governmental, not medical society, restrictions.

Since the unlawful restrictions have been effectuated through a conspiracy involving the constituent and component societies of AMA, it is necessary that any order entered in this proceeding eliminate the restrictions at all levels of the medical society federation. AMA strenuously objects to any provision in an order requiring it to instruct state and local societies to take or desist from taking action (AMA Conclusions of Law p. 9). AMA contends that subjecting independent and autonomous organizations to an order in a proceeding to which they were not parties "violates due process" (AMA Reply Brief, p. 64).

The restrictions with which this proceeding is concerned, and which the record shows to be unlawful, have involved constituent and component medical societies at the very heart of the ethics enforcement process. Local medical societies have been the initial enforcers of the ethical restrictions—this is the very core of the agreement or understanding. Leaving such societies free to carry on with the ethical restrictions would convert this proceeding into an empty exercise in futility. The order must provide an effective remedy that cannot be "by-passed with impunity." *Federal Trade Commission* v. *Ruberoid,* 343 U.S. at 473.

There is precedent for an order that will require state and local societies to abide by the Order entered herein if they desire to remain within the AMA federation of organizations. The order entered by the United States District Court in *Professional Engineers* required the national society to revoke the charter of, and to refuse affiliation to, any state society which engaged in conduct found to have been unlawfully engaged in by the national society in combination and conspiracy with its members and state societies (Complaint Counsel Reply Brief, Appendix pp. 1–8). This order provision was not overturned on appeal. *Professional Engineers,* 98 S. Ct. at 1368–69 (1978). [298]

In a recent proceeding, the Commission ordered respondents to cease and desist from dealing with parties who respondents knew were engaged in practices which the Commission found to be unlawful. *National Housewares, Inc.,* 90 F.T.C. 512, 596, 603 (1977). Furthermore, orders issued in antitrust proceedings in the courts and Commission orders entered in adjudicative proceedings often affect the rights of third-parties who were not parties to the proceedings. These orders have been upheld in the courts on review and found not to violate due process of any party. *See United States* v. *International Boxing Club of New York, Inc.,* 171 F. Supp. 841, 842 (S.D.N.Y. 1957), *aff'd.* 358 U.S. 242, 247 (1959); *L. G. Balfour Co.* v. *Federal Trade Commission,* 442 F.2d 1, 23 (1971).

Accordingly, the Order found to be necessary to remedy the unlawful conduct disclosed by the record and entered herein will require respondents to cease and desist from the practices found to be unlawful, to revoke and rescind any existing ethical principles or guidelines which restrict physicians' advertising, solicitation or contractual relations, to provide adequate notification to its members and affiliated societies of the terms of the Order and to deny affiliation to any society that engages in any practices which violate the terms of the Order. The Order will permit respondents to issue ethical guidelines affecting advertising and solicitation relations by

physicians in the future with permission of and approval by the Federal Trade Commission, which has the organizational flexibility and know how to work with respondents and assure that such guidelines as are approved are in the public interest.

CONCLUSIONS OF LAW

1. The Federal Trade Commission has jurisdiction over respondents and over the subject matter of this proceeding.

2. Each of the respondents is a "corporation" within the meaning of Section 4 of the Federal Trade Commission Act and is subject to the jurisdiction of the Federal Trade Commission.

3. The challenged acts, practices and methods of competition of respondents are in, and affect, commerce within the meaning of the Federal Trade Commission Act. [299]

4. Respondents American Medical Association, Connecticut State Medical Society, New Haven County Medical Association, Inc., constituent and component medical societies of the American Medical Association, component societies of Connecticut State Medical Society and members of respondents and such constituent and component medical societies have conspired, combined and agreed to adopt, disseminate and enforce ethical standards which ban physician solicitation of business, severely restrict physician advertising and prohibit certain contractual arrangements between physicians and health care delivery organizations and between physicians and nonphysicians.

5. The above conduct has hindered, restricted, restrained, foreclosed and frustrated competition in the provision of physicians' services throughout the United States and caused substantial injury to the public.

