IN THE MATTER OF

LEROY GORDON COOPER, JR. a/k/a GORDON COOPER

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

Docket C-2993. Complaint, Sept. 25, 1979 — Decision, Sept. 25, 1979

This consent order, among other things, requires an individual from Encino, Calif. engaged in advertising, selling and endorsing a product known, among other names, as the G.R. Valve, to cease representing, without substantiation, that installing the G.R. Valve or any substantially similar automobile retrofit device in a motor vehicle will result in fuel economy improvement. The order further prohibits respondent from using or providing any endorsement or testimonial which has not been properly authorized or which contains unsubstantiated representations; and bars him from misrepresenting an endorser's expertise in a field of knowledge, and the conclusions of tests or surveys relating to the performance of a product or service. Additionally, the order requires that advertising disclose any material economic interest in the sale of a product or service that may exist between endorser and marketer of such product or service.

Appearances

For the Commission: *Laurence M. Kahn.*

For the respondent: *Murray Lertzman,* Beverly Hills, Calif.

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act, and by virtue of the authority vested in it by said Act, the Federal Trade Commission having reason to believe that Gordon Cooper, an individual, hereinafter referred to as "respondent," having violated the provisions of the said Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues its complaint stating its charges in that respect as follows:

PARAGRAPH 1. Respondent Gordon Cooper is an individual whose address is 5011 Woodley Ave., Encino, California and is a former N.A.S.A. astronaut.

PAR. 2. Respondent, in conjunction with Dan Mar Products, Inc., a California corporation, RR International, Inc., a Delaware corporation, C.I. Energy Development, Inc., a California corporation, and American Consumer, Inc., a Pennsylvania corporation, has been and is now engaged in the marketing and advertising of a product variously known as the G.R. Valve, the Turbo-Dyne Energy Cham-

ber, and by other names, (hereinafter "product") which product is advertised to be a means of improving fuel economy in automobiles. Said product is an automobile retrofit device as "automobile retrofit device" is defined in § 301 of the Energy Policy and Conservation Act of 1975, 15 U.S.C. 2011. Respondent, in conjunction with the other above-named parties and in connection with the marketing of said product, has disseminated, published and distributed and now disseminates, publishes and distributes advertisements and promotional material for the purpose of promoting the sale of said product.

PAR. 3. One of the means that has been used to market and advertise said product has been to use a celebrity endorsement of said product. Respondent has aided the promotion of said product by providing such endorsement. This endorsement appeared in disseminated advertisements and other sales promotional materials for said product. In return for his role in the marketing of said product, respondent has received remuneration from the manufacturer and distributor of the product. The amount of such remuneration was and is dependent upon the number of products sold.

PAR. 4. In the course and conduct of his said business in conjunction with the other parties named in Paragraph Two, respondent has disseminated and caused the dissemination of certain advertisements for said product through the United States mail and by various means in or affecting commerce, as "commerce" is defined in the Federal Trade Commission Act, including but not limited to, the insertion of advertisements in magazines and newspapers with national circulations and the placement of advertisements through television stations with sufficient power to broadcast across state lines and into the District of Columbia; and has disseminated and caused the dissemination of advertisements for said product by various means, including but not limited to the aforesaid media, for the purpose of inducing and which are likely to induce, directly or indirectly, the purchase of said product in commerce.

PAR. 5. Among the advertisements and other sales promotional materials are the materials identified as Exhibits A-H which are attached hereto.

PAR. 6. Through the use of advertisements referred to in Paragraph Five and other advertisements and sales promotional materials, respondent, in conjunction with the other parties named in Paragraph Two, represented and now represents, directly or by implication, that

a. the G.R. Valve when installed in a typical automobile will significantly improve fuel economy;

b. a typical driver can ordinarily obtain, under normal driving conditions, a fuel economy improvement which will approximate or equal seven miles per gallon when the G.R. Valve is installed in his/her automobile;

c. competent scientific tests for fuel economy of automobiles in which the G.R. Valve has been installed prove the fuel economy claims made for the G.R. Valve;

d. Gordon Cooper bears only the relationship of endorser to the marketing of said product;

e. Gordon Cooper has the education, training, and knowledge necessary to qualify him as an expert in the field of automotive engineering;

f. results of consumer usage, as evidenced by consumer testimonials, prove that the G.R. Valve significantly improves fuel economy.

PAR. 7. At the time respondent, in conjunction with the other parties named in Paragraph Two, made the representations alleged in Paragraph Six of the complaint, he did not possess and rely upon a reasonable basis for such representations. Therefore, said advertisements are deceptive, misleading, or unfair.

PAR. 8. In truth and in fact, contrary to the representations in Paragraph Six:

a. the G.R. Valve when installed in a typical automobile will not significantly improve fuel economy;

b. a typical driver cannot ordinarily obtain under normal driving conditions a fuel economy improvement which will approximate or equal seven miles per gallon when the G.R. Valve is installed in his/her automobile;

c. no competent scientific tests for fuel economy of automobiles in which the G.R. Valve has been installed prove the fuel economy claims made for the G.R. Valve;

d. Gordon Cooper bears not only the relationship of endorser to the marketing of said product, but also bears the relationship of principal to the marketing of said product which fact is not disclosed and is material;

e. Gordon Cooper does not have the education, training, and knowledge to qualify him as an expert in the field of automotive engineering;

f. results of consumer usage, as evidenced by consumer testimonials, do not prove that the G.R. Valve significantly improves fuel economy.

Therefore, said advertisements are deceptive, misleading, or unfair.

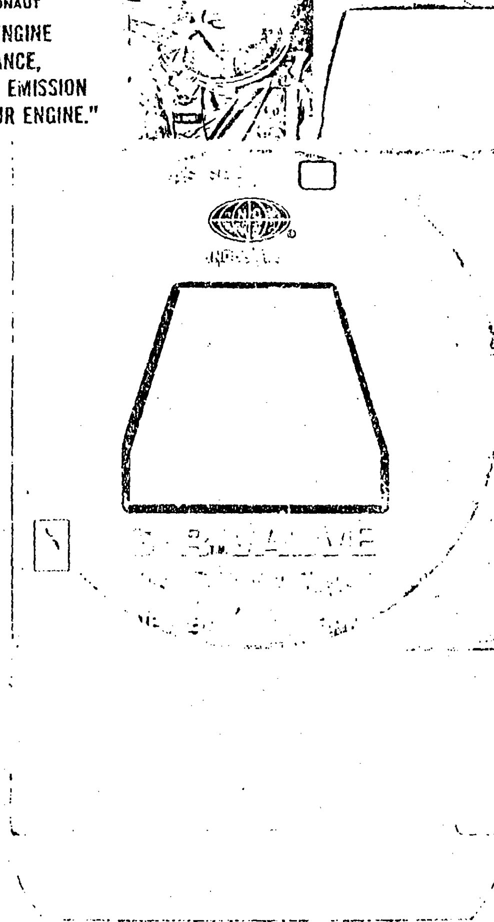
PAR. 9. Exhibits A–H and other advertisements represent, directly and by implication, that respondent had a reasonable basis for making, at the time they were made, the representations alleged in Paragraph Six. In truth and in fact, respondent had no reasonable basis for such representations. Therefore, said advertisements are deceptive, misleading, or unfair.

PAR. 10. In the course and conduct of his said business, in conjunction with the other parties named in Paragraph Two, and at all times mentioned herein, respondent has been, and now is, in substantial competition in or affecting commerce with corporations, firms and individuals engaged in the sale of automobile retrofit devices.

PAR. 11. The use by respondent, in conjunction with the other parties named in Paragraph Two, of the aforesaid unfair or deceptive representations and the dissemination of the aforesaid false advertisements has had, and now has, the capacity and tendency to mislead members of the consuming public into the erroneous and mistaken belief that said representations were and are true and into the purchase of substantial quantities of products sold by respondent, in conjunction with the other parties named in Paragraph Two, by reason of said erroneous and mistaken belief.

PAR. 12. The aforesaid acts and practices of respondent, as herein alleged, including the dissemination of the aforesaid false advertisements, were and are all to the prejudice and injury of the public and of respondent's competitors, and constituted and now constitute, unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce, in violation of Section 5 of the Federal Trade Commission Act.

Ex. A



Ex. B

Copy of ad published 5/19/78 Valley News

SPEC 2

Now! Transform air into fuel and increase your mileage up to 28%*!

lon, up to 220 gallons a year—all of which could save you up to $150 each year! Fill up 3 times a month instead of 4—with a space-age discovery that pays for itself—your 3rd tankful of gas!

MORE MILEAGE, LESS GAS

Yes!

COL. GORDON COOPER

LOOK HOW SIMPLE IT IS TO INSTALL

HOW DOES THE G.R. VALVE® WORK?

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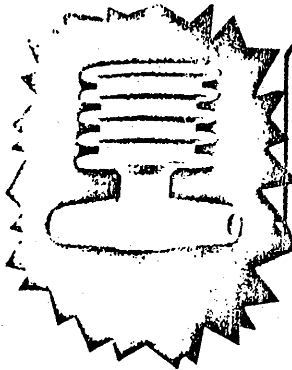
Ex. C



It Really Works!

THIS AMAZING DEVICE CAN INCREASE YOUR GAS MILEAGE *UP TO 8 MILES PER GALLON!*

Says GORDON COOPER, Gemini Astronaut

Yes! Save Gas by the Gallon!

Make Your Car Run Better Too!

New Gas Saver Slips On in Minutes!

If there's one thing an astronaut has no use for, it's a new invention that doesn't do what it's supposed to do! That's why we asked astronaut Gordon Cooper to test the G-R GAS SAVER VALVE in his independent engineering laboratory. Here's what Gordon Cooper told us the G-R GAS SAVER VALVE would do for any carbureted automobile:

* INCREASE GAS MILEAGE -- UP TO 28% MORE!
* ACTUALLY IMPROVE ENGINE PERFORMANCE AT THE SAME TIME!
* CLEAN THE ENGINE OF CRIPPLING CARBON DEPOSITS WHILE DRIVING!
* REDUCE SMOG EMISSIONS MEASURABLY!

Impressive results? Definitely. But we are particularly fussy about our cars. So, Mr. Cooper's results not withstanding, we went to the Dept. of Industrial Education at Loma Linda University and gave them a dozen or so G-R GAS SAVER VALVES. We asked them to test this new

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invention in city and highway driving -- use it on different kinds of cars, big and small -- even trucks -- and report the conclusions, good or bad. Here's what the Loma Linda University tests confirmed about the G-R GAS SAVER VALVE:

* It Cuts Gas Consumption in Every Car Tested -- Up to 28%!
* It Makes the Engine Run More Efficiently!
* It Reduces Polluting Exhaust Emissions as Much as 50%!

Then reports came back from our own "seat of the pants" test. That's where ordinary drivers like you and me pop a G-R GAS SAVER VALVE into their car and record the results for themselves.
For example:

> "...on my Pontiac Le Mans...mileage increased from 10 to 27.2...the improvement is phenomenal."
>
> -Mr. F. v. S.
> Newbury Park, Calif.

> "...on my Volkswagen Bus, it's mileage increased from 18 to 23 miles per gallon...also have better start in the morning."
>
> -Mr. Otto Geller,
> President, Volkswagen Club of America
> Ventura, Calif.

We found that a 1966 GMC 66-passenger school bus got 40% better gas mileage! A pickup truck with camper got 38.2% better mileage! A 1973 Ford got 28.7% better mileage! And so it went. Everybody we heard from reported a significant increase in gas mileage and often a noticeable improvement in performance the moment they snapped the G-R GAS SAVER VALVE on their car!

SLIP IT IN PLACE YOURSELF...IN SECONDS!

By now we were thoroughly convinced that there really was an exciting and easy way to save big money at the gas pump. We wanted a G-R GAS SAVER VALVE on every company car as fast as possible! But we still wondered if installing this fascinating money saver was as simple as it was cracked up to be. Instead of going to a mechanic we handed the

device and its simple instructions to three people:

1. A young lady who is so mechanically minded she really needed help opening the hood.
2. A self-admitted fumble-fingers copy chief who shies away from a pair of pliers.
3. A guy who spends his weekends tinkering with the innards of his imported English sports car.

Care to guess the outcome of the race?

> Frankly, it was a dead heat! (Subtracting the time it took the young lady to get the hood open). Mechanical skill just isn't required! Nearly everybody can follow the one-two-three step instructions and be saving gas by the gallon in minutes! (Susan Cooper, Gordon's lovely wife, popped a G-R GAS SAVER VALVE into her '74 Vega in a mere 30 seconds!)

BUY THOSE SPECIAL THINGS YOU WANT WITH WHAT YOU SAVE ON GAS!

Now, instead of spiraling gasoline prices stealing money from your pocket (even on short trips), you'll put the brakes to this money drain! You'll do it effortlessly in minutes -- and your insatiably thirsty carburetor will be under control at last! Certainly we all have plenty of things to do with our hard-earned money and pouring it into the gas tank isn't one of them!

FEEL YOUR ENGINE RUN BETTER - AND CLEAN ITSELF TOO!

The G-R GAS SAVER VALVE makes your carburetor work with optimum efficiency AT ALL SPEEDS. (Most carburetors are really efficient only at about 35 mph.) It makes your carburetor breathe freely, perfectly mixing, with almost computer accuracy, the precise ratio of gas and air needed at any given split second. Not a drop more gas than necessary -- just all you really need and no more. Better yet, the G-R GAS SAVER VALVE

makes your engine run so right that many exhaust fumes which used to pollute the air around your car are now re-burned as valuable fuel!

ORDER NOW ON OUR UNCONDITIONAL MONEY-BACK GUARANTEE!

We want you to put a G-R GAS SAVER VALVE on your car right away -- before you spend another unnecessary dollar for gas your car is now consuming ravenously.

We want to prove that Gordon Cooper's laboratory results, the special investigation by the staff at Loma Linda University and our own results are everything we say they are. Use the order form below...and if for any reason you don't agree -- enthusiastically, wholeheartedly -- that the G-R GAS SAVER VALVE is the best idea you've ever seen for your car, send it back for refund, no questions asked. Try it for two weeks; then if you're not convinced return it. The G-R GAS SAVER VALVE costs $15.95. You'll be amazed how fast it will pay for itself -- and start putting money back into your pocket!

HAPPY CUSTOMERS WRITE...

"I have a 1977 Malibu Classic Station Wagon which I use for work. I was getting an average of 11.9 miles per gallon . . . since the installation of the G-R Valve I am getting an average of 15.4 miles per gallon . . . I am a very cautious man about pushing or praising any item before I know from my own personal use that it works. I must say that I would advise everyone. . . to use the new G-R Valve, plus I feel my car's performance has increased."

Mr. T. M.
Compton, Calif.

"In my capacity as Sales Manager I drive several hundred miles per week. My work car is a 1968 Ford Galaxy. Last May I installed a G-R Valve, increasing the mileage from 15.2 to 19.8 m.p.g."

Mr. W. S.
Santa Monica, Calif.

"I installed one of your gas savers on my '74 Continental Mark IV in December. Since that time I have averaged at least 2¼ miles per gallon more than before."

Mr. D. A.
Tarzana, Calif.

ORDER FOR EVERY CAR IN YOUR FAMILY!

ORDER FORM

C. I. ENERGY DEVELOPMENT, INC.
18346 VENTURA BOULEVARD
TARZANA, CALIFORNIA 91356

Gentlemen: Send me ____ G-R GAS SAVER VALVES @ $15.95 each. I enclose $______ in ( ) Cash ( ) Check ( ) M.O. in full payment.

( ) Send my order COD. I enclose 20% deposit. (Sorry, no COD's outside the Continental USA).

ACCT. NO. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Exp. Date: Mo.☐☐ Yr.☐☐

INTERBANK NO. Mastercharge Only ☐☐☐☐ (The number over your Name)

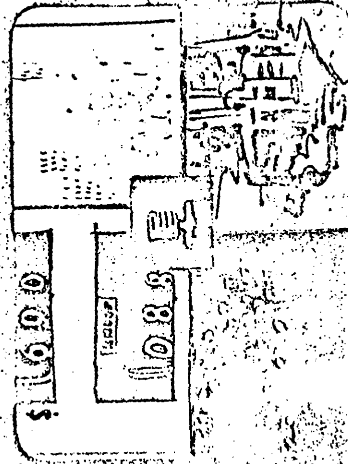
SIGNATURE ____________________

NAME ____________________

ADDRESS ____________________

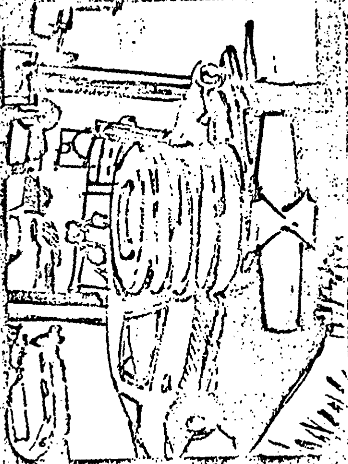
CITY ____________ STATE _____ ZIP _____

Ex. D (A frames only)



IN THESE DAYS OF RISING GAS PRICES
AND REDUCED AUTOMOTIVE PERFORMANCE,
WE INTRODUCE THE G.R. VALVE.

19 1A/B

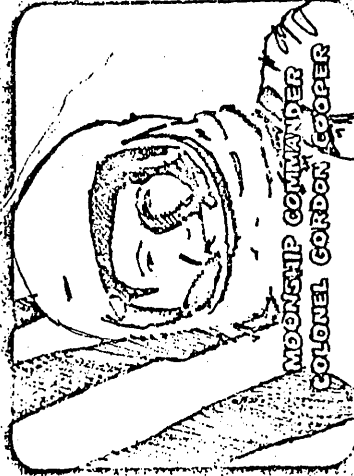


TO PUT THE GRRRRRR IN YOUR CAR. CARS
TESTED WITH G.R. VALVES IMPROVE THEIR
GAS MILEAGE

2A/B

3A/B

SPEC 2



AND IT'S A FACT: THE G.E. VALVE IS A
GO SYSTEM.

4A

UP TO 28%

3A/B

SPEC 2
2d

UP TO 28% MORE MILEAGE

7 cars tested a leading California university ranged in mileage increases of 14% to 28%

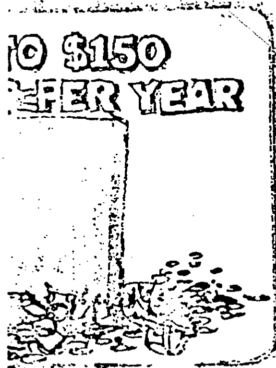
THAT'S RIGHT. GET UP TO 28% MORE MILEAGE

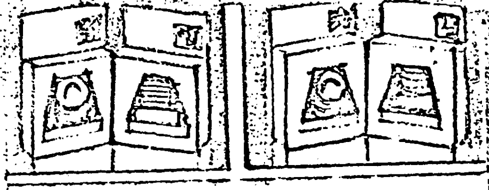
4B

UP TO $150 SAVINGS PER YEAR

AND SAVE UP TO $150 DOLLARS PER YEAR

5B





$150 DOLLARS PER YEAR

Ex. E

ALEXANDER HAMILTON CO., LTD.
[illegible] Shoreham Drive
West Hollywood, CA 90069
(213) 652-2396

SAM NASSI CO.
G.R. Valve
One Minute Commercial TV

VIDEO	AUDIO
OPEN CU GORDON COOPER	1. Hi, I'm Gordon Cooper. As you may know I was selected to be one of the first
SLOW ZOOM OUT TO SEE WOMAN IN THE BG WORKING ON A CAR.	2. astronauts to explore space due to my extensive engineering background. At the present time I'm actively heading my own engineering company, where we are
HE HOLDS UP G.R. VALVE, DOESN'T GESTURE TO IT....	engaged in the design and testing of products for industry.
AS HE DOES GESTURE TO VALVE CUT TO XCU VALVE HELD IN HIS HAND.	4. The G.R. VALVE I am holding has been tested and retested by leading independent laboratories
CUT TO CU 2/SHOT, COOPER'S FACE AND VALVE....	5. along with my own tests. And it's a fact....this G.R. Valve will increase
DISS. TO ROLLING FOOTAGE, CAR DRIVING DOWN PRETTY ROAD, PROFILE	6. your auto mileage
SUPER "INCREASE AUTO MILEAGE UP TO 28%"	7. up to twenty eight per cent....
CHANGE SUPER TO "IMPROVE PERFORMANCE" AND WIDEN SHOT ALLOWING CAR TO PULL AHEAD INTO A 3/4 REAR TO FRONT SHOT.....	8. improve your car's performance,
CHANGE SUPER TO "CLEAN YOUR ENGINE"	9. clean your engine.....
LET CAR PULL IN FRONT AND ZOOM IN ON MCU TAIL PIPE FEATURING LACK OF SMOKE, CHANGE SUPER TO "REDUCE SMOG EMISSIONS & ENGINE WEAR".	10. AND reduce smog emissions [illegible]r.
CUT BACK TO COOPER, MCU HOLDING VALVE (IN PACKAGE)	11. In short, the G.R. VALVE will save you money...and save precious fuel...while helping to clean the air for everyone.

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Complaint

SLOW ZOOM TO CU COOPER	12. Before I say a system is "go" I check it and recheck it...and the G.R. VALVE is a "go" system.
COOPER STEPS OUT OF SHOT. RACK FOCUS TO MLS SUSAN COOPER JUST CLOSING THE HOOD ON HER CAR, SHE TURNS TOWARD CAMERA A SMILES A SELF SATISFIED SMILE AS WE ZOOM MCU......	13. In the time I've taken to tell you abc about this important technological breakthrough, XXXXXXXXXXXX
COOPER WALKS INTO SHOT, PUT ARM AROUND WIFE....PUTS G.R. VALVE PACKAGE ON HOOD OF CAR....XXXX XXXXXXXXXXXXX	14. My wife Susan installed
CUT TO XCU PACKAGE ON HOOD OF CAR & HOLD	15. the G.R. VALVE on her car.
HOLD ON END SHOT, EXCU PACKAGE FOR LIVE SLIDE SUPER AT STATION	16. STATION ANNCR., VO.: TAG FOR LOCAL X STORES.

Ex. F

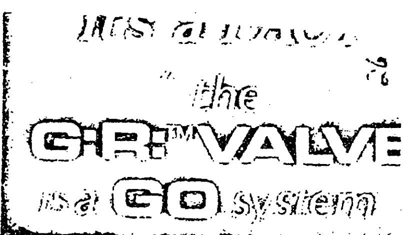
ADVERTISEMENT ADVERTISEMENT ADVERTISEMENT

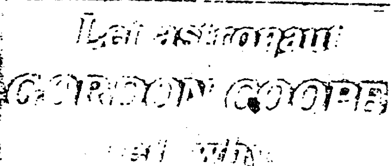
ASTRONAUT GORDON COOPER ANNOUNCES:

Now! CONVERT AIR INTO ENERGY— EXPLODE IT LIKE FUEL—and GET up to 7 MORE MILES PER GALLON!

Yes, save up to $18 a month, save up to 350 gallons of gas each year, save up to 2 full gallons every 60 minutes you drive — ALL FREE — because air costs you not one single penny!

National Enquirer. JTD-58 25





TECHNICAL DESCRIPTION

The G:R: VALVE is a precision engineered air induction valve which fits into the hose between the PCV valve and the carburetor. It is automatically controlled by the amount of vacuum produced by the engine under varying speeds and loads. The ideal mixture of air-to-fuel in an automobile engine is approximately 15.1. However, most normal carburetors are unable to provide this ideal mixture at all times. Normal carburetors are set when in the idle position with the correct mixture. This is efficient only until about 2000 rpm. Under acceleration, heavy loads and grades, this efficiency is lost because there is not enough air to properly mix with the added fuel being pumped into the combustion chamber. The G:R: VALVE is precision calibrated to help remedy this situation by shutting down when the mixture is correct and opening up when the mixture is air-starved. Its valve action is controlled by the constantly changing vacuum in the PCV hose as the engine makes it demands for air. An added feature of the G:R: VALVE is the re-energizing of dead gases as they return to the carburetor from the crankcase. As the PCV valve releases these gases, they are mixed with oxygen in the G:R: VALVE, thus making these gases a combustible fuel. Since the G:R: VALVE works in perfect harmony with the engine, carburetor and smog device, **THERE ARE ABSOLUTELY NO TUNING ADJUSTMENTS TO MAKE.** Since it is always working to provide the correct (not lean) air-to-fuel mixture, **IT CANNOT DAMAGE YOUR ENGINE IN ANY WAY.** On the contrary, it will give it cleaner, longer-lasting life. That is why the G:R: VALVE is covered with full product liability insurance.

(Typical Responses on File From Satisfied Customers)

	Miles Per Gallon		Percent Increase
	Without G:R:V	With G:R:V	
1972 V.W. BUS	18	to 23	27.78%
1974 MARK IV CONTINENTAL	10	to 12.25	22.5%
1973 FORD	10.1	to 13.0	28.7%
1966 C.C. SCHOOL BUS (66 passenger)	4.0	to 5.6	40%%
1972 DODGE	15.8	to 18.5	17.1%
1966 CHEVROLET PICK-UP WITH CAMPER	11	to 15.2	38.2%

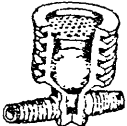
COMPARE THE G:R: VALVE

Similar devices are on the market, but the G:R: Valve operates on the time-proven, durable, trouble-free principle of the spring loaded ball-and-seat. Unlike "poppet" or "reed" type valves, the ball and seat has these distinct features:

* Continuous positive seating because the ball will always adjust to its seat.
* Self-cleaning action due to the constant rotation of the ball in its seat.

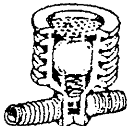
Look at the diagrams below and BUY THE VERY BEST for your car.

VALVE CLOSED



AT IDLING AND UP TO 35 MPH

VALVE OPEN



OVER 35 MPH

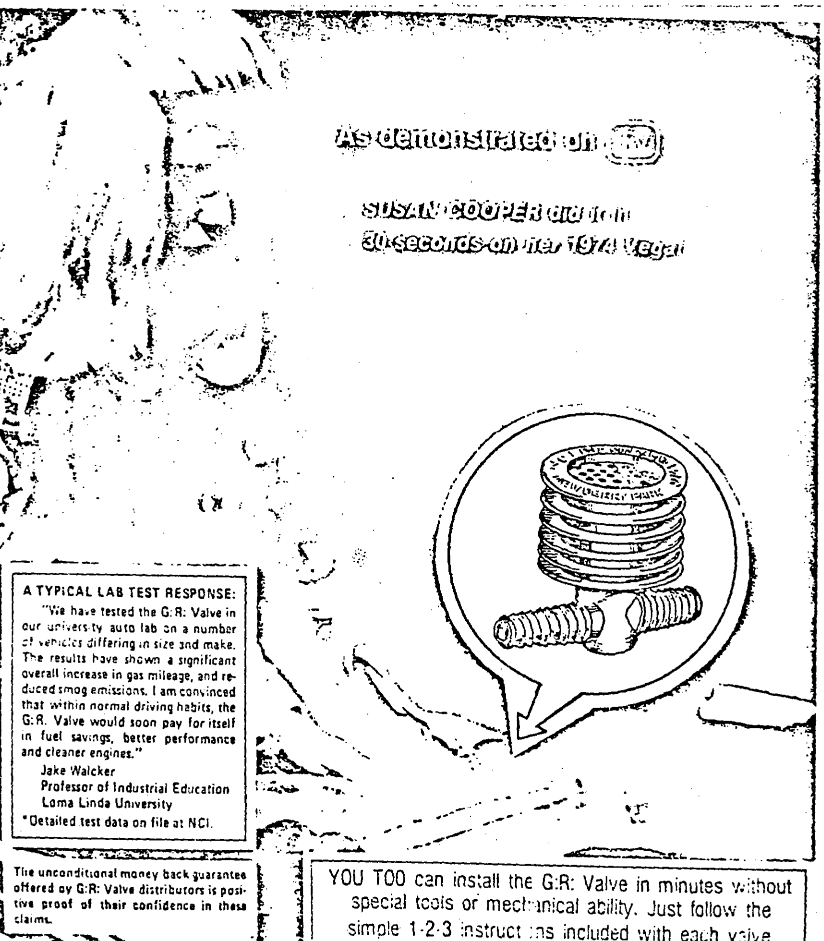
100% UNCONDITIONAL MONEY-BACK GUARANTEE

NCI guarantees that with proper installation of the G:R: VALVE . . . your automobile will result in instant improvement of engine performance and significant improvement in fuel economy. If, for any reason, you are not fully satisfied with the performance of the device after installation, return the G:R: VALVE to the dealer from whom it was purchased within 30 days and the full price will be cheerfully refunded.

N C Industries
Dan Norman, President

Pursuant to Executive Order O-31, the G:R: VALVE may be legally installed on 1974 and older vehicles in California in accordance with the provisions of Vehicle Code 27156, with the exception of VW, diesel, fuel injection or supercharged engine vehicle.

© 1974 N C INDUSTRIES PO BOX [illegible]



the facts are...

1. THE G:R: VALVE SAVES MONEY by giving your car, boat, truck, or motor home up to 8 more miles per gallon. That could mean a savings of up to 30¢ per gallon of gasoline. In a year this could amount to several hundred dollars, depending on how much you drive.

2. THE G:R: VALVE IMPROVES PERFORMANCE by allowing additional air to reach your engine only when it is needed. Most normal carburetors cannot meet the entire range of engine demands for air, so they are set for idle and speeds under 35 mph. This means your engine is air-starved when accelerating, climbing hills and pulling loads, but your car can reach its full horsepower every time you "step-on-it."

3. THE G:R: VALVE FIGHTS POLLUTION by insuring a more complete combustion of gasoline elements. It also re-energizes particles from the smog device so they can be burned. We call this process "Gas Re-energizing" (G:R:). Smog tests* have shown you can expect up to 50% decrease in air pollutants with this device on your present car.

4. THE G:R: VALVE INCREASES ENGINE LIFE by reducing the amount of carbon build up on valves and pistons. When gasoline burns more efficiently, it leaves less harmful by-products to clog and wear out your engine.

*Tests conducted at Loma Lindá University at engine idle utilitizing Marquette Exhaust Gas Analyzer: 42-151 Infra Red tube, used in testing exhaust emissions.

Ex. H

REVOLUTIONARY • SPACE AGE • GAS SAVER

OR HOW TO ATTRACT THOUSANDS OF NEW, SATISFIED CUSTOMERS TO YOUR STORE: INCREASE YOUR SALES AND PROFIT!

LET GEMINI ASTRONAUT GORDON COOPER GIVE YOU THE FACTS...

"IT'S A FACT! The G•R Valve gives you up to 8 more miles per gallon"
GAS MILEAGE INCREASE UP TO 28% — GEMINI ASTRONAUT GORDON COOPER

"IT'S A FACT!—INCREASES MILEAGE UP TO 8 MILES PER GALLON."

ASTRONAUT GORDON COOPER

Data compiled by independent research on the G•R Valve provide the following proof of increased gas miles per gallon:

LOMA LINDA UNIVERSITY
DEPARTMENT OF INDUSTRIAL EDUCATION

Auto Make Year Engine Size	Type of Driving	Carbon Monoxide in Percent: Without G•R Valve	Carbon Monoxide in Percent: With G•R Valve	Hydrocarbon in parts-million: Without G•R Valve	Hydrocarbon in parts-million: With G•R Valve	Mileage difference: Without G•R Valve		Mileage difference: With G•R Valve	Percent Change in gas mileage
Ford 1971 351 V8	City	0 9	0 7	160	120	14 1	to	16 1	14 18
Ford 1973	Freeway	3 0	2 8	100	80	10.1	to	13 0	28 71
Buick 1964 300 V8	City	7.8	5 3	280	200	13.0	to	15 5	18 23
Pontiac 1967	city	2 8	2 2	260	220	12.1	to	14 2	17 36

Marquette Exhaust Gas Analyser model 42 151 Infra Red Tube used in testing exhaust emmissions Note PCV Valve not changed as recommended

We have tested the G•R Valve on a number of vehicles differing in size and make The results on the whole are very favorable in both better mileage and also cleaner burning

Our tests indicate that within the normal driving habit the G•R Valve is a safe device and would soon pay for itself in fuel savings including other benefits, such as cleaner engines, noticeable increase in power, etc

Persons in charge of tests

Jake Jakleder

How can this $15.99 valve save hundreds of dollars a year on each car or truck?

The G•R Valve is a precision engineered regulator that is installed into the hose between the PCV Valve and the carburetor. It operates automatically by the amount of vacuum produced by the engine under varying speeds and loads.

The G•R Valve contains a calibrated spring and rotating self-cleaning ball that seats and remains closed at idling and up to 35 mph. It actually shuts off when air/fuel mixture is correct and opens when this mixture is air starved. The unit opens only sufficiently to give the proper fuel/air ratio.

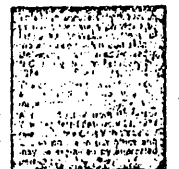
The G•R Valve also re-energizes the unburned fuel from the crankcase through the PCV Valve to the carburetor. The G•R Valve mixes air with the unburned fuel creating a combustible mixture that flows into the carburetor.

The G•R Valve is always operating to provide the proper air/fuel mixture based on RPM and engine load. This metering action saves gas and adds mileage.

The G•R Valve has been tested and retested by leading independent laboratories along with my own tests. And, it's a fact... this G•R Valve will increase your auto mileage up to 28 per cent — improve your car's performance — clean your engine and reduce smog emissions. In short, the G•R Valve will save money... and save precious fuel while helping to clean the air for everyone. Before I say a system is go I check it and recheck it... and the G•R Valve is a go system.

Gordon Cooper

FITS ANY CARE OR TRUCK
(except Diesel, Fuel Injection, Supercharged)
Takes 2 minutes to install.



SOLD WITH UNCONDITIONAL MONEY BACK GUARANTEE

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CHAIN STORE AGE, General Merchandise Edition, September 1977

28 ①

DECISION AND ORDER

The Federal Trade Commission having initiated an investigation of certain acts and practices of the respondent named in the caption hereof, and the respondent having been furnished thereafter with a copy of a draft of complaint which the Bureau proposed to present to the Commission for its consideration and which, if issued by the Commission, would charge respondent with violations of the Federal Trade Commission Act; and

The respondent and counsel for the Commission having thereafter executed an agreement containing a consent order, an admission by the respondent of all the jurisdictional facts set forth in the aforesaid draft of complaint, a statement that the signing of such agreement is for settlement purposes only and does not constitute an admission by respondent that the law has been violated as alleged in such complaint, and waivers and other provisions as required by the Commission's Rules; and

The Commission having thereafter considered the matter and having determined that it had reason to believe that the respondent has violated the said Act, and that complaint should issue stating its charges in that respect, and having thereupon accepted the executed consent agreement and placed such agreement on the public record for a period of sixty (60) days, now in further conformity with the procedure prescribed in Section 2.34 of its Rules, the Commission hereby issues its complaint, makes the following jurisdictional findings, and enters the following order:

1. Respondent Gordon Cooper is an individual whose address is 5011 Woodley Ave., Encino, California.

2. The Federal Trade Commission has jurisdiction of the subject matter of this proceeding and of the respondent, and the proceeding is in the public interest.

ORDER

PART I

It is ordered, That respondent Gordon Cooper, an individual, his agents, representatives, employees, successors and assigns, either jointly or individually, directly or through any corporation, subsidiary, division, or other device, in connection with the advertising, offering for sale, sale or distribution of the automobile retrofit device, variously known as the G.R. Valve, the Turbo-Dyne Energy Chamber, and by other names, or of any other automobile retrofit device, as "automobile retrofit device" is defined in §301 of the

Energy Policy and Conservation Act of 1975, 15 U.S.C. 2011, having substantially similar properties, in or affecting commerce as "commerce" is defined in the Federal Trade Commission Act, do forthwith cease and desist from representing, directly or by implication, that the automobile retrofit device variously known as the G.R. Valve, the Turbo-Dyne Energy Chamber, and by other names, or any other automobile retrofit device having substantially similar properties, will or may result in fuel economy improvement when installed in an automobile, truck, recreational vehicle, or other motor vehicle.

Part II

It is further ordered, That respondent, his agents, representatives, employees, successors and assigns, either jointly or individually, directly or through any corporation, subsidiary, division, or other device, in connection with the advertising, offering for sale, sale or distribution of any automobile retrofit device as "automobile retrofit device" is defined in §301 of the Energy Policy and Conservation Act of 1975, 15 U.S.C. 2011, in or affecting commerce as "commerce" is defined in the Federal Trade Commission Act, do forthwith cease and desist from representing, directly or by implication, that such device will or may result in fuel economy improvement when installed in an automobile, truck, recreational vehicle, or other motor vehicle unless (1) such representation is true, and (2) at the time of making such representation, respondent possesses and relies upon written results of dynamometer testing of such device according to the then current urban and highway driving test cycles established by an agency or department of the United States government and these results substantiate such representation, and (3) where the representation of the fuel economy improvement is expressed in miles per gallon or percentage, all advertising and other sales promotional materials which contain the representation expressed in such a way must also contain, in a way that clearly and conspicuously discloses it, the following disclaimer: "REMINDER: Your actual fuel saving may be less. It depends on the kind of driving you do, how you drive and the condition of your car."

Part III

It is further ordered, That respondent, his agents, representatives, employees, successors and assigns, either jointly or individually, directly or through any corporation, subsidiary, division, or other device, in connection with the advertising, offering for sale, sale or distribution of any product or service in or affecting commerce as

"commerce" is defined in the Federal Trade Commission Act, do forthwith cease and desist from:

a. representing, directly or by implication, that an endorser of such product or service has expertise in a field of knowledge unless the endorser has the education, training, and knowledge necessary to be qualified as an expert in that field;

b. using, publishing, or referring to any testimonial or endorsement from any person or organization for such product or service unless, within the twelve (12) months immediately preceding any such use, publication or reference, respondent has obtained from that person or organization an express written and dated authorization for such use, publication, or reference;

c. failing to disclose a material connection, where one exists, between an endorser of such product or service and respondent. A "material" connection shall mean, for purposes of this order, any direct or indirect economic interest in the sale of the product or service which is the subject of this endorsement other than (1) a fixed sum payment for the endorsement, all of which is paid before any advertisement containing the endorsement is disseminated, or (2) payment for the endorsement which is directly related to the extent of the dissemination of advertising containing it;

d. representing, directly or by implication, any performance characteristic of such product or service unless (1) at the time of making the representation, respondent possessed and relied upon competent and reliable scientific tests substantiating the representation, and (2) respondent possesses a written test report which describes both test procedures and test results. A competent and reliable "scientific test" is one in which one or more persons, qualified by professional training, education and experience, formulate and conduct a test and evaluate its results in an objective manner using testing procedures which are generally accepted in the profession to attain valid and reliable results. The test may be conducted or approved by (a) a reputable and reliable organization which conducts such tests as one of its principal functions, (b) an agency or department of the government of the United States, or (c) persons employed or retained by respondent if they are qualified (as defined above in this paragraph) and conduct and evaluate the test in an objective manner;

e. misrepresenting in any manner the purpose, content, or conclusion of any test or survey pertaining to such product or service;

f. misrepresenting in any manner either consumer preference for

such product or service or the results obtained by consumer usage of such product or service;

g. misrepresenting in any manner the performance, efficacy, capacity, or usefulness of such product or service.

PART IV

It is further ordered, That respondent, his agents, representatives, employees, successors and assigns, either jointly or individually, directly or through any corporation, subsidiary, division or other device in connection with the advertising, offering for sale, distribution or sale of any product or service in or affecting commerce, as "commerce" is defined in the Federal Trade Commission Act, do forthwith cease and desist from:

1. Providing an endorsement which relates directly or by implication to the performance or efficacy of such product or service, or which refers to any characteristic, property, use, or result of use of such product or service, unless:

a. when respondent's endorsement pertains to subject matter falling within respondent's area of expertise, at the time of the first dissemination of such endorsement, respondent possesses and relies upon competent and reliable scientific evidence to substantiate any representation made directly or by implication in the endorsement, or

b. in all other cases, at the time of the first dissemination of such endorsement, respondent has made a reasonable inquiry into the truthfulness of his endorsement, and possesses and relies upon information resulting from such inquiry which substantiates any representation made directly or by implication in the endorsement. "Reasonable inquiry" shall be defined as follows:

(1) obtaining information from at least two competent and reliable sources independent of the advertiser and any other party with an economic interest in the sale of the product or service which is the subject of the endorsement; or

(2) obtaining information from the advertiser or from other parties with an economic interest in the product or service which is the subject of the endorsement and having such information independently evaluated by at least two competent and reliable sources.

2. Failing to disclose a material connection, where one exists, between an endorser of such product or service and its advertiser(s). A "material" connection shall mean, for purposes of this order, any direct or indirect economic interest in the sale of the product or

service which is the subject of this endorsement other than (1) a fixed sum payment for the endorsement all of which is paid before any advertisement containing the endorsement is disseminated, or (2) payment for the endorsement which is directly related to the extent of the dissemination of advertising containing it.

PART V

It is further ordered, That respondent, his agents, representatives, employees, successors and assigns, either jointly or individually, directly or through any corporation, subsidiary, division, or other device, in connection with the advertising, offering for sale, sale or distribution of any product or service in or affecting commerce, as "commerce" is defined in the Federal Trade Commission Act, do forthwith cease and desist from failing to maintain the following accurate records which may be inspected by Commission staff members upon fifteen (15) days' notice: copies of and dissemination schedules for all advertisements, sales promotional materials, and post-purchase materials; documents authorizing use, publication, or reference to testimonials or endorsements; documents which substantiate or which contradict any claim which is a part of the advertising, sales promotional material, or post-purchase materials disseminated by respondent directly or through any business entity. Such records shall be retained by respondent for a period of three (3) years from the last date any such advertising, sales promotional, or post-purchase materials were disseminated.

PART VI

It is further ordered, That respondent promptly notify the Commission of the discontinuance of his present business or employment. In addition, for a period of ten years from the effective date of this order, the respondent shall promptly notify the Commission of each affiliation with a new business or employment where he is responsible, directly or, by his delegation, through any employee or agent, for the dissemination or approval of any advertising claim relating to any product or service. Each such notice shall include the respondent's new business address and a statement of the nature of the business or employment in which the respondent is newly engaged as well as a description of respondent's duties and responsibilities in connection with the business or employment. The terms of this paragraph shall not affect any other obligation arising under this order.

Part VII

It is further ordered, That the respondent shall within sixty (60) days after service upon him of this order file with the Commission a report, in writing, setting forth in detail the manner and form in which he has complied with this order.

IN THE MATTER OF

HASTINGS MANUFACTURING COMPANY

Docket 4437 ...rlocutc ...rder, Oct. 12, 1979

ORDER DENYING F ... UCTION OF

On September 6 ...
ings Manufactur ... o
rebrief certain ... his
proceeding. On ... an
order directir ... nents
purportedly bear ... . The
Commission's F ... discov-
ery in conne ... whether
to reopen ... F.R. 40635,
40637 (J ... cluded that
the disco... ... elay, without
materially assis... of whether to
reopen this proceeding.

Respondent's arguments re... ights under the
Freedom of Information Act ... are not properly
presented to the Commission ... motion. However,
the Commission notes that it ... will be ruling shortly
on respondent's separate ... ation Act appeal in
accordance with Rule 4 ... ommission's Rules of
Practice (16 CFR 4.11(a)(...

It is ordered That res... lanufacturing Company's
motion for discovery b...

[1] If the Commission decides to ... will conduct any necessary evidentiary hearing
in accordance with Rule 3.72(b)(2) o... 0635, 40637 (July 12, 1979).

[2] Compulsory discovery was likewise ... predecessor rule, 16 CFR 3.72(b)(2)(1979), prior to
a Commission decision to conduct a new e...

In the Matter of

THE AMERICAN MEDICAL ASSOCIATION, ET AL.

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

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

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

Appearances

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

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

Complaint

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PAR. 7. Respondents and others have:

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

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

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

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

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

APRIL 18, 1979

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Initial Decision by Ernest G. Barnes, Administrative Law Judge

Nov. 13, 1978

Preliminary Statement

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

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

[4] *Id.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Continued)

FINDINGS OF FACT

I. DESCRIPTION OF RESPONDENTS AND THEIR STRUCTURAL INTERRELATIONSHIPS

A. American Medical Association

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

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

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

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

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

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

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

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

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

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

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

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

B. Connecticut State Medical Society

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

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

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

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

C. New Haven County Medical Association, Inc.

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

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

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

D. Commerce

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

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

The United States mail has been used by CSMS and NHCMA in corresponding with AMA and others, including specific applications of AMA's restrictions on advertising and solicitation (CX 78B, 673, 781, 783, 785; CSMS and NHCMA Adm. 20(b), (d), filed June 20, 977), and in obtaining from AMA and distributing to their members opies of, or excerpts from, AMA's Principles of Medical Ethics and [11] interpretations thereof (CX 202-19, 221, 1748, 1787; CSMS and HCMA Adm. 19(c), (d), filed June 20, 1977). Also, delegates, ecutives, members and employees of CSMS and NHCMA attend MA conventions and conferences outside Connecticut, including nventions of AMA's House of Delegates at which AMA's Principles Medical Ethics, and interpretations thereof, are adopted, amend-

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

II. ACTIVITIES OF AMERICAN MEDICAL ASSOCIATION

A. Background

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

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

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

B. Educational Activities

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

The Division of Medical Education Evaluation, which is concern

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Scientific Activities

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

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

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

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

(c) *The Department of Environmental, Public and Occupational Health* provides the medical profession and the general public with information on environmental and occupational health problems (Tr. 4417). The AMA works with the Public Health Service and the National Center for Disease Control and has sponsored publicity efforts and television advertising to inform the general public of immunization campaigns (Tr. 4418). In the area of environmental health, the AMA publishes a number of brochures dealing with such topics as air pollution (RX 81), water pollution (RX 82) and noise pollution (RX 83), and has sponsored a series of conferences on various environmental matters, some of which have been published in book form (Tr. 4419; RX 84, 85, 86). The conferences are open to anyone who wishes to attend; AMA members receive no price discount in purchasing the various brochures and publications (Tr. 4420). In the field of occupational health, the AMA authors a number of publications, dealing with topics ranging from airport

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

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

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

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

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

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

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

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

1681). These efforts are directed at AMA and non-AMA members alike (Tr. 4682–83).

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

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

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

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

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

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

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

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

In the automobile safety area, the AMA has helped develop a ies of training films for driver's license examiners, has helped elop the Abbreviated Crash Injury Scale and has collaborated 1 the National Safety Council on subjects such as the efficacy of belts and motorcycle helmets (Tr. 4587–88). In addition, the \ publishes several pamphlets in this area: "Drinking and

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

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

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

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

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

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

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

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

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

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

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

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

The nine specialty journals have the following approximate circulation characteristics:

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

(Tr. 5102–03)

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

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

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

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

D. Public Health Activities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Data Collection and Analysis

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Miscellaneous

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

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

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

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

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

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

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

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

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

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

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

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

G. AMA Education and Research Foundation

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

H. American Medical Political Action Committee

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Organizational Attributes and Acknowledged Benefits to Members

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

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

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

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

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

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

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

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

CX245 D

What's the AMA done for you lately?

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

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

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

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

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

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

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

Drafted and Sponsored

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

Supported

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

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

- Model school health screening programs
- Model emergency medical services programs for the nation's airports
- Pilot nutritional education programs for the poor
- Model drug abuse programs for loca[l] communities
- Innovative rural health care delivery systems
- New approaches to health care deliver[y] for the poor
- Exploration of environmental, occupation[al] health problems and development of sc[ol]utions.
- Distribution of over 10 million pieces [of] health education literature to the publ[ic] schools, and public health agencies
- Investigation and exposure of quacks a[nd] quack products
- Guidelines for comprehensive emerge[ncy] medical care systems, training of am[bu]lance personnel, and categorization [of] hospital emergency care capabilities

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

- As a member of CCME, the AMA par[tici]pates in accreditation of medical sch[ools] and review and certification of intern[ship] and residency programs
- As a member of JCAH, the AMA sh[ares] responsibility for accreditation of h[ospi]tals and other health care facilities [and] services
- Accredits schools and training prog[rams] for allied health personnel
- Assists in the development of conti[nuing] education study programs in every b[ranch] of medicine. Instituted the Physician [Rec]ognition Award
- Participated in development of [...] review committees of medical staffs
- Guardian of medical ethics
- Sponsors or co-sponsors more than [500] meetings and medical and health sessions each year

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[41] B. Efforts to Influence Governmental Action

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

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

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

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

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

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

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

C. Price Controls on Physicians' Fees

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

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

D. Medicare

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

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

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

E. National Health Insurance

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

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

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

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

F. Health Maintenance Organizations

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

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

G. Keogh Act

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

H. Professional Liability Insurance

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

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

I. Relicensure and Continuing Medical Education

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

J. Hospital Cost Containment

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

K. Relative Value Studies

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

L. Allied Health Professionals

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

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

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

M. Professional Standards Review Organizations

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

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

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

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

N. National Health Service Corp.

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

O. Foreign Medical Graduates

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

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

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

P. Miscellaneous Legislation

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

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

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

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

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

Q. American Medical Political Action Committee

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

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

R. AMA's Activity with Third-Party Payers

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

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

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

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

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

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

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

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

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

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

S. Promotion of Hospital Medical Staff Physicians' Economic Interests

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

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

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

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

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

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

T. Litigation

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

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

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

U. Professional Liability Insurance Activities

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

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

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

V. Economic Research

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

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

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

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

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

W. Public Relations

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

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

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

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

X. Negotiations Assistance

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

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

Y. Practice Management

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

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

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

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

Z. Legal Services

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

AMA cosponsors "medicolegal" symposiums on various topics,

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

AA. Miscellaneous Activities

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

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

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

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

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

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

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

BB. Federal Income Tax Status of AMA

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

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

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

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

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

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

A. Identification of the Experts

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

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

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

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

B. The Budget Analysis Approach

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

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

(A) educational, scientific and association maintenance activities (Tr. 6344);
(B) activities resulting in indirect economic benefit (Tr. 6343-44, 6363);
(C) activities resulting in direct economic benefit (Tr. 6344, 6364); and,
(D) Miscellaneous (RX 743, p. 5).

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

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

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

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

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

A_1 Lay Public Education - Activities designed to disseminate public health information, *i.e.*, information on mental retardation, the importance of brushing teeth, etc. (Tr. 6353–54);

A_2 Journals and Scientific Publications - Activities designed to disseminate scientific materials to professionals (Tr. 6354–55);

A_3 Scientific Policy - Activities lending to the formulation of scientific policy (Tr. 6355–56);

A_4 Other Scientific - Scientific activities not falling into the three previous categories (Tr. 6356);

A_5 Data on Physicians and Health Care - Activities relating to the generation and distribution of socioeconomic information about the practice of medicine and the status of public health in the United States (Tr. 6356–57);

A_6 Medical Quality Control and Education - Activities designed to certify that knowledge is correctly taught and mastered (Tr. 6358–59);

A_7 Government Interface - Activities designed to present the views of the medical profession on issues related to the practice of medicine and the public health (Tr. 6359–62); and,

A_8 Organizational Maintenance and Operations - Activities designed to generate and retain members and perpetuate the Association (Tr. 6362). [64]

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

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

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

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

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

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

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

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

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

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

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

The expenditure variables utilized were:

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

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

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

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

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

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

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

C. Evaluation of the Budget Analysis Approach

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Conclusion

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

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

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

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

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

V. ACTIVITIES OF CONNECTICUT STATE MEDICAL SOCIETY

A. Committees and Programs

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

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

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

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

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

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

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

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