Proposed grant of exclusive right to offer radiology services at a hospital would not violate the FTC Act. [*833 0003, Burnham Hospital*]

February 24, 1983

Dear Mr. Nord:

This is in response to your request for an advisory opinion concerning a contract by which Burnham Hospital has granted to a physician group the exclusive right to provide radiology services to patients in the hospital. You have asked whether any law enforced by the Commission would be violated if Burnham, acting pursuant to the contract, determines that a physician not affiliated with that group should not be given access to its radiology facilities or authorization to provide radiology services to Burnham's patients.

Based on the information you have supplied, it is the Commission's understanding that Burnham Hospital is a nonprofit general acute care hospital located in Champaign, Illinois. Among the services Burnham offers to the public are diagnostic radiology services. The hospital owns radiology laboratory facilities and employs approximately 20 radiology technicians. Throughout its history, Burnham has provided radiology services either through a radiologist employed by the hospital or a radiology group under exclusive contract with it.

You have explained that in 1980 the hospital, after receiving and considering proposals from other radiology groups, entered into a contract with a group of radiologists practicing under the name Prairie Professionals ("Prairie") that gives Prairie the exclusive right to operate the hospital's radiology laboratory and to render radiology services to patients at the hospital. Prairie is responsible for providing radiology services as needed; supervising and discharging the radiology technicians who are employed by the hospital; consulting with the hospital on the selection and replacement of equipment; and participating in educational and scientific activities at the hospital, including the training of radiology technicians. In addition, Prairie is to designate a radiologist to function as department chief, who will be responsible for operating the department and helping the hospital to control the department's budget. The contract has a term of three years; thereafter it is renewable for one-year periods and may be terminated by either party on 180-days notice. The hospital bills patients for the use of its radiology facilities. Prairie bills the patient separately for its professional services on a fee-for-service basis.

Prairie physicians are members of Christie Clinic ("Christie"), a large multispecialty physician group. Pursuant to a separate contract with Burnham, Christie purchased a full-body computed tomographic

("CT") scanner which it installed on hospital premises. Under the contract, Christie designates the physicians who may use the scanner.

You state that a physician has requested to practice radiology independently at Burnham notwithstanding the exclusive agreement with Prairie. Burnham would like to deny this physician access to its radiology facilities in order to adhere to, and retain the benefits of, the contract with Prairie.

According to your letter, Burnham believes that the contract is in the hospital's economic interest and that it improves the quality of services provided at the hospital. Specifically, the hospital believes that the contract creates cost efficiencies in procuring radiological services for its patients, operating and maintaining its equipment, and supervising its radiology technicians.

In addition to Burnham Hospital, there are three other general acute care hospitals in the Champaign-Urbana area from which Burnham draws patients. Burnham has 214 beds, Mercy Hospital has 255 beds, Carle Foundation Hospital has 281 beds, and Cole Hospital has 65 beds.[1] Thus, Burnham has about 26 percent of the beds in what Burnham describes as the relevant area. Carle is associated with a clinic, and only members of the clinic are permitted to have privileges at that hospital. Mercy and Cole each has an exclusive contract with a different group of radiologists; Carle has a closed staff in all its departments. The radiology contracts at both Cole and Burnham have changed hands in recent years.

Your letter states that Burnham offers no facilities or services not available in at least one of the other area hospitals. Both Carle and Burnham have full-body CT scans, the one at Burnham being owned by Christie Clinic rather than by the hospital. Both Carle and Mercy offer therapeutic radiological services that are not available at Burnham.

You also state that some Champaign-Urbana radiologists provide services to hospitals in surrounding communities. Radiology services are also available outside the hospital from independent radiology laboratories. Burnham accepts radiological studies from other hospitals or from independent laboratories at the discretion of the attending physician.

Antitrust analysis of hospital exclusive contracts can be complicated because the contracts create relationships among hospitals, physicians, and patients that have no clear parallels in commercial practice and that are difficult to characterize. The contract occurs at one level—between the hospital and the physician—while the direct financial transaction occurs at a different level—between the physi-

[1] There are three other hospitals in the Champaign-Urbana area that do not seem to be in substantial competition with the four mentioned above. McKinley Memorial Hospital has 31 beds and is affiliated with the University of Illinois. Herman Adler Mental Health Center is a state-run long-term care facility for children with 46 beds. The hospital at Chanute Air Force Base has 55 beds, but apparently is not open to the general public.

cian and the patient, with payment usually made by an insurer. Some court decisions suggest that in analyzing exclusive contracts the patient should be considered the buyer and the hospital and the physician group the sellers of the service in question.[2] Another court has suggested that the hospital rather than the patient should be considered the buyer of the service, and the physician group the seller, in cases where the patient generally does not make a personal decision to obtain the service and does not personally select the provider.[3] The Commission is of the opinion that each approach may be helpful in some circumstances, because exclusive contracts may affect both competition among physicians and hospitals for patients and competition among physicians to market their services to hospitals. Accordingly, antitrust analysis should be flexible enough realistically to take into account the impact of these contracts on hospitals, physicians, and patients.

An exclusive contract for radiology services can have both procompetitive and anticompetitive aspects. The contract grants exclusivity within the hospital to a particular radiologist or group of radiologists and thereby limits the ability of the patient and the attending physician to choose among competing radiologists. It may also, if radiologists contract in groups, make it more difficult for individual physicians to enter the market since a physician may have to join an existing group or form a new group in order to practice in the area.

A contract of reasonable duration does not, however, eliminate competition among radiologists or prevent entry. Instead, it shifts the focus of competition among both established and entering radiologists to the securing of the contract. The exclusive contract may also have procompetitive effects by providing a number of benefits to hospitals and to their patients. There is reason to believe that in some circumstances at least, the use of exclusive contracts in certain hospital departments can facilitate efficient delivery of services in a number of ways. It can increase the hospital's control over operation of the department, ensure full-time availability of services, lower costs through standardization of procedures and centralized administration of the department, permit better scheduling of the use of facilities, facilitate maintenance of equipment, improve supervision of support staff and working relationships between the staff and physicians, and improve the quality of services by assuring that physicians perform enough procedures to maintain their proficiency, have an incentive to upgrade their skills, and are effectively subject to hospital standards of quality.[4] To the extent that these objectives are real-

[2] *Robinson v. Magovern*, 521 F.Supp. 842, 885 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 842 (3d Cir. 1982), *cert. denied*, 51 U.S.L.W. 3340 (U.S. Nov. 1, 1982) (No. 82–415); *Hyde v. Jefferson Parish Hosp. Dist. No. 2*, 513 F.Supp. 532 (E.D. La. 1981), *rev'd on other grounds*, 686 F.2d 286 (5th Cir. 1982), *petition for cert. filed*, No. 82–1031 (Dec. 17, 1982).

[3] *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346 (7th Cir. 1982).

[4] *See, e.g.*, Foster, *Exclusive Arrangements Between Hospitals and Physicians: Antitrust's Next Frontier in Health?*, 26 St. Louis U.L.J. 535, 540–41 (1982); M. Thompson, *Antitrust and the Health Care Provider* 151–52, 154

ized, a hospital is better able to compete with other hospitals.

Hospitals must assure that radiology services are available as needed and of acceptable quality if they are to attract attending physicians and their patients. When the decision to use an exclusive contract to staff a hospital-based department is made unilaterally by a hospital in order to promote efficient operation of the department, when the hospital lacks significant power in the relevant market, and when the contract is of reasonable duration or terminable by the hospital on reasonable notice, the contract would not generally be likely to have a substantial anticompetitive effect in any market.[5]

Several courts considering antitrust challenges to exclusive contracts for hospital services have treated the agreements as vertical restraints subject to rule of reason analysis.[6] In balancing the procompetitive and anticompetitive effects of the contracts in the hospital and physician services markets, the courts have considered such factors as the characteristics of the market, particularly the market power of the hospital in question; the purpose of the contract; its duration; the manner in which the decision was made to use an exclusive arrangement; and the procompetitive benefits of the contract. These courts have not found that the exclusive contracts considered had significantly anticompetitive effects, and they have found that the contracts resulted in significant competitive benefits to the hospitals.

One recent decision, however, held that an exclusive contract for anesthesia services constituted a per se illegal tying arrangement. *Hyde v. Jefferson Parish Hospital District No. 2,* 686 F.2d 286 (5th Cir. 1982), *petition for cert. filed,* No. 82–1031 (Dec. 17, 1982). The court in that case construed the contract as tying the sale of the hospital's chosen anesthesia service to the use of its operating rooms, found that the hospital had appreciable economic power in the township in which it was located, and concluded that the contract restrained, and indeed eliminated, competition among anesthesiologists in the hospital.

The Commission is of the opinion that the per se rule of illegality for tie-ins is not applicable to Burnham's contract with Prairie Profes-

[5] A different case would be presented if the hospital joined a conspiracy among members of the medical staff to restrain competition among hospital-based physicians. *See Robinson v. Magovern,* 521 F.Supp. 842, 906 (W.D. Pa. 1981), *aff'd mem.,* 688 F.2d 824 (3d Cir. 1982), *cert. denied,* 51 U.S.L.W. 3340 (U.S. Nov. 1, 1982) (No. 82–415); *State of Maryland v. The Medical Staff of Harford Memorial Hospital,* Circuit Court for Harford County, Equity No. 27734 (Oct. 29, 1981) (assurance of discontinuance obtained from hospital staff that allegedly threatened to refuse to deal with any but a specified group of radiologists in an attempt to coerce the hospital into contracting with the group on terms demanded by it). In addition, different questions would be raised under the antitrust laws if a large proportion of the specialists in a market formed a group and negotiated jointly with a number of hospitals in the area.

[6] *Hyde v. Jefferson Parish Hosp. Dist. No. 2,* 513 F.Supp. 532 (E.D. La. 1981), *rev'd,* 686 F.2d 286 (5th Cir. 1982), *petition for cert. filed,* No. 82–1031 (Dec. 17, 1982); *Smith v. Northern Michigan Hospitals, Inc.,* 518 F.Supp. 644 (W.D. Mich. 1981), No. 81–1513 (6th Cir. argued Oct. 21, 1982). *See also Dos Santos v. Columbus-Cuneo-Cabrini Medical Center,* 684 F.2d 1346 (7th Cir. 1982); *Robinson v. Magovern,* 521 F.Supp. 842 (W.D. Pa. 1981), *aff'd mem.* 688 F.2d 824 (3rd Cir. 1982), *cert. denied,* 51 U.S.L.W. 3340 (U.S. Nov. 1, 1982) (No. 82–415).

sionals. Although radiology services are physically separable from other services and facilities supplied by Burnham, mere separability is not a sufficient basis for characterizing an arrangement as a tie-in. Instead, the function of the aggregation must be examined to see if the restraint represents the forced purchase of a second distinct commodity to leverage power from one market to another in order to avoid competition on the merits.[7] The purposes and effects of the contract in question are very different from such a classic tie. Rather than avoiding competition on the merits, Burnham is attempting to compete with other hospitals by obtaining efficiencies and a desired level of quality and service in its radiology department, according to the submission. Using a form of vertical integration to combine functionally related services, the hospital is apparently seeking to improve the array of health care services that it offers to the public. Moreover, the case law indicates that no tie-in should be found to exist where, as here, the hospital derives no direct or exploitative financial benefit from requiring that all diagnostic radiology services in the hospital be provided by a particular group of physicians.[8] In short, the contract is not the type of pernicious, naked restraint of trade to which the per se rule of illegality applies.

The Commission believes that Burnham's contract is most closely analogous to a requirements contract, a type of exclusive dealing arrangement, that should be judged under the rule of reason in a fashion similar to that for more traditional vertical restraints.[9] The Commission's analysis of the contract focuses on whether its effects on competition among radiologists and among hospitals are on balance harmful or beneficial. Factors relevant to the analysis include the proportions of the hospital and physician services markets involved in the contract, the purposes of the contract, its duration, the extent to which it deters entry, the benefits the hospital and the public derive from it, and the extent of competition for the contract.[10]

Based on the information available to the Commission, it does not appear on balance that Burnham's adherence to its contract with Prairie Professionals would violate the Federal Trade Commission Act or any other law enforced by the Commission. You report that the contract was intended to, and does, facilitate efficient operation of the radiology department. The Commission understands that the decision

[7] *See Times-Picayune Publishing Co. v. United States,* 345 U.S. 594, 614 (1953); *Hirsh v. Martindale-Hubbell, Inc.,* 674 F.2d 1343 (9th Cir. 1982), *cert. denied,* 51 U.S.L.W. 3340 (U.S. Nov. 1, 1982) (No. 82-570); *Krehl v. Baskin-Robbins Ice Cream Co.,* 664 F.2d 1348 (9th Cir. 1982); *Principe v. McDonald's Corp.,* 631 F.2d 303 (4th Cir. 1980), *cert. denied,* 451 U.S. 970 (1981).

[8] *See, e.g., Boddicker v. Arizona State Dental Ass'n,* 680 F.2d 66 (1982), 1982-2 Trade Cas. (CCH) ¶ 64,812 (9th Cir. March 24, 1982); *Keener v. Sizzler Family Steak Houses,* 597 F.2d 453 (5th Cir. 1979); *Kentucky Fried Chicken Corp. v. Diversified Packaging Corp.,* 549 F.2d 368 (5th Cir. 1977); *Rodrigue v. Chrysler Motor Corp.,* 421 F.Supp. 903 (E.D. La. 1976); *Crawford Transport Co., Inc. v. Chrysler Corp.,* 338 F.2d 934 (6th Cir. 1964); *Rumple v. Bloomington Hospital,* 422 N.E. 2d 1309 (Ind. App. 1981).

[9] *See Tampa Electric Co. v. Nashville Coal Co.,* 365 U.S. 320 (1961); *Twin City Sportservice Inc. v. Charles O. Finley & Co.,* 676 F.2d 1291 (9th Cir. 1982), *cert. denied,* 51 U.S.L.W. 3354 (Nov. 8, 1982).

[10] *See Beltone Electronics Corp.,* FTC Docket 8928, slip op. at 34 [100 F.T.C. 68 at 204] (July 6, 1982).

to enter into the contract, and thus to deny radiology privileges to other physicians, was made unilaterally in the interest of the hospital, and was neither coerced by members of the medical staff nor taken in furtherance of a combination between the hospital and the medical staff or any of its members to restrain competition among physicians. Burnham competes with at least three other hospitals, and does not occupy a dominant position in the market. It is not a unique facility. The contract has an initial term of three years with one-year extensions thereafter, and is terminable on 180-days notice by either party. Thus, opportunities for competition among radiology groups to secure the contract are preserved, and there is evidence that some competition for contracts does occur. In addition, radiology can be practiced to at least some extent on an outpatient basis, and Champaign-Urbana radiologists apparently have some access to hospitals in the surrounding area. In addition, there is no reason to believe that effectuation of the contract would result in higher prices for radiology services. Based on these factors, it appears that the contract does not unreasonably restrict competition among radiologists and that it may facilitate competition among hospitals.

Based on its understanding of the facts surrounding the decision to enter into the exclusive contract and the planned denial to other applicants of the right to practice radiology in the hospital, pursuant to that contract, as those facts are outlined above and further detailed in your submission, it is the Commission's opinion that Burnham Hospital's adherence to its grant to Prairie Professionals of the exclusive right to offer radiology services at the hospital would not violate the Federal Trade Commission Act or any other statute enforced by the Commission.[11]

This advisory opinion, like all those issued by the Commission, is limited to the proposed conduct described in the petition being considered. Because by necessity it is based on factual representations by the hospital, it does not constitute approval of action taken by the hospital on any specific application for privileges that may become the subject of litigation before the Commission or any court, when those facts may be controverted. The conclusions stated in this letter are based on the Commission's understanding of present market conditions in the Champaign-Urbana area and in the health care field generally. The Commission retains the right to reconsider the questions involved or to rescind or revoke its opinion if the public interest so requires in accordance with Section 1.3(b) of the Rules of Practice.

By direction of the Commission.

[11] By responding to Burnham's request for an advisory opinion concerning the described facts, the Commission takes no position on the presence or absence of any or all of the jurisdictional prerequisites to a law enforcement proceeding under Section 5 of the FTC Act, 15 U.S.C. 45.

Letter of Request

November 17, 1982

Dear Mr. Thomas:

I am writing on behalf of Burnham Hospital, located in Champaign, Illinois, for an advisory opinion. The Hospital desires to limit the physicians entitled to use its radiological laboratory equipment and render radiological services to inpatients to that physician group with which the Hospital has exclusively contracted to provide these services.

Burnham Hospital is a public, not for profit, general acute care hospital. Among other services that it offers the public, the Hospital provides diagnostic radiology services. It owns its own radiology laboratory facilities and equipment, and employs approximately 20 radiology technicians. Throughout its history, the Hospital has provided radiology services to the public through either a radiologist employed by the Hospital, or a single radiology group under exclusive contract to the Hospital.

On April 9, 1980, the Hospital entered into a contract with a group of radiologists, practicing under the name of Prairie Professionals, that gives that group the exclusive right to operate the Hospital's radiology laboratory, and to render radiological services to patients at the Hospital's facilities. The contractual responsibilities of Prairie Professionals include providing radiology services as needed; supervising and discharging radiology technicians who are employed by the Hospital; consulting with the Hospital on the selection and replacement of equipment; and participating in education and scientific activities at the Hospital, including the training of radiology technicians. In addition, Prairie Professionals designates the radiologist who serves as chairman of the department of radiology, who is responsible for operating the department of radiology and helping the Hospital to control that department's budget. The Hospital bills patients for use of its radiology facilities, while Prairie Professionals submits its own bill to the patient for professional services rendered, on a fee-for-service basis. The contract has a term of three years and may be renewed thereafter for one year periods. It may be terminated at any time by either party upon 180 days notice. A copy of the Agreement between Burnham Hospital and this physician group is attached.*

Physicians in Prairie Professionals are members of Christie Clinic, a large multi-specialty physician group located in Champaign, Il-

* Not reproduced herein. Copies of all Attachments are available for inspection in Room 130, Public Reference Branch, Federal Trade Commission, 6th St. and Pa. Ave., N.W., Washington, D.C. 20580.

linois. Non-radiologists practicing as members of Christie Clinic also hold privileges at Burnham Hospital. By a separate contract, which preceded and is unrelated to the exclusive contract that is pertinent to this request, Christie Clinic has installed a full body CT scanner the Clinic owns at Burnham Hospital. Pursuant to that separate agreement, Christie Clinic receives a percentage of revenues attributable to use of the CT scanner, and limits the physicians who may use the CT scanner to certain specified radiologists and neurologists.

The Hospital believes that the exclusive contract with Prairie Professionals is in the Hospital's economic interest, and that it improves the quality of services provided at the Hospital. Specifically, the contract creates cost efficiencies in procuring radiological services for its patients, operating and maintaining its equipment, and supervising its radiology technicians.

A former employee of Prairie Professionals has requested that the Hospital permit him to use the Hospital's equipment and render radiological services to in-patients, notwithstanding the Hospital's exclusive agreement with the physician group. The physician withdrew from practice and resigned from Prairie Professionals due to disability. He retains privileges at Burnham Hospital and recently sought permission from the Hospital to reactivate his practice. The Hospital would like to adhere to its exclusive contract with the physician group and deny this physician access to its radiological facilities for that reason.

In addition to Burnham Hospital, three other general, acute care hospitals serve the same area (Champaign-Urbana, Illinois) from which Burnham Hospital draws its patients. Burnham Hospital has 214 beds, Mercy Hospital has 255 beds, Carle Foundation Hospital has 281 beds and Cole Hospital has 65 beds. In addition to these hospitals, two other hospitals in the area appear to serve a more restrict patient group (McKinley Memorial Hospital has 31 beds and is affiliated with the University of Illinois; Chanute Air Force Hospital, at the Air Force base of that name, has 55 beds). Without considering these hospitals that serve specific patient populations, Burnham Hospital has about 26 percent of the hospital beds in the relevant geographic area.

Burnham offers no facilities or services not available at one or more of the other area hospitals. Both Carle Foundation Hospital and Burnham Hospital have full body CT scanners (the one at Burnham being owned by Christie Clinic, rather than the Hospital). Both Carle Foundation Hospital and Mercy Hospital offer therapeutic radiological services that are not available at Burnham Hospital. Mercy Hospital and Cole Hospital are believed to have exclusive contracts for radiology services, each with a different group of radiologists. Carle Foundation Hospital is associated with the Carle Clinic, and only physicians

who are members of that clinic are granted privileges at that hospital; it therefore has a closed staff in all of its departments.

Within the past four years, Burnham Hospital has twice entered into an exclusive contract with different groups of radiologists. On both occasions, the Hospital received and considered competing proposals from several groups of radiologists before making its decision. In addition, it is believed that Cole Hospital has also changed the radiology group that provides its radiology services.

In addition to opportunities with radiology groups serving specific hospitals, radiologists in the Champaign-Urbana area also engage in independent, private practice through their own laboratories. Burnham Hospital accepts pre-admission radiological studies of patients by other hospitals or by independent radiology laboratories without any need for duplication of x-rays, except where the quality of the specific study is deemed to be unacceptable by the treating physician. Some radiologists in the Champaign-Urbana area also provide radiological services to hospitals up to 35 miles away, while a radiologist group from a nearby town serves one of the Champaign hospitals.

By consent decree, the Commission is understood to have created an opportunity for certain hospital-based physicians to practice as full time employees of the hospital, *In the Matter of The American Society of Anesthesiologists,* 93 F.T.C. 101 (1979). By permitting full time employment of hospital-based physicians, the Commission has correctly viewed the vertical integration of such hospital-physician services as pro-competitive. Where such integration of services is determined by a hospital to be in its competitive interest, by reducing a variety of its costs and increasing the quality of the service it provides to patients, the form of such vertical integration—by direct employment or by exclusive contract—is irrelevant to the effect of the particular hospital-physician arrangement upon competition in the provision of the service.

Burnham Hospital can compete in providing health care services only through the services rendered on its premises. The teaching of *Continental TV, Inc. v. GTE Sylvania, Inc.,* 433 U.S. 36 (1977), concerning a supplier's interest in fostering interbrand competition by diminishing the effects of intrabrand competition, should be directly applicable. No manufacturer is obligated by law to accept all prospective distributors nor to retain all distributors it has ever used. Similarly, no hospital should be required to permit any particular physician to practice at the hospital if it determines that to do so would make the hospital a less effective competitor. The hospital's competitive self-interest entitles it to determine both how it will organize itself and who it will employ (as employee or as independent contractor) to render hospital-based services to its patients.

Any theoretical benefit achieved by making every hospital a "physi-

cian's utility", as would exist if each hospital were required to organize and operate as a business forum for every qualified physician, is outweighted by increased costs of operation and the loss of substantial control over the quality of one's own "product", i.e., health care services. In such a system, the patient consumer would be the loser. Hospital services would cost more because of increased administrative costs to coordinate and manage the hospital's medical staff. And the patient's information costs would greatly increase because he or she could no longer rely on the hospital's choice of its staff as an indicator of quality.

The purpose of this request for an advisory opinion is to determine whether, by denying the request of this individual physician which Burnham Hospital believes to be in its economic self interest, the Hospital will thereby expose itself to possible prosecution by the Commission for violation of any law the Commission is charged to enforce. Moreover, with the burgeoning of suits filed against hospitals by physicians arising out of a denial or withdrawal of medical staff membership or hospital clinical privileges, Burnham Hospital believes that this question is a matter of significant public interest and involves a substantial question of law as to which there is no clear Commission or court precedent.

We request the opportunity to supplement the information as set forth in this letter insofar as Burnham Hospital, or the Commission, may determine that additional facts or analysis is appropriate.

Very truly yours,

/s/ *Robert E. Nord*

Disclosure of individual well information to persons not involved in the production or sale of natural gas who required the data solely for research or study purposes, provided they agree not to disclose individual well data, would be permissible, as well as proposed data collection and use program, subject to certain qualifications. [*Resource Analysis & Management Group, 833 0001*]

April 18, 1983

Dear Mr. Legg:

This responds to your request for an advisory opinion concerning the collection by the Resource Analysis & Management Group (the RAM Group) of certain information from high-cost natural gas producers for use in consulting services.

The Commission has been advised that the RAM Group is a consulting operation with no owner or principal engaged in the exploration for or production of natural gas. The Commission understands that the RAM Group proposes to collect price and contract term information for existing supply contracts from producers of high-cost natural gas as defined by Section 107 of the Natural Gas Policy Act of 1978, and to use such information principally in price recalculations under redetermination clauses in supply contracts between producers and purchasers.

The Commission further understands that the RAM Group will provide, on a non-discriminatory basis, redetermination counseling services, which use the data collected under this proposed program, to any natural gas producer or purchaser which requests, and which possesses the ability and willingness to pay for, such services. Individual well information will be revealed only to the producer and purchaser involved in a specific price recalculation and only as specifically required by the redetermination clause in an existing supply contract for a Section 107 well. Individual well information will not be disclosed to any other party or client of the RAM Group.

As you are aware, price information exchanges among competitors in particular marketing environments could raise serious antitrust concerns. In view of the Supreme Court's opinion in *United States* v. *Container Corp.*, 393 U.S. 333 (1969), the legality of the RAM Group's proposal to provide natural gas producers and purchasers with current competitive price and other data for redetermination purposes depends upon a factual assessment of the structure and other economic characteristics of the markets involved, the nature and purpose of the plan to obtain and provide such data by the RAM Group, and the probable effect of the collection and dissemination of such data on

natural gas prices and the interdependency of natural gas producers in such markets.

On the basis of available information indicating low concentration of natural gas production on a national basis, the availability of price information to larger producers and purchasers, and the need for reliable price adjustment mechanisms in natural gas supply contracts, the Commission does not presently see any competition problems posed by the RAM Group's proposed program of providing Section 107 well price and other data to natural gas producers and purchasers in accordance with the limitations noted above. The Commission cautions, however, that the program must not be used by the RAM Group or its clients to restrict independent business decisions by any individual firm, to secure adherence to quotas of production or sales, to facilitate joint determination of prices by competitors, or to effect any other such unlawful trade restraint. The Commission reserves the right to conduct any further investigation of the RAM Group program as may be in the public interest based on additional information or changed circumstances which may indicate an anticompetitive purpose or effect.

Accordingly, the Commission does not presently object to the proposed data collection and use program of the RAM Group, subject to the above qualifications. The Commission also does not object to the RAM Group's disclosure of individual well information to persons not involved in the production or sale of natural gas who require the data solely for research or study purposes, provided that they agree not to disclose individual well data.

By direction of the Commission.

Letter of Request

November 25, 1980

Dear Sir:

Our client is Resource Analysis and Management Group, 2500 First National Building, Oklahoma City, Oklahoma, whose business is to act as economic consultants to the oil and gas industry. Its Managing Partner is William W. Talley II, Ph.D. whose curriculum vitae is enclosed.* It is consulted by numerous private producers and purchasers of oil and gas produced throughout the United States, and by several State Governments and consumer groups. As a consultant, our client is requested on a recurring basis to give guidance with respect to economic conditions, including prices, in the natural gas

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producing arm of the petroleum industry. It attempts to assemble, for its immediate use as a consultant, the latest economic data with respect to the range of prices being paid to producers of natural gas in all parts of the United States.

Because of its reputation in the foregoing area of consultant operations, our client receives numerous requests for guidance from producers of natural gas who have gas sales contracts with price redetermination clauses. Price redetermination may be triggered by several sets of circumstances anticipated by individual contracts which are non-uniform in their language. For example, the Natural Gas Policy Act of 1978 provides in Section 107 for the deregulation of the price of gas produced from zones below the depth of 15,000 feet and this deregulation occurred on November 1, 1979. Thereafter the price of such gas is not subject to a ceiling price under the Act. Natural gas sales contracts previously entered into, provide in some instances, that the price of natural gas which at any time during the tenure of the contract becomes deregulated shall be the subject of redetermination. The redetermination provisions in such contracts are not uniform in language but usually give some parameters within which the negotiations must take place, such as all pertinent economic factors, including the highest prices being paid for similar gas in a given adjoining area. Three examples of redetermination clauses are appended hereto for your reference.*

In order to be of service in such price redetermination situations, our client contemplates, in connection with its economic consultant operations, acting as a "clearing house" for pricing information in the various areas of the United States. It will assemble then-current pricing information from various sources, ranging from informal bits of casual information to data acquired from government sources such as State tax commissions and regulating agencies. In addition, it contemplates requesting existing pricing information from its private producer clients and other private industry sources. It will then, through the use of computer storage facilities and analysis capability within its existing organization, be able to provide current pricing information in the various producing fields and parts of fields within the United States. This service would be conducted and promulgated as a part of its consultant work and will be charged for on the basis of current consultant fees.

Our client's request for pricing information will be to specific producers for detailed information concerning dollar pricing, escalation features of the contract, and any other pricing structure affecting the present or future price of the natural gas under a specific contract. A request may also be included for a copy of the pricing clause of an

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existing contract. Of course, compliance with such requests on the part of the producer would be voluntary, but we believe a need for such a clearing house of pricing information is widely recognized in the industry. In this regard, to our knowledge there is now no ready source of such information in any government agency or private or industry organization, other than a current attempt on the part of Foster Associates, Inc. of Washington, D.C., to analyse gas pricing information taken from contracts filed with the Federal Energy Regulatory Commission. It should also be noted that our client is neither a producer, seller or purchaser of natural gas or any other hydrocarbon, acting only in the capacity of consultant.

The information with respect to price divulged by our client would include the general locations of the wells where pricing data is known, and the specific existing price data, without revealing sources. The names of producer-purchaser contracting parties would not be divulged. In this regard it can be stated that there are scores of gas producers and purchasers of varied size operating in the United States and usually no concentration of any one company in a given gas producing field.

We respectfully request an advisory opinion whether the above economic consultant activity would conform to the laws and regulations administered by the Federal Trade Commission, and specifically whether, if undertaken, there would be any violation of antitrust or similar prohibitions of the Federal law. Included in the opinion we hope will be a statement not only with reference to our client's proposed operations but also with regard to the furnishing of such information to our client, for the restricted purposes above indicated, by private producer-sellers of natural gas. We would be pleased to furnish any additional information which you may need in regard to our client's proposed activities or any other natural gas industry information which you may require. Since the need for the proposed consultant service is immediate in the industry, we would respectfully request that an advisory opinion be issued at the earliest convenient time.

Respectfully submitted,

/s/ William J. Legg

Proposed use of intermediaries to collect and supply natural gas price and other data for use in contract redeterminations would be permissible, subject to certain qualifications. [*Santa Fe Energy Co., 833 0002*]

April 18, 1983

Dear Mr. De Lung and Miss Rieck:

This responds to your request for an advisory opinion concerning the use by Santa Fe Energy Company (Santa Fe) of certain firms—including the Resource Analysis & Management Group—as intermediaries to obtain price and other data from competitors for the purpose of implementing natural gas price redetermination provisions in contracts for the sale of natural gas from deregulated natural gas wells.

The Commission understands that Santa Fe is a relatively small natural gas producer owning, or having interests in, a number of natural gas wells in gas producing regions in the western and southwestern United States. The Commission further understands that Santa Fe's need for certain price and other data in order to redetermine prices for natural gas wells in accordance with various redetermination clauses is the result of the deregulation of natural gas wells which has occurred, or will take place, under present provisions of the Natural Gas Policy Act of 1978.

As you are aware, price information exchanges among competitors in particular marketing environments could raise serious antitrust concerns. In view of the Supreme Court's opinion in *United States* v. *Container Corp.,* 393 U.S. 333 (1969), the legality of Santa Fe's use of various firms to provide it with current price and other data for redetermination purposes depends upon a factual assessment of the structure and other economic characteristics of the markets involved, the nature and purpose of the plan to obtain and provide such data by the various firms, and the probable effect of the collection and dissemination of such data on natural gas prices and the interdependency of natural gas producers in such markets.

On the basis of available information indicating low concentration of natural gas production on a national basis, the availability of price information to larger producers and purchasers, and the need for reliable price adjustment mechanisms in natural gas supply contracts, the Commission presently does not see any competition problems posed by Santa Fe's proposed use of intermediaries to obtain and supply it with price and other data for redetermination purposes. The Commission cautions, however, that the program must not be used by Santa Fe, or any concern supplying redetermination data to Santa Fe,

to restrict independent business decisions by any individual firm, to secure adherence to quotas of production or sales, to facilitate joint determination of prices, or to effect any other such unlawful trade restraint. The Commission reserves the right to conduct any further investigation of the Santa Fe program as may be in the public interest based on additional information or changed circumstances which may indicate an anticompetitive purpose or effect.

Accordingly, the Commission does not presently object to the proposed use by Santa Fe of intermediaries to collect and supply it with natural gas price and other data for use in contract redeterminations, subject to the above qualifications.

By direction of the Commission.

Letter of Request

December 15, 1981

Pursuant to the applicable regulations at 16 C.F.R. 1.1 through 1.4, Santa Fe Energy Company (Santa Fe) respectfully requests an opinion from the Commission concerning the legality of employing the services of firms able to furnish composite natural gas pricing information for contract redetermination purposes.

I. BACKGROUND.

Santa Fe is an independent oil and gas production firm actively involved in exploration and development of domestic oil and gas reserves both onshore and offshore. Since enactment of the Natural Gas Policy Act (NGPA) in 1978 a majority of the natural gas contracts Santa Fe has entered contain price deregulation provisions. These provisions are included in anticipation of gradual decontrol of various categories of natural gas. The typical natural gas deregulation provision in Santa Fe's and other natural gas companies' contracts states:

If, at any time and from time to time, the price to be paid hereunder for all or a portion of the gas sold under this Agreement is not subject to federal regulation, then the price to be paid thereafter for such deregulated or nonregulated gas shall be determined for each Delivery Quarter to equal one of the following prices, which shall be selected by Seller as hereinafter provided:

A. * * *

B. The arithmetic average of the highest price per MMBTU, excluding taxes and other production related costs, paid for gas delivered in the first month of the preceding Delivery Quarter by each of two (2) interstate pipeline companies, one of which may be Buyer, for gas produced within the county or counties in which the gas subject to this Agreement is produced. The contracts used in determining such two (2) highest prices shall cover wells that were producing during the first month of the preceding Delivery Quarter and shall have been entered into between nonaffiliated buyers and sellers during the twenty-four (24) month period immediately preceding the effective

date of the redetermined price hereunder pertaining to gas of substantially the same quantity and quality and delivered under terms and conditions comparable to this Agreement. The arithmetic average of such two (2) highest prices, together with supporting calculations and data and copies of either the contracts involved or other documentary evidence satisfactory to Buyer utilized by Seller in calculating such average price, shall be furnished to Buyer prior to the commencement of each Delivery Quarter in which this method of determining the price remains in effect. If such documentary evidence is not timely received by Buyer, the price payable hereunder during such Delivery Quarter shall be the higher of the prices as determined by either A., C., or D. of this 3. In no event shall the price determined in accordance with this B. exceed 1.3 times the MMBTU price for Fuel Oil No. 2, as determined in accordance with the provisions of C. of this 3.; . . . .

The quoted contract provision is taken from Santa Fe's contract with El Paso Natural Gas Company dated February 20, 1981 covering a well in Roger Mills County, Oklahoma.[1] The purpose of such a provision is to establish the fair market value of like quality gas being sold under similar contract conditions.

II. EXPLANATION OF SANTA FE'S QUESTION.

Santa Fe respectfully requests an opinion from the Commission whether, in exercising the option to receive natural gas prices equal to "the average of the three highest prices being paid under contracts by other pipeline companies" or similarly worded pricing options, it may employ the services of a firm which provides information regarding prices being paid by pipelines buying gas of similar quality and quantity. In particular, Santa Fe requests advice whether it may employ the services of the Resource Analysis and Management Group (RAM Group), an Oklahoma City, Oklahoma firm, to determine fair market value for deregulated natural gas being sold to El Paso under the quoted contract. The RAM Group publicizes itself as follows:

The RAM Group is a consulting firm in the energy field offering special services to operators and producers in the oil and gas business. As a part of this service, the RAM Group assists companies in their compliance with policies and regulations of the Federal Energy Regulatory Commission. Also, the RAM Group assists companies in the management of energy related business transactions including the establishment of prices permitted under existing contracts.

The RAM Group has represented to Santa Fe orally and in its correspondence that it obtains comparative pricing information by reviewing "public records, commercial sources and proprietary information available to the RAM Group" to identify the highest prices being paid

[1] See Appendix A, attached, for the complete text of the pricing provisions of Article IX, Sections 1 through 3, under the quoted contract between Santa Fe and El Paso Natural Gas Company. [Not reproduced herein. Copies of all attachments are available for inspection in Room 130, Public Reference Branch, Federal Trade Commission, 6th St. and Pa. Ave., N.W., Washington, D.C. 20580.]

for gas of similar quantity and quality, thereby establishing fair market value of such gas as nearly as possible.

III. THE LAW UNDER WHICH THE QUESTION ARISES.

The question posed by Santa Fe arises under the Sherman Antitrust Act and the Clayton Act, 15 U.S.C. 1–7 and 12–27. Santa Fe's request for advice is essentially a request for an opinion from the Commission whether the use of services provided by the RAM Group or similar firms in other states violates either the letter or the spirit of the antitrust laws.

IV. ADDITIONAL MATERIAL FACTS.

In addition to the foregoing explanation of facts and issues, Santa Fe emphasizes that the RAM Group is a professional organization and its services are available to the public. Two possible exceptions to this general rule are (1) where a potential client is unable to pay for the services and (2) where a potential client would place the RAM Group in a conflict of interest in serving another client. Also, it should be pointed out that although many of Santa Fe's contracts contain deregulation provisions similar to that quoted above, not all contracts provide a choice of options for price redetermination. Instead, many contracts contain the "average of the three highest prices being paid" as the sole means of redetermining price in the event of deregulation. Therefore, Santa Fe must be able to confirm prices being paid by employing the services of a firm such as the RAM Group.

IV. IDENTITY OF THE COMPANIES INVOLVED.

(1) Santa Fe Energy Company
1616 S. Voss Street
Houston, Texas 77057

(2) Resource Analysis and Management Group
First National Center
Oklahoma City, Oklahoma 73102

In addition to the foregoing companies, Santa Fe asserts that many similarly situated natural gas producers are facing the dilemma posed by this request for advice with increasing frequency and severity of impact as more natural gas becomes deregulated. It is noteworthy that probably the only companies not experiencing difficulty are major natural gas companies which have pipeline affiliates. These companies are able to obtain price information through their pipeline affiliates without resort to the services of a firm such as RAM Group.

V. CONCLUSION.

Santa Fe is faced with the prospect of price renegotiation for several contracts, including the El Paso contract quoted above, within the upcoming calendar quarter. Therefore, the Commission's advice on the matter raised herein will have an immediate and direct impact. Santa Fe respectfully requests the Commission's advice at the earliest possible date.

Respectfully submitted.

/s/ Harry L. De Lung, Jr.
/s/ Ann Straw Rieck

Peer review by organization's participating physicians of health care services provided under health benefits plans involving private employers and insurers rather than under governmental programs would not violate Section 5 of the Federal Trade Commission Act. [*Rhode Island Professional Standards Review Organization, 833 0004*]

May 9, 1983

Dear Mr. Lynch:

This is in response to your request for an advisory opinion concerning a proposed program for private peer review to be undertaken by the Rhode Island Professional Standards Review Organization ("RIPSRO"). By letter of January 5, 1983, you asked the Bureau of Competition whether RIPSRO and its participating physicians would violate the antitrust laws by performing peer review for private employers' health benefits programs. You clarified your request by telephone with Bureau of Competition Assistant Director Arthur N. Lerner, sending supplemental materials to him, including a draft of the contract to be used in the program. Since your request raises an issue of significant public interest, under Section 1.1 of the Commission's Rules of Practice an advisory opinion from the Commission itself, rather than from the Bureau of Competition, is warranted.

Based on the information provided, the Commission understands that RIPSRO is a nonprofit organization of physicians in Rhode Island that intends to perform certain services as part of its private peer review program "to assure that only medically necessary care is provided and that this care meets professionally recognized standards of quality." Services RIPSRO will perform under the program include: 1) preadmission review of hospital admissions for elective surgery; 2) concurrent review of in-hospital health services, including certification or non-certification of admissions, assignment of recommended appropriate length of stay, and periodic recommendation concerning continued stay; 3) retrospective review of certain hospital admissions; 4) monitoring of hospital discharge planning; and 5) quality review studies. The Commission also understands that RIPSRO has no current plans to perform any fee review under this program.

According to your submission, determinations made by RIPSRO through its reviewing physicians and registered nurses will be advisory in nature. RIPSRO has no legal or contractual authority to bind any party—including the contracting employer, insurer, health care provider, or beneficiary—concerning its determinations. Final decision regarding payment of all health care benefit claims will rest with the employer and/or the applicable insurer.

In considering your request, the Commission has reviewed the Supreme Court's recent ruling in *Union Labor Life Insurance Co. v. Pireno*, __ U.S. __, 102 S.Ct. 3002 (1982). The professional peer review activities in that case were held not to be exempt from the antitrust laws as part of the "business of insurance." The Commission also has considered the recently enacted federal Peer Review Improvements Act of 1982, which facilitates private peer review, even mandating it in certain circumstances. Although there is no direct judicial precedent on the legality under the antitrust laws of a peer review program such as the one you have proposed, the Commission has taken into account both its advisory opinion letter of April 8, 1982 on fee review to the Iowa Dental Association [*see* 99 F.T.C. 648] and the business review letter of March 2, 1977 from the Department of Justice, indicating that it did not intend to oppose under the antitrust laws the operation of peer review committees by the International Chiropractors Association.

Based on the Commission's review of your proposed peer review program, the Commission is of the opinion that operation of the program as described would not violate Section 5 of the Federal Trade Commission Act or any other provision of law the Federal Trade Commission enforces. The program does not appear to involve any price-fixing, concerted refusal to deal, agreement not to compete, or other conspiracy in restraint of trade. The program could, in fact, promote competition, thereby providing substantial benefits to consumers. Contracting insurers and employers can use the information generated by RIPSRO's peer review program in deciding whether to pay for medical care in particular instances, and consumers can use this information in deciding whether to receive or "purchase" medical care. To the extent that the peer review program helps participating prepaid health care plans reduce costs, it also will increase the competitive incentives for other third-party payers to participate in effective cost-containment programs. In addition, RIPSRO's peer review program can help health care providers practice in a cost-conscious manner, and give them greater incentive to do so.

This advisory opinion, like all those the Commission issues, is limited to the proposed conduct your submission describes. Thus, as noted in the Commission's opinion letter concerning the Iowa Dental Association's fee review program, ". . . great care must continually be taken in carrying out the program to assure that its purpose remains legitimate and that it does not produce significant anticompetitive effects and thereby run afoul of the antitrust laws." You should, for example, avoid any misuse of the peer review program to discriminate against innovative competitors whose practices, although legitimate and appropriate, may pose a competitive threat to other physicians involved in the peer review program.

Finally, the Commission retains the right to reconsider the questions involved and, with notice to the requesting party in accordance with Section 1.3(b) of the Commission's Rules of Practice, to rescind or revoke its opinion if implementation of the proposed peer review program results in anticompetitive effects, if the program is used for improper purposes, or if the public interest otherwise so requires.

By direction of the Commission.

Letter of Request

January 5, 1983

Dear Mr. Campbell:

As you know, peer review groups have been operating under the federal statute, Section 249 F, Public Law 92–603, since 1972. Then, in the last Congress, as a rider to the Tax Equity and Fiscal Responsibility Act of 1982, Senator Durenberger submitted the Peer Review Improvement Act which was signed into law on September 3, 1982 along with the other provisions of the Tax Equity and Fiscal Responsibility Act.

I note, again, some comments in the *Employee Benefit Plan Review* magazine of December, 1982 that Mr. Miller has suggested that the FTC would give an opinion regarding possible antitrust implications.

As a peer review organization and following the initiative of the federal law, that is, the Peer Review Improvement Act of 1982, we now would like to enter into private review arrangements with large corporations, small businesses, cities and towns, unions, and other groups that would be interested in eradicating overutilization and waste in the health care system for their hospitalized employees. Since we are undertaking this task right now with the possibility of developing a business coalition in the State of Rhode Island, we wonder what the FTC's opinion would be in terms of antitrust implications if our physicians became involved in making specific denials of services and days for hospitalized patients in the private review sector.

We believe that the physicians in our organization, who have undertaken the task to review medical necessity, appropriateness, and quality of care since the adoption of the PSRO statute, have acquitted themselves with high distinction in the public's interest.

We feel that any adverse decisions by the FTC regarding PSRO review or PRO review would not be in the interest of the nation. We, especially, believe that with the initiative of the Senate Finance Committee in approving unanimously the Peer Review Improvement Act of 1982, the extension of such review into the private sector with

corporations directly or through business coalitions is certainly in the interest of assuring quality of care for the American people while, at the same time, eradicating waste and overutilization.

Would you give us an opinion regarding antitrust implications for physicians participating in our program as we move forward in the 80's to extend our review into the private sector?

Thank you for your attention to this matter. With best wishes, I am

Sincerely yours,

/s/ Edward J. Lynch
Executive Vice President

Proposed health care delivery program that restricts participation to a limited number of doctors and emphasizes lowering costs would not violate federal antitrust laws. [*Health Care Management Associates, 833 0005*]

June 7, 1983

Dear Dr. Smith:

This letter responds to your request for an advisory opinion concerning a proposed "Cooperating Provider Program" ("CPP") by Health Care Management Associates ("HCMA") for the organization, financing, and delivery of health care services. HCMA is a private, for-profit firm incorporated under the laws of the State of New Jersey. Its purpose is "to provide professional consulting and administrative services in order to promote cost-containment in the health care industry." You also have informed us that "no actively practicing provider, hospital, payer (employer or insurer) has any direct or indirect financial, controlling, or non-controlling interest in HCMA."

The Commission understands that HCMA wishes to establish and operate the Cooperating Provider Program "to promote competition . . . by encouraging the awareness of cost [of health care] on the part of the user and to 'pressure' individual physicians, hospitals and other PPOs [preferred provider organizations] to be cost competitive. . . ." The Cooperating Provider Program is a variation on the so-called "preferred provider organization," or "PPO," with HCMA serving as the intermediary between health care providers wishing to "sell" their services and third-party payers[1] wishing to "purchase" those providers' services on behalf of their insureds or beneficiaries.

HCMA intends to contract individually with health care providers such as allopathic and osteopathic physicians, podiatrists, oral surgeons, clinical psychologists, and possibly also optometrists, dentists, nurse midwives, and physical therapists. HCMA will not enter into cooperating provider agreements with any groups or organizations of independently practicing competing providers; it may enter into such agreements with integrated group practices, professional partnerships, and institutions employing salaried professional staff. "Cooperating providers" will agree to provide health care services to insureds or beneficiaries covered by third-party payers that contract with HCMA to offer the Cooperating Provider Program. Cooperating providers will total not more than 10–15 percent of all local area providers, with this participation rate relatively uniform across specialties.

[1] Third-party payers, such as insurance companies, service benefit companies or employers, are entities that either reimburse patients for all or part of the cost of medical and health care services or make direct payments to providers of those services on behalf of patients.

Cooperating providers will have a choice between two methods of reimbursement determined by HCMA: 1) the lesser of the charges submitted by the cooperating provider or a maximum payment schedule for services determined by HCMA; or 2) the cooperating provider's "usual, customary and reasonable" fee for the service, less a percentage discount (up to a maximum of 15 percent) as set forth in the third-party payer's contract with HCMA. Each cooperating provider will decide independently whether to contract with HCMA and will continue to set his or her charges for services independent of any other cooperating providers. Nothing in the Cooperating Provider Program or the cooperating provider agreement will affect the charges that a cooperating provider may make to patients not covered by the Cooperating Provider Program. Reimbursement to a cooperating provider under the Cooperating Provider Program for services covered by the program will constitute payment in full to the cooperating provider.

HCMA will prepare and periodically update a directory of "cooperating providers" for distribution to persons covered by third-party payers under the Cooperating Provider Program. Third-party payers using the Cooperating Provider Program will incorporate in their coverage provisions certain financial incentives for persons covered under the Cooperating Provider Program to encourage use of the services of cooperating providers. Beneficiaries remain free, however, to obtain covered services from providers who are not "cooperating providers," albeit at the cost of incurring some additional, out-of-pocket expense that would not exist if a cooperating provider were used.

HCMA will negotiate contracts for Cooperating Provider Program services with third-party payers, such as commercial insurance carriers and self-funded or self-insured employer groups. These payers make all claims payments, and underwrite any insurance risk. HCMA does not act as an insurer in the Cooperating Provider Program. HCMA also will provide utilization review and quality assurance services under the Cooperating Provider Program. As payment for its services, HCMA will receive an annual fee negotiated with each third-party payer. Cooperating providers will make no payment to HCMA, although a "nominal annual membership fee" may be initiated at a later date.

HCMA plans to market the Cooperating Provider Program initially in Burlington, Camden, and Gloucester Counties of New Jersey, with possible expansion to adjacent counties in the future. The primary market for the Cooperating Provider Program consists of those persons in this geographic area who are covered under commercial and self-insurance programs, estimated to be approximately 30 percent of the total employed population of the area.

Nothing in the program prohibits or limits participating providers from contracting with or participating in the programs of any other PPO, HMO, or other third-party payer. Similarly, third-party payers participating in the Cooperating Provider Program remain free to engage in other programs.

The proposed Cooperating Provider Program, in essence, would be a form of vertical arrangement between individual sellers of services (cooperating providers) and purchasers of services (third-party payers, on behalf of their insureds or beneficiaries) for the sale and purchase of health care services. HCMA proposes to facilitate these transactions by performing certain functions much like an agent or broker. HCMA is not itself a primary party to the underlying transaction. Also, the Cooperating Provider Program involves no agreements among either competing providers or third-party payers concerning any aspect of their involvement in the program.

Based on the description of the Cooperating Provider Program outlined above and further detailed in your submissions, it is the Commission's opinion that operation of the program would not constitute a horizontal or vertical price fixing arrangement or an unlawful joint sales agency arrangement. Nor does the Cooperating Provider Program, as described, raise a colorable claim of boycott or concerted refusal to deal under the antitrust laws. Finally, the program, as described, contains no suggestion of a specific intent to monopolize, nor does HCMA appear to be capable of acquiring, maintaining, or improperly using monopoly power. It appears, moreover, that the Cooperating Provider Program proposed by HCMA is likely to be procompetitive, both by generating competition between cooperating providers and other local providers and by increasing competition among third-party payers. It is the Commission's opinion that this program would not violate the Federal Trade Commission Act or any provision of antitrust law the Commission enforces.[2]

The Commission retains the right to reconsider the questions involved, and to rescind or revoke its opinion with notice to the requesting party in accordance with Section 1.3(b) of the Rules of Practice, if the implementation of the Cooperating Provider Program results in anticompetitive effects, the purposes of the program no longer remain legitimate, or the public interest otherwise so requires.

By direction of the Commission.

[2] This Advisory Opinion, like all those the Commission issues, is limited to the proposed conduct described in the request being considered. Therefore, it does not constitute approval for actions that are different from those described, or those not specified, in the request. Nor does this Advisory Opinion conclude or imply that to avoid illegality under the antitrust laws a PPO must be structured and operated in every respect like HCMA's Cooperating Provider Program.

Letter of Request

October 12, 1982

Dear Mr. Pollard,

I would like to express my appreciation for the time you spent with me on the telephone discussing Preferred Provider Organizations. As you recommended, I am writing to request a staff opinion letter concerning the possible antitrust liability for Health Care Management Associates (HCMA) and/or its cooperating physicians and other clinical professionals with respect to the proposed Cooperating Provider Program (CPP) which is described in the enclosed information.

I believe that, rather than hindering competition, the proposed CPP is one expression of the high level of competition which already exists in the service area. Furthermore, it can be expected to generate other competitive responses. Moreover, the structure and operation of the CPP is clearly designed with the objective to increase the competitive environment as follows:

- The maximum number of cooperating providers in the CPP is projected to be approximately 10–15% of the actively practicing providers in the service area.
- The cooperating providers will represent all specialties without an undue or disproportionate concentration in any one clinical area.
- The primary market for the CPP is those employed persons covered by self-funded or commercial insurance health programs. This market is only approximately 30% of all employed persons residing in the service area.
- HCMA, which is a private independent entity neither sponsored nor controlled by any provider group or payer, will, in effect, be the broker for the cooperating providers with interested payers in establishing the CPP.
- Although there are no CPPs currently in the service area, there is one operational HMO and a second one in development. However, more significantly, the local health care environment demonstrates growing competition among institutional and professional providers.

I would appreciate your timely review of this material and look forward to receiving your opinion as soon as feasible. If I can provide further information or clarification, please let me know.

Sincerely,

/s/ Irwin S. Smith, M.D.
President

Proposed code of ethics concerning various aspects of professional conduct by ophthalmologists would not violate federal laws. [*American Academy of Ophthalmology, 833 0006*]

June 17, 1983

Dear Mr. Jacobs:

This letter responds to your request for an advisory opinion concerning the proposed code of ethics of the American Academy of Ophthalmology. The Academy, an organization of physicians specializing in medical and surgical care of the eye, intends to adopt a code of ethics to govern the professional conduct of its members. This code would become part of the Academy's bylaws, to which ophthalmologists agree to subscribe when they join the organization. You have requested that the Commission advise the Academy whether the proposed code of ethics[1] complies with Section 5 of the Federal Trade Commission Act and all other applicable statutes administered or enforced by the Commission.

The laws enforced by the Commission do not prohibit professional associations from adopting reasonable ethical codes designed to protect the public. Such self-regulatory activity serves legitimate purposes, and in most cases can be expected to benefit, rather than to injure, competition and consumer welfare. In some instances, however, particular ethical restrictions can unreasonably restrict competition and thereby violate the antitrust laws.

The legality of a professional society's ethical rules under the antitrust laws depends upon their purposes and competitive effects.[2] The materials accompanying your request state that the purpose of the proposed code of ethics is "exclusively to protect and benefit patients of ophthalmologists who are members of the Academy." In accordance with its customary practice when considering advisory opinion requests, the Commission has relied upon the Academy's statement as to the good faith purpose of the code. Thus, the Commission has focused its attention on the probable effects on competition of the various provisions contained in the Academy's proposed code of ethics.

The Academy's proposed code of ethics contains three sections: (1) "Principles of Ethics," which are aspirational guidelines for professional conduct and are not enforceable; (2) "Rules of Ethics," which establish specific enforceable standards of conduct for members of the Academy; and (3) "Administrative Procedures," which set forth the structure and operations of the Academy's Ethics Committee and the

[1] Submitted on August 31, 1982 and modified by your submission on January 17, 1983.

[2] *See National Soc'y of Prof. Eng'rs v. United States*, 435 U.S. 679 (1978); *American Medical Ass'n*, 94 F.T.C. 701 (1979), *aff'd*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 452 U.S. 960 (1982).

procedures for investigative and disciplinary proceedings concerning ethics complaints. Members found to have violated the rules of ethics may be reprimanded, suspended from the Academy for a definite time period, or permanently expelled.

The ethical principles express the Academy's views regarding the duties of an ethical ophthalmologist. They state, for example, that ophthalmological services must be provided with compassion and integrity, competence must be maintained through continued study, confidentiality of patient communications must be respected, fees should not exploit patients or others, ophthalmologists deficient in character should be reported to the proper authorities, and the patient's welfare must be the ophthalmologist's primary consideration. The Commission does not find any significant threat to competition posed by these proposed guidelines. It is the Commission's opinion that adoption of the proposed "Principles of Ethics" for the purpose described by the Academy would not violate the Federal Trade Commission Act or any other statute enforced by the Commission.

The second section of the code contains the ethical rules, which the Academy intends to enforce. As their titles indicate, these rules address various aspects of professional conduct:

A. Competence
B. Informed Consent
C. Clinical Experiments and Investigative Procedures
D. Other Opinions
E. The Impaired Ophthalmologist
F. Preoperative Assessment
G. Delegation of Services
H. Postoperative Care
I. Medical and Surgical Procedures
J. Procedures and Materials
K. Commercial Relationships
L. Communications to Colleagues
M. Communications to the Public

Most of these rules do not raise significant antitrust issues. For example, the Academy has proposed rules that would assure to patients such important protections as informed consent, careful preoperative evaluations, and appropriate consultations. Other ethical rules in the proposed code prohibit practices that cause injury to patients, such as misrepresentations of services performed or the ordering of unnecessary procedures for pecuniary gain. Such rules appear unlikely to have anticompetitive effects and may, in some instances, promote competition.

A few of the ethical rules—because of the nature of the restraints that they impose—require separate discussion. These are the provisions addressing clinical experiments and investigative procedures,

delegation of ophthalmological services, postoperative care, and communications to the public.

Clinical Experiments and Investigative Procedures

Rule C of the Academy's proposed code requires ophthalmologists to obtain approval from "adequate review mechanisms" before undertaking a "clinical experiment" or an "investigative procedure." The ophthalmological procedures subject to this requirement are defined in the rule as "those conducted to develop adequate information on which to base prognostic or therapeutic decisions, or to determine etiology or pathogenesis, in circumstances in which insufficient information exists." The rule does not require a particular type of review mechanism for all cases. In supplemental materials, the Academy has indicated that the concept of an "adequate" review mechanism is intended to be flexible, and that the rule has been drafted to permit use of "informal" review mechanisms, such as a telephone conference with a colleague, when formal review would be impracticable. The rule also provides that informed consent for clinical experiments and investigative procedures "must recognize their special nature and ramifications."

Although unnecessarily strict controls on the use of new ophthalmological procedures could unreasonably restrict competition and innovation, the Academy's proposed rule appears to provide safeguards to patients—to protect them from uncontrolled experimentation—with no apparent lessening of competition. Serious antitrust concerns would be raised, of course, should the rule be applied in a discriminatory manner to discourage vigorous and innovative competitors or be otherwise abused in an attempt to restrain legitimate competition.

Delegation of Services

Rule G addresses delegation of eye care services. This rule declares that certain eye care services may not be delegated to nonphysician health care professionals (referred to by the Academy in its rule as "auxiliary health care personnel"). Under the rule, non-delegable services are "those aspects of eye care within the unique competence of the ophthalmologist (which do not include those permitted by law to be performed by auxiliaries)." Materials accompanying your request* state that the term "auxiliaries" as used in the code includes optometrists, nurses, technicians, orthoptists and others. Rule G further provides that when an opthalmologist maintains responsibility to the patient for eye care services not "within the unique competence

* Not reproduced herein. Copies of all attachments are available for inspection in Room 130, Public Reference Branch, Federal Trade Commission, 6th St. and Pa. Ave., N.W., Washington, D.C. 20580.

of the ophthalmologist," these services may be delegated to qualified non-physician health care professionals with adequate supervision.

Rule G addresses practice arrangements between ophthalmologists and non-physician health care professionals, and does not apply to arrangements between ophthalmologists and other physicians, since physicians are not "auxiliaries." The Commission understands that the rule would not prevent ophthalmologists from making arrangements for delegation of eye care services to non-physicians as long as those arrangements are structured and carried out in accordance with applicable state law. State laws regulating health care professionals permit those non-physicians that the Academy has described as "auxiliaries" to provide a variety of eye care services, sometimes as independent practitioners and in other cases under the supervision of a licensed physician. Under the code, such services are not "within the unique competence of the ophthalmologist," and therefore they may be delegated.

It is also the Commission's understanding that the supervision requirement contained in the rule, applicable when an ophthalmologist retains responsibility for eye care that may be delegated, is not intended to mandate a particular type or degree of supervision for all situations. Supervision requirements under state law vary greatly, and may range from direct, on-site supervision to practice under standing orders or telephone consultation. The Academy has indicated in supplementary materials provided to the Commission* that the level of supervision required by the rule will be determined by reference to applicable state law. Finally, the Academy has specifically provided for flexibility in Rule G by the last sentence of the rule, which states: "An ophthalmologist may make different arrangements for the delegation of eye care in special circumstances, such as emergencies, if the patient's welfare and rights are placed above all other considerations."

Serious antitrust concerns would, of course, be raised by an ethical rule that unreasonably interfered with legitimate competition by ophthalmologists working in conjunction with non-physician health care professionals, or prevented optometrists or others from providing services that they are legally and professionally qualified to provide. It is the Commission's opinion, though, based on its understanding set forth above and the Academy's supplemental assurances and explanations, that Rule G should not have these effects.

Postoperative Care

Rule H addresses arrangements for care following eye surgery. Like Rule G, it concerns aspects of eye care—in this particular rule postop-

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erative eye care—that are "within the unique competence of the ophthalmologist (which do not include those permitted by law to be performed by auxiliaries)." Rule H declares that those aspects of postoperative eye care must be provided either by the operating ophthalmologist or by another ophthalmologist with whom a referral arrangement has been made. It is the Commission's understanding that the Academy prefers that the operating ophthalmologist provide the aspects of postoperative care covered by Rule H, but that, nonetheless, the code has been drafted to leave Academy members free to refer patients to another ophthalmologist for this postoperative care.

The rule also provides that when a patient is referred for postoperative care, the operating ophthalmologist must make the arrangements before surgery, and the patient and the other ophthalmologist must agree. The rule further declares that fees for postoperative care should reflect the arrangements that have been made, "with advance disclosure to the patient." Finally, Rule H states that "different arrangements" for postoperative eye care may be made in emergencies or other special circumstances, as long as the patient's welfare and rights are the primary consideration. Explanatory materials accompanying your request* state that special circumstances include, for example, cases in which no ophthalmologist is available to perform the postoperative care in the geographic area where the patient resides.

Rule H addresses aspects of postoperative eye care falling within the range of services that only physicians are qualified by law to perform. For example, the rule would not prevent ophthalmologists from arranging for optometrists to provide postoperative eye care services consistent with state law. It appears, however, that the rule could affect postoperative care arrangements with physicians who are not ophthalmologists. The question arises whether Rule H's identification of some postoperative eye care services as "within the unique competence of the ophthalmologist" might unreasonably prevent Academy members from referring patients to qualified physicians who are not specialists in ophthalmology, either individual private practitioners or those in health maintenance organizations and other group settings.

Agreements among competitors to exclude another group of competitors from a market are highly suspect under the antitrust laws. Thus, if Rule H were a strict prohibition that had the effect of categorically excluding non-ophthalmologist physicians from some aspects of medical practice, it might raise serious antitrust questions. It is the Commission's understanding, however, that the Academy has

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endeavored to provide for flexibility in Rule H. One example of this flexibility is the last sentence of the rule, which provides for other referral arrangements in "special circumstances." Another area of flexibility involves the determination of what eye care functions are unique to ophthalmology.

The Commission understands that it is the Academy's position that the precise eye care functions deemed to be "within the unique competence of the ophthalmologist" will vary depending upon the circumstances involved. Although the proposed code defines an "ophthalmologist" as "a physician who is educated and trained to provide medical and surgical care of the eyes and related structures," state statutes and regulations do not define areas of medical specialization, such as ophthalmology, and thus do not delineate an area of medicine that might be considered "within the unique competence of the ophthalmologist." Moreover, the Academy states in its explanatory materials submitted with the proposed code* that it is not seeking through its code of ethics to define the appropriate scope of practice of health care personnel. Rather, these supplementary materials set forth a flexible approach, and state that in determining what eye care services fall within the special sphere of the ophthalmologist, the Academy will look to "the circumstances of each situation" and "whatever governing mandatory or voluntary credentialing mechanisms might exist." Thus, as the Commission understands it, Rule H would not preclude an Academy member from referring patients to a non-ophthalmological specialist for postoperative eye care, as long as the individual physician's training and experience qualified him or her to provide the particular postoperative services.

In light of this flexibility, the Commission concludes that Rule H is a reasonable rule that could provide valuable protection to consumers. As long as it is applied fairly and objectively, and is not interpreted more broadly than necessary to achieve its legitimate goal, it should not unreasonably impair competition. Careful attention will have to be paid to interpretation and enforcement of Rule H, because the lack of any clear definition for "aspects of eye care within the unique competence of the ophthalmologist" may make the rule susceptible to abuses in application. Obviously, if the effect of the rule were to impede new and potentially cost-effective methods for the delivery of quality eye care or to exclude unreasonably family physicians or other doctors from certain aspects of medical practice, serious antitrust concerns would be raised. Nonetheless, based on the available information, it appears that adoption of Rule H would not pose an unlawful threat to competition or consumer welfare.

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Communications to the Public

Rule M sets forth several requirements for advertising and other communications to the public. The rule bans false or deceptive communications, both affirmative misrepresentations and misrepresentations arising from the failure to disclose a material fact. It does not ban any particular form of communication, such as testimonials or pictorial representations; rather, it provides that these and other forms of communications must not convey false or deceptive information.

Rule M also prohibits certain specific types of representations. The rule bans communications that: "appeal to an individual's anxiety in an excessive or unfair way"; "create unjustified expectations of results"; "misrepresent an ophthalmologist's credentials, training, experience or ability"; or "contain material claims of superiority that cannot be substantiated."

These provisions elaborate on the rule's general proscription of false or deceptive communications. With respect to appeals to anxiety, the Academy has taken into account the fact that information on health care topics may often create anxiety and has drafted the rule to make clear that it is aimed at those communications that unfairly or oppressively cause anxiety. The Commission understands that this provision will be enforced reasonably and objectively, to avoid discouraging the dissemination of valuable information to consumers. The ban on communications that "create unjustified expectations of results" prohibits deceptive representations regarding the likely results of ophthalmological treatment. The last two provisions identified above address false or misleading statements about the qualifications of an ophthalmologist. The Commission notes that the rule prohibits "material claims of superiority that cannot be substantiated" and does not contain a ban on "self-laudatory" or "self-aggrandizing" statements.

Finally, Rule M contains two disclosure requirements. Disclosures regarding safety, efficacy, and the availability of alternatives must be made if a communication refers to "benefits or other attributes of ophthalmic procedures or products that involve significant risks," and in some cases descriptions or assessments of alternative treatments must be given. In addition, a communication must include a disclosure that it "results from payment by an ophthalmologist," when this is the case and it is not obvious from the nature, format, or medium of the communication.

The Commission understands that all of the disclosures identified in the rule are required only when necessary to avoid deception. The Academy has specifically represented that the disclosure requirements with respect to communications that "refer to benefits or other attributes of ophthalmic procedures or products that involve signifi-

cant risks" are intended and will be construed by the Academy to require disclosures only to the extent necessary to prevent deception of the public. The Commission also understands that mere identification of an ophthalmic procedure or product that involves significant risks, without reference to its benefits or other qualitative attributes, will not trigger the disclosure requirement. Furthermore, the Academy has represented that an advertisement for routine eye examinations, such as "safeguard your health; get your eyes checked; careful and thorough eye examinations by appointment," would not need to contain the disclosures identified in Rule M. Similarly, the disclosure requirements of the rule would not be triggered by a communication that advertised the fitting or provision of contact lenses and noted such attributes as improved appearance, user comfort, or inexpensiveness.

Based on its understanding of Rule M and the Academy's supplemental assurances and explanations, the Commission believes that this rule does not pose an unreasonable threat to competition or consumers. Rules that are tailored to prevent false or deceptive advertising serve to enhance the competitive process and provide valuable consumer protection. Care should be exercised, of course, to ensure that interpretation and enforcement of the rule does not have the effect of suppressing nondeceptive advertising or other communications to the public.

It is the Commission's opinion, based on the foregoing and the Academy's supplemental assurances and explanations, that adoption of the proposed "Rules of Ethics" would not violate the Federal Trade Commission Act or any other laws enforced by the Commission. The Commission notes that the Academy has stated that its aim is to "assure that the code is interpreted and enforced objectively and with fairness." This is essential, for even the most carefully drafted ethical rules can create antitrust problems if they are abused. Rule K, for example, declares that an ophthalmologist must not let his or her clinical judgment and practice be affected by commercial interests. This rule could raise serious concerns if it were broadly interpreted to effect a flat ban on certain types of legitimate commercial relationships.

The final section of the proposed code of ethics describes the administrative procedures that will be used to implement the ethical rules. The procedures established by the code include: notice to the accused of the existence of an investigation; opportunity for a hearing; right to counsel; opportunity to cross-examine witnesses and offer evidence; right to appeal an adverse decision; and preservation of a written record.

Courts have held that when membership in an organization of competing firms or individuals confers a significant competitive advan-

tage, disciplinary measures such as suspension or termination may not be imposed without adequate procedural safeguards. The proposed code provides significant procedural safeguards. It is the Commission's opinion that adoption and use of the "Administrative Procedures" contained in the proposed code would not violate the antitrust laws or any other laws enforced by the Commission.

Accordingly, the Commission concludes that adoption of the American Academy of Ophthalmology's proposed code of ethics would not violate Section 5 of the Federal Trade Commission Act or any other statute enforced by the Commission. This advisory opinion, like all those issued by the Commission, is limited to the proposed conduct described in the petition being considered. It does not, of course, constitute approval for specific instances of implementation of the code that may become the subject of litigation before the Commission or any court, since interpretations and enforcement of the code in particular situations may prove to cause significant injury to competition and consumers, and thereby violate the Federal Trade Commission Act. The Commission maintains the right to reconsider the questions involved and, with notice to the requesting party in accordance with Section 1.3(b) of the Commission's Rules of Practice, to rescind or revoke its opinion in the event that implementation of the proposed code of ethics results in significant anticompetitive effects, should the purposes of the code or any of its individual provisions be found not to be legitimate, or should the public interest otherwise so require.

By direction of the Commission.

Letter of Request

August 31, 1983

Dear Mr. Thomas:

This is a request that the Federal Trade Commission issue an advisory opinion with respect to compliance by the proposed Code of Ethics of the American Academy of Ophthalmology with Section 5 of the Federal Trade Commission Act.

The Academy's request involves substantial questions for which there are no clear Commission or court precedents. The request and consequent publication of Commission advice is of significant public interest.

This advisory opinion request is submitted under the Commission's General Procedures, Section 1.1 and following; it is subject to enactment of legislation that may affect Commission authority with respect to the Academy.

Submitted with the request are these attachments.*

1. The Proposed Code of Ethics of the American Academy of Ophthalmology;
2. Background on the Proposed Academy Code of Ethics; and
3. The First, Second and Third Reports on Revisions to the Proposed Code.

The Academy respectfully requests an expedited response to its request. The membership of the Academy will consider the proposed Code at its annual meeting beginning October 30, 1982. The Academy would appreciate receiving a final Commission response to this request by that date.

Very truly yours,

Leighton Conklin Lemov Jacobs and Buckley

/s/ Jerald A. Jacobs

Supplement to Request for Advisory Opinion

January 14, 1983

Dear Mr. Thomas:

This supplements a request, submitted on August 31, 1982, that the Federal Trade Commission issue an advisory opinion with respect to compliance by the proposed Code of Ethics of the American Academy of Ophthalmology with Section 5 of the Federal Trade Commission Act.

This supplement results from communications that have occurred between representatives of the American Academy and Commission staff since the advisory opinion request was submitted.

1. The Academy's August 31 request seeks an advisory opinion as to compliance by its proposed Code of Ethics with Section 5 of the Federal Trade Commission Act. By this supplement, the Academy modifies its request to seek an advisory opinion as to compliance by that Code with Section 5 of the Federal Trade Commission Act *and all other applicable statutes administered or enforced by the Commission.*

2. In Part II, the Rules of Ethics, of the Academy's proposed Code,

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included in Attachment 1 of the August 31 request,* Rule C concerns "Clinical Investigative Procedures." It requires approval by "adequate review mechanisms" for ophthalmic procedures that are "investigative." FTC staff have suggested that the rule provide further information for use by Academy members in identifying what procedures are to be considered investigative and therefore subject to review mechanisms. The Academy has added explanatory information to the rule. The denomination of the rule has been changed to "Clinical Experiments and Investigative Procedures." A sentence has been added to the rule as follows: *"Clinical experiments and investigative procedures are those conducted to develop adequate information on which to base prognostic or therapeutic decisions, or to determine etiology or pathogenesis, in circumstances in which insufficient information exists."* These changes clarify that the determination whether an ophthalmic procedure is subject to this provision, in the absence of a binding determination by an entity in authority (such as a hospital board or a government agency), depends upon the extent to which reliable information regarding the procedure is available.

3. Rule G of the Rules of Ethics concerns "Postoperative Care" and Rule H concerns "Delegation of Ophthalmological Services."

The Academy has reversed the order of these two rules to emphasize that the delegation provisions (now in Rule G) are of broader scope than the postoperative care provisions (now in Rule H).

The rule on "Delegation of Ophthalmological Services" is intended to declare, in the interest of patient protection, that eye care functions which are unique to the ophthalmologist must ordinarily be performed only by an ophthalmologist and that, when other aspects of eye care are delegated by an ophthalmologist to an auxiliary, the auxiliary must be trained and supervised.

The Academy has revised the rule on delegation in the light of FTC staff suggestions.

A definition of "delegation" is now provided for clarification—*"Delegation is the use of auxiliary health care personnel to provide eye care services for which the ophthalmologist is responsible."* And the main dictate of the rule has been rewritten to declare: *"An ophthalmologist must not delegate to an auxiliary those aspects of eye care within the unique competence of the ophthalmologist (which do not include those permitted by law to be performed by auxiliaries). When other aspects of eye care for which the ophthalmologist is responsible are delegated to an auxiliary, the auxiliary must be qualified and adequately supervised."*

Earlier in the proposed Rules of Ethics, under the subject "Competence," it is stated that "An ophthalmologist is a physician who is

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educated and trained to provide medical and surgical care of the eyes and related structures." Thus the ophthalmologist has already been distinguished in the Code from other health care personnel by virtue of singular education and training. In the rule on delegation, the Academy has now carried forward the distinction by focusing upon "those aspects of eye care within the unique competence of the ophthalmologist."

In addition to eye care functions "within the unique competence of the ophthalmologist," however, an ophthalmologist is often responsible to the patient for the performance of other aspects of eye care. Furthermore, if and while they maintain responsibility for these other aspects, ophthalmologists routinely choose either to perform the other aspects of eye care themselves or to delegate them to other qualified, supervised health care personnel. Included among the other aspects of eye care that may not ordinarily be within the "unique competence of the ophthalmologist" are patient history review, visual acuity testing, refractions, visual field determinations, measurement of eye pressure, nursing care and other functions. "Other aspects of eye care" are, depending upon the circumstances, performed by such health care personnel as nurses, technicians, orthoptists, optometrists, technologists, and others. While some of these can and do perform eye care functions independently, they may be termed "auxiliaries" when, and to the extent that, they are performing delegated functions that remain the responsibility of others such as ophthalmologists. The Academy's rule on delegation now clearly states its meaning—to the extent that, and for as long as, an ophthalmologist is responsible for other aspects of eye care beyond those within the unique competence of the ophthalmologist, those "other aspects" may be delegated to health care personnel who are qualified and adequately supervised.

Neither the American Academy of Ophthalmology nor the Federal Trade Commission is a regulator of the scope of practice of health care personnel. Any determination of what precise eye care functions are "within the unique competence of the ophthalmologist" and what functions are "other aspects of eye care" must depend upon factual inquiry into the circumstances of each situation and legal inquiry into whatever governing mandatory or voluntary credentialing mechanisms or authority might exist. One criterion of eye care functions which is obviously not "within the unique competence of the ophthalmologist" is the existence of laws permitting non-ophthalmologists to perform those functions. This criterion is referenced in a parenthetical in the rule. Similarly, determination of what precise level of supervision is minimally necessary in delegation of functions for which the delegating individual is responsible must also be made by reference to the pertinent facts and any applicable law.

Working determinations on these issues are routinely made by practicing ophthalmologists. And, as with any ethical tenet, non-routine emergency or other such circumstances may justify special responses. The last sentence of the proposed rule on delegation envisions such possibilities and mandates that the patient's welfare and rights always be the foremost considerations.

4. The rule concerning "Postoperative Care," which has been changed from Rule G to Rule H, requires essentially that, where an Academy member performs surgery and cannot attend the patient postoperatively, he or she must arrange in advance for the postoperative care with another ophthalmologist; and fees must reflect the arrangement.

As revised, the rule makes clear that it deals only with the performance of "postoperative eye care within the unique competence of the ophthalmologist." Just as in the previous rule on delegation, this rule requires that those aspects of postoperative eye care be performed by an ophthalmologist, with the stated preference that it be the operating ophthalmologist who performs the services.

The Academy recognizes that there may exist emergency circumstances or those in which, indeed, no ophthalmologist is available in the geographic locale of the patient to perform postoperative eye care on a referral basis. The last sentence of the postoperative care rule is specifically intended to cover emergency or other such situations. It establishes the patient's welfare and rights as the ultimate determinants in questions involving postoperative eye care.

In addition, there are certain instances of minor ophthalmological surgery which do not involve extraordinary risks to patients and for which non-ophthalmologist physicians can and do routinely perform postoperative eye care. They include chalazions, hordeolums, abrasions and superficial lacerations on the eyeball or deeper lacerations on the lid, etc. Also it is not unusual or inappropriate for a preliminary eye care diagnosis of a patient to be performed by a non-ophthalmologist medical doctor such as in larger clinics. The language of Rule H envisions that non-ophthalmologists are not to be precluded from performing such postoperative care since the rule limits itself to aspects of postoperative eye care "within the unique competence of the ophthalmologist" and since it requires that the patient's welfare and rights be placed above all other considerations.

5. Rule M concerns "Communications to the Public." It requires that communications be accurate and it prohibits false or deceptive communications by Academy members. It also describes certain criteria for evaluating whether specific communications are false or deceptive. In discussions with FTC staff, requests have been made for clarification of several of these criteria for the benefit of Academy members.

The rule requires that communications "not omit material information." The Academy intends that the use of the term "material" will be understood to mandate that communications by members include all information which the public would require as essential to avoid being deceived; the term does not mandate that communications must contain all information which the public might prefer to receive. To assure clarification of this mandate, it has been changed to state: *"They must not omit material information without which the communications would be deceptive."*

The rule requires that communications not "appeal primarily to an individual's anxiety . . ." The Academy recognizes that all or most health care topics could raise anxiety for some recipients; and it intends Academy members to regard this criterion as prohibiting only communications which "primarily" raise anxiety, *i.e.*, do so in an excessive or unfair manner. To assure clarification, this criterion has been changed to state: *"Communications must not appeal to an individual's anxiety in an excessive or unfair way . . .".*

The rule has a "full disclosure" provision. It requires: "If communications refer to benefits or other attributes of ophthalmic services or products, realistic assessments of their safety and efficacy must also be included, as well as the availability, benefits or other attributes of any alternatives." FTC staff have asked whether the reference to "ophthalmic services or products" might be mis-understood by Academy members as requiring "full disclosure" even for procedures that do not involve significant risks. The Academy has changed the term to "ophthalmic procedures or products that involve significant risks."

Finally, the question has been raised whether disclosure of "the availability, benefits or other attributes of any alternatives" might sometimes be unnecessary or impracticable once the communication has fully disclosed the safety and efficacy of a procedure or product. The Academy believes that it is minimally necessary, in order to avoid deception, to require disclosure by ophthalmic surgeons who are Academy members at least of the fact of the existence of alternatives when qualitatively describing to the public ophthalmic procedures or products that involve significant risks and that have alternatives, and to require identification or even description of the alternatives in circumstances in which that information is essential to avoid deception to the public. This criterion in Rule M has been changed accordingly.

Enclosed with this supplement to the Academy's request for an advisory opinion is a copy of the Rules of Ethics from the proposed Code* which rules have been revised to reflect all changes described in the supplement.

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All clarifications and explanations contained in this supplement regarding issues in the Academy's proposed Code of Ethics will be included fully and reflected precisely in any Academy advisory opinion, informal interpretation or enforcement of its Code that involves those issues.

The Academy reiterates the importance of receiving an expedited response to its advisory opinion request to the Federal Trade Commission.

Very truly yours,

Leighton Conklin Lemov Jacobs and Buckley

/s/ Jerald A. Jacobs

TABLE OF COMMODITIES*

DECISIONS AND ORDERS

*Commodities involved in dismissing or vacating orders are *italicized*

INDEX

DECISIONS AND ORDERS

☆ U.S. GOVERNMENT PRINTING OFFICE : 1984 O - 429-089 QL 2