6. The aforesaid acts, practices and methods of competition engaged in by respondents American Medical Association, Connecticut State Medical Society and New Haven County Medical Association, Inc. in concert of action with each other, with constituent and component medical societies of the American Medical Association and Connecticut State Medical Society and with the members of respondents and such other constituent and component medical societies constitute unfair methods of competition and unfair acts or practices in or affecting interstate commerce and are in violation of Section 5 of the Federal Trade Commission Act.

7. The Order entered in this proceeding is necessary to remedy the violations of law which have existed and to protect the public now and in the future. [300]

ORDER

I.

It is ordered, That respondents American Medical Association, Connecticut State Medical Society and New Haven County Medical Association, Inc., and their delegates, trustees, councils, committees, officers, representatives, agents, employees, successors and assigns, directly or indirectly, or through any corporate or other device, in or in connection with the purchase, sale, distribution or delivery of physicians' services in or affecting commerce, as "commerce" is defined in the Federal Trade Commission Act, do forthwith cease and desist from:

A. Restricting, regulating, impeding, declaring unethical, interfering with, or advising against the advertising or publishing by any person of the prices, terms or conditions of sale of physicians' services, or of information about physicians' services, facilities or equipment which are offered for sale or made available by physicians or by any organization with which physicians are affiliated;

B. Restricting, regulating, impeding, declaring unethical, interfering with, or advising against the solicitation through [301] advertising or by any other means, of patients, patronage, or contracts to supply physicians' services, by any physician or by any organization with which physicians are affiliated;

C. Restricting, regulating, impeding, advising on the ethical propriety of, or interfering with the commercial terms or conditions on which any physician contracts or seeks to contract for the sale, purchase or distribution of his or her professional services;

D. Restricting, interfering with, or impeding the growth, development or operations of any prepaid health care delivery plan or of any other organization which offers physicians' services to the public, by means of any statement or other representation concerning the ethical propriety of their operations, activities, or relationships with physicians; and

E. Inducing, urging, encouraging, or assisting any physician, or any medical association, group of physicians, hospital, [302] insurance carrier or any other nongovernmental organization to take any of the actions prohibited by Paragraphs A through D above. *Provided, however,* that nothing in this Order shall be construed to prohibit respondents, their constituent or component organizations or their members from reporting in good faith to governmental authorities any alleged violation of law, including but not limited to:

(1) Reporting to appropriate governmental authorities any advertising, solicitation or representation by a physician which they have a reasonable basis for believing is false or deceptive, along with the basis for such belief;

(2) Reporting to appropriate governmental authorities any case of uninvited, in-person solicitation of actual or potential patients who because of their special circumstances are vulnerable to harassment or duress. *Provided, further,* that after this Order has become final for two years, nothing herein shall prohibit respondents from formulating, adopting and [303] disseminating to their constituent and component medical organizations and to their members ethical guidelines governing the conduct of their members in respect to advertising and solicitation activities, if respondents first obtain permission from and approval of the guidelines by the Federal Trade Commission.

II.

It is further ordered, That respondents:

A. Serve a copy of this Order by mail upon each of their present members and upon each constituent and component organization of respondents, within sixty (60) days after this Order becomes final.

B. Provide each new member of each respondent and each constituent and component organization of respondents with a copy of this Order at the time the member is accepted into membership.

C. Remove from respondent American Medical Association's Principles of Medical Ethics and the *Judicial Council Opinions and Reports,* and from the constitution and bylaws and any other existing policy statement or [304] guideline of respondents, any provision, interpretation or policy statement which is inconsistent with the provisions of Part I of this Order.

D. Require as a condition of affiliation with any respondent that any constituent or component organization agree by action taken by the constituent or component organization's governing body to be bound by the provisions of Part I of this Order.

E. Terminate their affiliation with any constituent or component organization which, after the effective date of the Order, to respondents' knowledge engages in any act or practice prohibited by Part I of this Order.

III.

It is further ordered, That, within sixty (60) days after this Order becomes final: