Delinquency: The House of Delegates voted to lay over until the next session, a proposed amendment to the *Constitution* to provide that any permanent member who did not pay for the published *Transactions* for three successive years shall be considered as withdrawn. May 1855:52.

Dues Increased: The House of Delegates approved increase in dues from $3 to $5, June 1865:39; May 1866:40; May 1867:42–43; May 1868:42.

Dues Increased: The House of Delegates tabled a resolution recommending an increase in dues from $3 to $6 until a fund of ten thousand dollars is raised, June 1867:47.

Dues Increased: The House of Delegates tabled a resolution recommending an increase in dues from $5 to $10, June 1874:37.

Dues Increased: The House of Delegates amended regulation VI of the *Constitution* to provide for a maximum annual assessment of ten dollars on each of the delegates and permanent members, May 1881:51; May 1884: J.A.M.A. 2:571.

Delinquency: The House of Delegates amended the *Bylaws*, substituting the word *one* for the word *three* so that a permanent member who failed to pay his dues for one year, unless absent from the country shall be dropped from the roll of permanent members, June 1899: J.A.M.A. 32:1339–1340.

Service Members: The House of Delegates amended book I, chapter I, section 1 of the *Bylaws* to provide that commissioned medical officers of the U. S. Army, U. S. Navy, and U. S. Public Health and Marine Hospital Service shall be members and not required to pay annually dues and shall not receive THE JOURNAL unless on personal subscription, June 1906:23.

Allocation for The Journal: The House of Delegates amended chapter I, sections 1 and 4 of the *Bylaws*, substituting in these sections the words *assessment and subscription to The Journal* for the word *dues* and inserted the following new book and chapter, immediately following book IV:

Book V. Assessment and Subscription to THE JOURNAL. Chapter XIV. The annual assessment for membership shall be one dollar; and the price of subscription to THE JOURNAL shall be four dollars for members and five dollars for nonmembers a year, June 1909:49, 51, 52.

Fellowship Created: The House of Delegates approved amendments to the *Constitution and Bylaws* to provide two classifications of membership: (1) membership—any physician joining a county medical society of a constituent state or territorial body "logically becomes a member of the American Medical Association"; (2) Fellowship—members who pay dues for support of THE JOURNAL and the scientific work and the scientific session of this Association, June 1911:40; June 1912:26–27, 45, 46; June 1913:10–11, 38, 50.

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Fellowship Dues Increased: The House of Delegates amended the *Bylaws* to provide an increase in Fellowship dues from $5 to $6 of which not less than $5 shall be credited to a one year subscription to THE JOURNAL. Nov. 1920:1–4.

Regulation by the Board of Trustees: The House of Delegates amended chapter XVII of the *Bylaws* to read as follows, May 1922:12, 39, 40:

The annual Fellowship dues and the subscription price of THE JOURNAL of the American Medical Association shall be fixed by the Board of Trustees, and the same shall be payable in advance, on the first day of January of each year, provided that the annual dues shall not exceed $6, and provided that the amount of the same shall be announced in THE JOURNAL of the American Medical Association not later than November 1 of each year.

Fellowship Dues Increased: The House of Delegates approved a *Bylaws* amendment to provide that annual Fellowship dues should not exceed $8 rather than $6. July 1929:40, 42.

Dues During Depression: For those Fellows who found it impossible to make immediate remittance for Fellowship dues and who promised to pay within a reasonable time, the House of Delegates approved Board action in (1) continuing subscription to THE JOURNAL; (2) keeping names on the Fellowship roster. June 1933:11, 54, 55.

Dues for Service Members: The House of Delegates disapproved revision of the *Constitution and Bylaws* to provide remission of dues for Fellows who were in the military service, "as no member as such pays any dues to the American Medical Association. His membership is contingent on being a member in good standing in his country or district society, and of the dues which he pays to his county and state societies not one cent accrues to the American Medical Association. Only Fellows pay dues, and these dues are largely in payment of the publications to which they may subscribe," June 1942:7, 61, 63.

The House of Delegates rejected a resolution from Wisconsin which urged constituent associations and component societies to consider establishment of some form of dues for their members in service, June 1943:71, 73:

Subscription to The Journal: The House of Delegates amended chapter XII, section 2 of the *Bylaws*, deleting the words *and subscribe to The Journal* and adding the following sentence: *Fellows shall receive The Journal of the American Medical Association*, July 1946:6, 55–56, 56.

Fellowship Dues Increased: The House of Delegates amended the *Bylaws* to provide that annual Fellowship dues should not exceed $12 rather than $8, Jan. 1948:4, 5, 10, 13, 15.

Dues for all Active Members: The House of Delegates approved amendments to the *Constitution and Bylaws* establishing annual dues, not to exceed $25, for all

active members. Chapter II, section 2 of the *Bylaws* as amended by the House of Delegates reads as follows. June 1949:27, 42, 43; Dec. 1949:33, 57, 62, 69, 70, 70–71:

Sec. 2. Dues.—Annual dues, not to exceed $25, may be prescribed for the ensuing calendar year in an amount recommended by the Board of Trustees and approved by the House of Delegates. Each active member shall pay said annual dues to his constituent association for transmittal to the Secretary of the American Medical Association.

Unlimited Dues Assessment: The House of Delegates disapproved a resolution from California proposing an amendment to article XI of the *Constitution* which would provide authority for unlimited dues or assessments by the Association. June 1949:31, 48, 49.

Exemption from Dues: The House of Delegates adopted a resolution from California amended to read as follows. Dec. 1949:75–76:

Resolved, That all members of the medical profession in active practice in the United States in order to maintain membership in the American Medical Association must pay the prescribed dues of the American Medical Association, and that the question of nonpayment of these dues in exceptional circumstances be left to the discretion of the Board of Trustees.

Active Members: The House of Delegates approved recommendation of the Board of Trustees that membership dues be $25 for the year 1951 and amended the *Bylaws* to provide that a subscription to THE JOURNAL shall be included with membership dues. June 1950:6, 40, 50, 51, 60.

Authority to Raise Funds; Exemption: The House of Delegates approved the following amendments to the *Constitution and Bylaws*, June 1950:6, 50, 51; June 1951:29, 30, 34, 34–35, 36:

(1) Amend article XI so that the first sentence reads as follows:
Funds may be raised by equal annual dues or by assessment on each of the active members on recommendation by the Board of Trustees and after approval by the House of Delegates.

(2) Amend division one, chapter II, section 2 to read in part as follows:
Annual dues may be prescribed for the ensuing calendar year in an amount recommended by the Board of Trustees and approved by the House of Delegates. Each active member shall pay said annual dues to the constituent association for transmittal to the Secretary of the American Medical Association. Dues will include subscription to THE JOURNAL of the American Medical Association. The Board of Trustees may excuse a member from payment of dues for the following reasons, provided he is fully or partially excused from the payment of local dues by his component and constituent associations:

(a) Members on whom the payment of dues would work a financial hardship.

This fact must be certified to by the secretary of the member's component society;

(b) Members retired from practice;

(c) Interns and residents during the first five years following graduation except that the time spent in the military service may be excluded in calculating the five-year limit;

(d) A member temporarily in the armed forces. Dues will be remitted and prorated January 1 to July 1 following the date of the member's entrance into military service.

(e) Members over 70 years of age may be excused, on request, from the payment of American Medical Association dues regardless of local dues exemptions . . .

Fellowship Dues: A decision was made not to abolish Fellowship when dues-paying membership was created by action of the House of Delegates in December 1949. The Board of Trustees recommended, and the House approved, that annual Fellowship dues be set at $5, in addition to the $25 paid for membership, June 1950:58, 59, 60; Dec. 1950:7, 64, 65; 44, 67, 68.

The following amendments to the *Bylaws* were approved by the House of Delegates:

(1) Division two, chapter IV, section 2(A) to read as follows:
A Member Fellow shall pay annual Fellowship dues which shall be determined by the Board of Trustees and announced in THE JOURNAL of the American Medical Association. It shall be the privilege of a Member Fellow to subscribe for any other scientific journal published by the Association in lieu of THE JOURNAL of the American Medical Association to which he is entitled as a member.

(2) Division two, chapter IV, section 2(C), last sentence to read as follows:
Affiliate Fellows shall pay Fellowship dues and shall enjoy the privileges of the Scientific Assembly without the right to vote or hold office.

Dues for Active Members: The House of Delegates amended division one, chapter II, section 2, first paragraph of the *Bylaws* to read as follows, Dec. 1950:44, 67, 68:

Sec. 2. Dues.—Annual dues may be prescribed for the ensuing calendar year in an amount recommended by the Board of Trustees and approved by the House of Delegates. Each active member shall pay said annual dues to his constituent association for transmittal to the Secretary of the American Medical Association.

The Board of Trustees may excuse a member from paying dues when it is deemed advisable, provided he is excused from the payment of full dues by his component society and constituent association. Dues shall include subscription to THE JOURNAL of the American Medical Association . . .

Delinquency: The House of Delegates amended chapter II, section 2, second paragraph of the *Bylaws* to read as follows, Dec. 1950:44, 67, 68:

An active member is delinquent if his dues are not paid by December 31 of the year for which dues are prescribed and shall forfeit his active membership in the American Medical Association if he fails to pay the delinquent dues within 30 days after the notice of his delinquency has been mailed by the Secretary of the American Medical Association to his last known address, Dec. 1950:41, 67, 68.

Fellowship Abolished: The House of Delegates amended the *Constitution and Bylaws* to establish a single membership classification, June 1951:26, 27–28, 29, 33, 35; Dec. 1951:8, 85; 58–60, 81; June 1952:25–28, 46, 47, 48–49.

Payment of 1950 Dues: In December 1949, dues were established for active members, and all members of state and county medical associations up to and including 1950 were required to pay 1950 A. M. A. dues in 1951 or any subsequent year. Resolutions were submitted by delegates from Minnesota (June 1951), Texas (June 1951), and Kentucky (Dec. 1951) recommending reconsideration of the action regarding delinquent 1950 dues.

The House of Delegates adopted a substitute for the resolution from Kentucky authorizing the Secretary of the A. M. A. "to negotiate with each state organization separately as to the method of correcting misunderstandings which exist relative to the collection of 1950 dues only."

In December 1953, the House of Delegates adopted the following substitute for a resolution submitted by the Minnesota delegation at the June 1953 session:

Resolved, That any active member of the American Medical Association who failed to pay dues for the year 1950, and who was suspended for such delinquency, may be reinstated during the first six months of 1954 by the payment of 1954 dues only. Should such an individual fail to pay his 1954 dues by July 1, 1954, he shall continue to be considered delinquent, June 1951:24, 29, 39; Dec. 1951:71, 78, 79; June 1953:38, 52, 53; Dec. 1953:9, 95.

Dues for Service Members: The House of Delegates adopted a report of the Board of Trustees which reads in part as follows, Dec. 1950:7, 64, 65:

. . . With respect to the dues paying status of members of the Association who leave their practice for active service with the armed forces, the Board has adopted the policy that members who go into service prior to July 1 of any year need remit only for the first half of the year; that those who enter service after July 1 must remit for the full year but thereafter, while they are in service will not be expected to pay dues and that from 1951 on members who go into service will be regarded as nonpaying members in military service, it being understood that such members will not receive THE JOURNAL.

Exemption From Dues: The House of Delegates adopted the following rules from the Board of Trustees on payment of dues by physicians who are regarded as hardship cases, Dec. 1950:41, 64, 65:

1. If a physician pays only partial dues in his county and state society due to hardship, he will be exempted from payment of American Medical Association dues but will not receive THE JOURNAL; this exemption, however, will not be granted except on written recommendation of the secretary of the county or state society that it would be a hardship on the physician to pay the regular dues.

2. If a physician pays full dues in his county and state society, he must pay full dues in the American Medical Association.

Choice of Journal; Exemption From Dues: The House of Delegates amended the *Bylaws* to provide that members shall have their choice of scientific journal from the Association, and adopted the following amendments relating to exemption from dues:

(1) Chapter II, section 2. Amend the third sentence to read: The Board of Trustees may excuse the following members from payment of dues, provided they are fully or partially excused from the payment of local dues by their component societies and constituent associations.

(2) Chapter II, section 2(D). Amend to read: Dues will be remitted from January 1 or July 1 following the date of the member's entrance into military service, regardless of local dues exemption.

(3) Chapter II, section 2(E). Amend first paragraph of (E) of section 2, chapter II to read: Members may be excused, on request, from the payment of American Medical Association dues, regardless of local dues exemptions, on January 1 following their 70th birthday, Dec. 1951:61, 81, 83.

Exemption From Dues: The House of Delegates adopted the following amendments to the *Bylaws*, June 1953:26, 52, 53:

(1) Revise subsection (A) of section 4, chapter III to read: (A) A member for whom the payment of dues would be a financial hardship, by reason of physical disability or illness. A member may also be excused from payment of dues because of financial hardship for other reasons, but these must be set forth by the secretary of the member's component society.

(2) Revise subsection (D) of section 4, chapter III, to read: (D) A member temporarily in the armed forces may be excused from the payment of American Medical Association dues, regardless of local dues exemption for the period beginning January 1 or July 1 following the date of the member's entrance into military service.

Delinquency: The House of Delegates amended chapter III, section 5, adding the following sentence. Dec. 1953:77, 95, 96:

Members of the American Medical Association who have been dropped from the membership roll for nonpayment of annual dues cannot be reinstated until such indebtedness has been discharged, but such indebtedness shall apply only to the one year of delinquency, provided that the year 1950 shall not constitute a year of indebtedness.

Exemption From Dues: The House of Delegates amended chapter III, section 4 of the *Bylaws*, adding the following new paragraph, Nov.-Dec. 1955:112, 128:

F. Associate members shall not be required to pay membership dues to the American Medical Association and shall not receive any publication of the American Medical Association except by subscription.

Dues Increase: On recommendation that consideration be given to a dues increase for the benefit of the American Medical Education Foundation and for other purposes, the House of Delegates approved supplementary report F of the Board of Trustees which reads as follows, June 1956:10, 22, 64, 71, 72:

. . . In view of the fact that income was in excess of expense for 1955, the Finance Committee feels that it cannot recommend that an increase in dues be proposed to the House of Delegates at this time. However, because of the increased activities being undertaken by the Association's councils, committees, and departments, it is getting more and more difficult to balance the budget and a probable increase in dues must be faced. If the activities of the Association continue to expand over those of the past year, as all trends indicate, either the Association activities will have to be curtailed or the state associations must undertake more of these responsibilities. The Finance Committee recommends that the following action taken by the House of Delegates in June 1955 be reiterated:

Your Reference Committee [on Reports of Board of Trustees and Secretary] is in hearty accord with the suggestion to the House in this and future sessions that each delegate seriously consider organizational, financial, and personnel problems involved when they recommend that a new council or study committee be formed for this or that activity.

Dues Increase: The House of Delegates approved a recommendation that no action be taken on resolution no. 8 from Oklahoma opposing an increase in American Medical Association dues, as no increase in dues is contemplated at this time, June 1956:36.

Delinquency: The Secretary reported "that the delinquency date for suspension of membership in the American Medical Association will be advanced to June 1 in 1957 and that a physician cannot be reinstated for membership in the Association until his dues delinquency for the year in which he was dropped from membership is cleared through his constituent medical association," Nov. 1956:7, 8.

Resident Physicians: The House of Delegates amended chapter III, section 4 (C) of the *Bylaws* to remove the provision limiting the dues exempt status of residents to five years after graduation. To implement this, the words in italics were added and the words in bold face deleted in the following paragraph, June 1958:45; Dec. 1958:106, 107:

Chapter III, section 4. Exemptions

(C) Interns and residents during the first five years following graduation except that the time spent in the military service may be excluded in calculating the five year limit, serving in training programs approved by the Council on Medical Education and Hospitals of the American Medical Association.

ECONOMICS, MEDICAL

See also Incomes, Medical

Bureau of Medical Economics Established: The House of Delegates approved creation of a Bureau of Medical Economics to function under the direction of the Board of Trustees, June 1930:3, 30–31, 33, 34, 35–36, 39, 40.

Expansion of Bureau: On recommendations proposing an increase in funds for the study of medical economic problems, the Board of Trustees reported, and the House approved, that every possible aid had been given to the Bureau of Medical Economics and that as it becomes apparent that more aid is needed, the Board would attempt to provide what is necessary, May 1932:15–18, 46, 48:32–33, 33.

Use of Term "Medical Economics": The delegation from New York introduced a resolution recommending that the term "economics of medical service" replace the term "medical economics" and that in the naming of the Bureau and special committees, the unmodified term "economics" be used.

The House of Delegates recommended continued use of the term "medical economics," June 1933:85, 88.

Principles of Medical Economics: The Bureau of Medical Economics reported preparation of *Introduction to Medical Economics* which "for the first time set forth principles surrounding the economics of the profession and endeavor to differentiate between the economics of industry, commerce and business, and the economics of professional service," June 1934:11, 50.

Relationship to Medical Ethics: The House of Delegates recommended for distribution, a report of the Bureau of Medical Economics entitled *Economics and the Ethics of Medicine*, May 1936:23, 24, 51, 52.

Expansion of Bureau: The House of Delegates approved a resolution from the Section on Radiology which recommended expansion of the Bureau of Medical Economics to accomodate the growing demand among state and county medical associations for help and advice, Sept. 1938:55.

Amalgamation of Bureau With Council on Medical Service and Public Relations. The House of Delegates disapproved reorganization or amalgamation of the Bureau of Medical Economics with the Council on Medical Service and Public Relations, June 1944:58, 75, 85, 86.

who are not specifically employed on a part time basis shall be required to devote their full time to the activities of the Association for which they are employed and shall not engage in outside activities from which they derive financial income." Dec. 1945:62, 73, 74.

Fidelity Insurance: A review of fidelity insurance carried against certain officers and employees of the Association was made by the Board of Trustees to determine the advisability of increasing the amount now carried. The Board reported, and the House approved, that the present arrangements were satisfactory, July 1946:62; Dec. 1946:12.

Bureau of Industrial and Personnel Relations: The Board of Trustees reported establishment of the Bureau of Industrial and Personnel Relations, June 1947: 22, 101, 103.

Voluntary Health Insurance: The House of Delegates voted, on resolutions from Arizona, District of Columbia, Florida, Michigan, Missouri, New York and Rhode Island, that at the expiration of the present contract of hospital and medical health coverage, the Association make every effort to procure this coverage for its employees through Blue Cross-Blue Shield local organization, June 1948:69, 71, 73, 74, 75, 101, 102.

Voluntary Health Insurance: The House of Delegates amended its action of June 1948, substituting for the words "Blue Cross-Blue Shield local organization," the words "any approved voluntary health insurance plan," June 1949:30, 55, 56.

ETHICS, MEDICAL — PRINCIPLES OF MEDICAL ETHICS

Code of Medical Ethics Adopted: The House of Delegates adopted in 1847, a *Code of Medical Ethics*, May 1846:17, 18; May 1847:35, 43, 83–106.

Medical Graduates: The House of Delegates referred the following recommendations to the Committee on Licensing Power, May 1853:36, 40, 43–44, 44, 45, 48–49:

(1) that every graduate in medicine be required to subscribe a pledge to submit to the revocation of his diploma upon conviction of having knowingly violated the *Code of Ethics* of this Association; (2) that the several medical colleges and such other boards as are by law authorized to examine candidates for admission into the medical profession, require from every graduate or licentiate his signature to the *Code of Ethics* of this Association; (3) that the formal administration of a pledge to observe and keep said code, form part of the public exercises of medical commencement.

Adoption by Medical Societies: The House of Delegates adopted the following resolution, May 1855:56:

Resolved, That no state or local society shall hereafter be entitled to representation in this Association, which has not adopted the *Code of Ethics*.

Resolved, That no state or local society which has violated or discarded any article or clause in said *Code of Ethics*, shall any longer be entitled to representation in this body.

Adoption by Organizations Represented in A.M.A.: The House of Delegates adopted the following resolution, May 1855:60:

Resolved, That no organization or institution entitled to representation in this Association shall be considered in good standing which has not adopted its *Code of Ethics*.

Code Appended to Transactions: The House of Delegates approved appending of the *Code of Ethics* to each volume of the *Transactions*, May 1857:32.

Abolition: The House of Delegates tabled a resolution which provided for the "entire abolition of the *Code of Ethics*." May 1870:39.

Revision: The House of Delegates adopted a report of the Judicial Council which disapproved revision of the *Code of Ethics*, (1) so that the *Code* may be converted into a set of rules or bylaws; (2) in those sections relating to specialties and contracts, May 1873:44; June 1874:28–33.

Revision: The House of Delegates referred to the Judicial Council, recommendation of President Sims that those portions of the *Code of Ethics* relating to advertising, consultations, and patents be amended, June 1876:46, 96–99.

Revision: The House of Delegates tabled a resolution which recommended appointment of a committee to consider revising the *Code of Ethics*, June 1883: J.A.M.A. 1:9.

Revision: The House of Delegates indefinitely postponed action on report of the Committee on Revision of the Code of Ethics which recommended (1) omission of all sections "describing obligations of patients to their physicians, and of the public to physicians"; (2) removal of that section in the *Code* which related to the "patenting of mechanical appliances used in medicine"; (3) a "more accurate definition of the term 'consultation'"; (4) reorganization and rewriting of the *Code*, June 1892: J.A.M.A. 18:802; June 1893: J.A.M.A. 20:623, 691–693, 694; June 1894: J.A.M.A. 22:944, 950–952, 952.

Revision: The House of Delegates adopted the following resolutions, June 1895: J.A.M.A. 24:766:

Resolved, That the American Medical Association renews and hereby confirms its long-standing allegiance to and defense of the letter and the spirit of the unamended *Code of Ethics* and etiquette of the American Medical Association; and further

Resolved, That any revision of that code on the lines hitherto adopted or proposed, should be rejected by every regular practitioner of medicine as being inimical to the honor of the medical profession and subversive of the best interests of the people of the United States.

Principles of Medical Ethics Approved: The House of Delegates adopted in 1903, the *Principles of Medical Ethics*, a revision of the *Code of Ethics*. June 1901: J.A.M.A. 36:1717; June 1902: J.A.M.A. 38:1649–1652, 1653; May 1903: J.A.M.A. 40:1371–1372, 1374, 1379–1381.

Elaboration: The House of Delegates adopted report of the Committee on Elaboration of the Principles of Medical Ethics, which recommended that "it is not expedient to take any action at present." June 1908:2, 33, 34; June 1910:30.

Revision: The House of Delegates approved a revised *Principles of Medical Ethics*, June 1912:5, 11–16, 46–47.

Revision: The House of Delegates approved editorial revisions submitted by the Judicial Council, May 1922:2, 39; June 1923:19, 49.

Principles, Not Laws: On a resolution submitted by the California delegation, the House of Delegates adopted the following report, June 1938:56, 57–58:

The ethics of medicine is stated as it should be in principles of conduct instead of rules. To define and interpret these principles so as to cover every relation of the medical man would be to set up an endless system of rules, regulations and laws approaching in character a criminal code, with its invitation to violation by sophisticated reasoning or through technicality. A rule, regulation, or law may be circumvented, but the principle underlying the law cannot be avoided by such means. As occasion arises, amendments will doubtless be made in the future as they have in the past, but these are strenuous times of rapid and radical change and no one can predict the immediate or remote future. The Judicial Council, as your reference committee, recommends that "amplification, clarification, codification, and revision of the *Principles of Medical Ethics*" be postponed.

Revision: On a resolution from the California delegation which recommended rewording and rearranging of the *Principles*, the Judicial Council reported that "there is at present so much turmoil in medical organization and its relation to government" and that "the present is not the time to do the rewriting." May 1939:75, 82; June 1940:45, 53.

Revision: The House of Delegates adopted a resolution from California which recommended revision of the *Principles of Medical Ethics*, June 1946:55, 62.

Revision: The House of Delegates adopted a revised *Principles of Medical Ethics*, June 1948:48–54; Nov.–Dec. 1948:29; June 1949:26, 38–42.

Indoctrination Courses: The House of Delegates adopted a report which (1) urged the Judicial Council to take steps to "educate the young doctor and re-educate the older doctor of medicine" in the *Principles of Medical Ethics*; (2) suggested that county medical societies be urged to "institute indoctrination courses for all new members which courses would include a thorough understanding of the *Principles of Medical Ethics*," Nov.–Dec. 1948:28–29, 68.

Preamble: The House of Delegates approved recommendation of the Council on Constitution and Bylaws that the quotation from Sir Thomas Percival and the conclusion of the *Principles of Medical Ethics* be replaced with a preamble, June 1953:27, 59, 60.

Character and Responsibility of the Physician: The delegation from the Section on Military Medicine proposed a section to be substituted for sections 1 and 2 of chapter I of the *Principles of Medical Ethics.*

The Council on Constitution and Bylaws recommended, and the House approved, (1) that section 1 (Character of the Physician) be retained without modification; (2) that section 2 (Responsibility of the Physician) be deleted and a modification of the proposed section be substituted. June 1953:44–45, 59, 60; Dec. 1953:76, 95; June 1954:30, 54, 55.

Format: The House of Delegates approved change in format of the *Principles of Medical Ethics* to achieve a consistency in terminology, Dec. 1953:77, 99, 100.

Revision: The House of Delegates approved addition of the following new section to the *Principles of Medical Ethics*, Nov.–Dec. 1955:112, 133, 134:

These Principles may be amended on approval of two-thirds of the members of the House of Delegates present and voting, provided an amendment shall not be acted on until the session following that on which it is introduced.

Revision: The House of Delegates amended chapter XXI of the *Bylaws*, adding a new paragraph which reads as follows, June 1956:52–53, 64, 65:

Section 2.—The *Principles of Medical Ethics* may be amended by the House of Delegates at any session on the approval of two-thirds of the members of the House of Delegates present and voting, provided that the proposed amendment shall have been introduced at the preceding session.

Revision: The House of Delegates approved in June 1957, a revised *Principles of Medical Ethics*, Nov.–Dec. 1955:76, 112–116, 133, 134; June 1956:33–34, 53–54, 64–65, 65; Nov. 1956:66, 93–94, 95–96, 103, 106–107, 107–108, 109; June 1957:25–26; Dec. 1957:99–100.

PRINCIPLES OF MEDICAL ETHICS, ADOPTED JUNE 1957.

PREAMBLE.—These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws

but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1.—The principle objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged, he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in

...ittee which have the purpose of improving both the health and the well-...e of the individual and the community.

...sion: The House of Delegates disapproved resolution no. 15 from Colorado ... disapproved the proposed revision of the *Principles of Medical Ethics* and ...quested preparation of a new revision "containing specific prohibitions rather ...an general statements of principles." June 1957:47.

...ciples Adopted by Constituent Associations: The House of Delegates approved ... following resolution no. 44 from New York, June 1956: J.A.M.A. 162: ...680; Nov. 1956: J.A.M.A. 163:193, 194; June 1957:54–55:

...olved, That in those states which have their own principles of professional ...nduct (or ethics), these principles shall be binding upon all of the members ... the state society or association providing they are not inconsistent or in con...ict with the *Constitution and Bylaws* of the American Medical Association; ...nd be it further

Resolved, That the enforcement of the component state ass...iation's or society's ...rinciples of professional conduct (or ethics) is a function of the state medical ...ociety or association, as the case may be.

...Revision: On report of the Judicial Council regarding the 1957 edition of the *Principles of Medical Ethics*, the House of Delegates adopted a report which reads in part as follows. Dec. 1957:72–73:

. . . The committee calls attention to that Council's statement that the 1957 edition of the *Principles of Medical Ethics* was not intended to and does not abrogate any ethical principle of the 1955 edition of the *Principles of Medical Ethics*. Your committee endorses the statement of the Judicial Council that if local societies fail to curtail unethical practices, ethics lose their effectiveness. Failure on the part of the component society to demand respect for and adherence to the *Principles* breeds contempt and disrespect for them.

The reference committee notes with satisfaction that the opinions and reports of the Judicial Council have been abstracted and annotated. The committee believes that this document should receive wide distribution since it will be of assistance to medical societies when called upon to resolve ethical questions within their own jurisdictions.

ETHICS, MEDICAL — PROCEDURE

Discipline by Vote of the Association: The House of Delegates laid over until the next session, a resolution which recommended that the following paragraph be appended to the *Constitution*. May 1855:60:

The Association shall, at all times, have power to punish any of its members by reprimand, suspension, or expulsion, upon a three-fourths' vote of the members present at any meeting at which no less than one hundred are in attendance.

Committee on Ethics: The House of Delegates resolved "that all questions of complaints or accusations directed against individuals or societies be immediately referred to the Committee on Ethics, and not be discussed before the Association until reported on by the said committee," May 1871:25.

Committee on Ethics: The House of Delegates adopted a resolution which provided "that all questions of a personal character, including complaints and protests, and all questions on credentials, be referred at once, after the report of the Committee on Arrangements or other presentation, to the Committee on Ethics without discussion," May 1872:33–35, 71.

Judicial Council Created: The House of Delegates amended the *Bylaws*, in 1873, to provide for the establishment of a Judicial Council "whose duty it shall be to take cognizance of and decide all questions of an ethical or judicial character which may arise in connection with the Association" and to which all questions of a personal nature, including complaints and protests, and all questions on credentials shall be referred at once, after the report of the Committee on Arrangement or other presentation, and without discussion," May 1872:26; May 1873:34, 35–36.

Judicial Council Name Change: The House of Delegates disapproved change in name of the Judicial Council to "Medical Senate," May 1873:53.

Rules of the Judicial Council: The Judicial Council approved appointment of a committee "to draft rules and regulations for the government of the Judicial Council," May 1879:59.

Decisions of the Judicial Council: The House of Delegates indefinitely postponed action on (1) an amendment to Bylaw no. XI to provide that decisions of the Judicial Council "on all matters referred to it by the Association shall be reported at the earliest practicable moment, and shall be final unless revised by the Association"; (2) an amendment to insert in the *Constitution*, a section entitled "the Code of Ethics," to be known as article VIII, June 1892: J.A.M.A. 18:811; June 1894: J.A.M.A. 22:952; May 1895: J.A.M.A. 24:761, 762–763.

Appointment of Judicial Council Members: The House of Delegates amended book III, chapter X, section 4 of the *Bylaws*, substituting the words in italics so that the first sentence will read as follows, June 1906:33, June 1907:25, 32:

The Judicial Council shall be composed of five members, to be *appointed by the President on the first day of the annual session from the delegates present, and to continue in office until their successors are appointed.*

Merger of Judicial Council with Committee on Amendments to the Constitution and Bylaws: The House of Delegates disapproved a resolution which recommended that the "Committee on Amendments to the Constitution and Bylaws and the Judicial Council be made one committee, known as the Judicial Advisory Committee," June 1909:49, 51.

Jurisdiction of Judicial Council: The House of Delegates approved the following amendments to chapter VII, section 4 of the *Bylaws*. June 1914:10–11, 43–44, 44:

1. Paragraph 2 to read as follows:

The judicial power of the Association shall be vested in the Judicial Council, whose decision shall be final. This power shall extend to and include (1) all controversies arising under this *Constitution and Bylaws* to which the American Medical Association is a party; and

(2) controversies (a) between two or more recognized constituent associations, (b) between a constituent association and a component society (or component societies) of another constituent association (or other constituent associations), (c) a member (or members) of any other constituent association (or other associations), and (d) between members of different constituent associations. In all these and other cases the Judicial Council shall have original jurisdiction.

2. Strike out paragraph 3 and substitute the following:

In all cases which arise between a constituent association and one of its component societies; between component societies of the same constituent associations; between a member of a constituent association and the component society to which said member belongs; or between members of different component societies of the same constituent association, the Judicial Council of the American Medical Association shall have appellate jurisdiction.

The constituent associations herein referred to are those defined in article 4 of the *Constitution*, and the component societies are the county or district medical societies which unite to support and maintain the several constituent associations.

The Judicial Council may, at its discretion, investigate general professional conditions and all matters pertaining to the relations of physicians to one another and to the public, and shall make such recommendation to the House of Delegates and the constituent associations as it deems necessary.

Jurisdiction of the Judicial Council: The House of Delegates amended chapter XIV, section 4 of the *Bylaws* to read as follows. June 1911:3, 4, 32, 36–37, 40–41, 43:

Section 4. Judicial Council. The Judicial Council shall consist of five members, who shall be nominated by the President and elected by the House of Delegates. At the annual session in 1911, one member shall be elected to serve for five years, one for four years, one for three years, one for two years and one for one year, and thereafter one member shall be elected each year to serve for five years. It shall select a chairman from its membership. The Secretary of the Association shall be, ex officio, secretary of the Council. It shall expend money and contract debts only on the authority of the Board of Trustees. It shall keep a permanent record of its actions at its office which shall be at the headquarters of the Association. It shall make an annual report of its decisions and the results of its investigations to the House of Delegates.

The Judicial power of the Association shall be vested in the Judicial Council, the decisions of which shall be final, and shall extend, (1) to all cases arising

under this *Constitution and Bylaws*; (2) to all controversies to which the American Medical Association is a party; to controversies, (3) between two or more recognized state or territorial associations, these being constituent associations within the meaning of article 4 of the *Constitution*; (4) between a constituent association and members of another association; (5) between members of different constituent associations.

In all cases in which the American Medical Association or one of its constituent associations is a party, the Judicial Council shall have original jurisdiction. In all other cases before mentioned, the Judicial Council shall have appellate jurisdiction, both as to law and fact, with such exceptions and under such regulations as it may adopt and publish in *The Journal*, provided that such regulations must be approved by the next ensuing session of the House of Delegates and be officially certified to each constituent association. The Judicial Council may investigate professional conditions and all matters pertaining to the relations of physicians to one another and to the public and shall make such recommendations to the House of Delegates and the constituent associations as it deems necessary.

Rules of the Judicial Council: The House of Delegates approved rules to govern the Judicial Council, June 1912:10–11, 46.

Jurisdiction of Judicial Council: The House of Delegates amended section 4, chapter IX of the *Bylaws*, inserting the words in italics, June 1912:11, 46:

The Judicial Council may, *at its discretion*, investigate general professional conditions and all matters pertaining to the relations of physicians to one another and to the public and shall make such recommendations to the House of Delegates and the constituent associations as it deems necessary.

Procedure in Preferring Charges: The House of Delegates approved enactment of the following standing rule, June 1915:11, 60, 61:

Procedure in Preferring Charges—The Secretary of the American Medical Association shall file charges with the Judicial Council against Fellows of the Association when overt acts on the part of such Fellows supported by reasonable evidence, are brought to the attention of the Secretary of the American Medical Association.

Jurisdiction of the Judicial Council: The House of Delegates amended chapter VII, section 4 of the *Bylaws*, striking out paragraph 3 and substituting the following, June 1916:11, 68:

In all cases which arise (a) between a constituent association and one or more of its component county societies; (b) between component societies of the same constituent association; (c) between a member or members and the component society to which said member or members belong; or (d) between members of different component societies of the same constituent state association, the Judicial Council of the American Medical Association shall have appellate jurisdiction in questions of law and procedure but not of fact.

Jurisdiction of the Judicial Council: On a communication from Mississippi State Medical Association which stated that it would not admit appellate jurisdiction by the Judicial Council in matters of discipline of county society members and which insisted that the county societies alone shall judge the qualifications of their members, the House of Delegates approved a report of the Judicial Council, which reads in part as follows, June 1917:3, 8-9, 67-68.

. . . The careful reading of the section of the *Bylaws* giving appellate jurisdiction to the Judicial Council will show that the only matters which can be appealed to the Judicial Council are questions of law and procedure, not of fact. This leaves the question of discipline and the questions of fact concerning whether or not a member should be disciplined where it belongs; in the county societies, where it has always been. The appellate jurisdiction given to the Judicial Council in simple language means this, that any member of a county society or state association—any member of the American Medical Association—may appeal to the Judicial Council if in the course of some dispute he is not given what he considers to be his just rights in questions of law or procedure.

The qualifications of membership in county societies are not involved in this question at all, because only those already members of the Association may avail themselves of the protection of this appeal . . .

Jurisdiction of the Judicial Council: On recommendation of the Judicial Council, the House of Delegates approved the following amendments to the chapter IX of the *Bylaws*:

(a) Section 1, first paragraph, second sentence: add the words in italics and renumber the present items:

. . . This power shall extend to and include (1) *all questions involving Fellowship in the Scientific Assembly or the obligations, rights and privileges of Fellowship;* . . .

(b) Section 1: add a third paragraph: The Judicial Council shall have jurisdiction in all questions of ethics and in the interpretation of the laws of the organization.

The House disapproved a resolution from New York which recommended that the words in italics be added to chapter IX, section 1, first paragraph, first sentence:

The Judicial power of the Association shall be vested in the Judicial Council, whose decision shall be final, *except that appeal may be made from their decision to the House of Delegates, in which case the decision of this body shall be final.* May 1922:16–17, 40–41.

Jurisdiction of the Judicial Council: On reports of the Judicial Council regarding provisions by which state and national organizations may, under certain conditions determine their own membership, the House of Delegates approved an amendment to the *Bylaws*, adding the following sentence to chapter XI:

Sec. 12.—Infraction of *Constitution, Bylaws* or *Principles of Medical Ethics.*—The House of Delegates shall have the power to discipline or expel a member of

the American Medical Association or a Fellow of the Scientific Assembly on recommendation of the Judicial Council.

The House disapproved an amendment to chapter IX, section 1 of the *Bylaws* (under Judicial Council), which would add the words in italics to the following sentence:

. . . This power shall extend to and include (1) all questions involving *membership in the American Medical Association* or Fellowship in the Scientific Assembly; Apru 1926:28-29, 47-48; May 1927:26-27, 50, 51, 53, 60; June 1928: 6, 30–31, 45–46.

Jurisdiction of the Judicial Council: The House of Delegates disapproved a resolution from Indiana which proposed a *Bylaws* amendment to make decisions of the Judicial Council subject to review and final action by the House of Delegates. May 1927:60; June 1928:6, 29, 30, 46.

Questions Affecting Professional Reputation: The House of Delegates approved amendment to article I, chapter II, section 7 of the *Principles of Medical Ethics*, adding the following sentence, May 1927:38, 48:

All questions affecting the professional reputation or standing of a member or members of the medical profession should be considered only before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations.

Original Jurisdiction: The Judicial Council submitted a report on responsibilities of constituent and component organizations in dealing with questions of ethics and in disciplining their members, June 1928:29.

Original Jurisdiction and Procedure in Charges and Appeals: The House of Delegates adopted, as amended, a report of the Judicial Council regarding original jurisdiction, responsibility of component medical societies, and proper preparation of charges and appeals, June 1930:23-24, 37.

Jurisdiction of the Judicial Council: The House of Delegates amended the *Bylaws* to correct the discrepancy between chapter XI, section 12 and chapter IX section 1, deleting the following words in italics, June 1930:39, 40, 41.

The House of Delegates shall have the power to discipline or expel a member of the American Medical Association or a *Fellow of the Scientific Assembly* on recommendation of the Judicial Council.

Appeal Procedure: The Judicial Council submitted recommendations clarifying appeal procedure, May 1932:25.

Original Jurisdiction: On report of the Judicial Council regarding original jurisdiction and powers of the Judicial Council, the House of Delegates emphasized the importance of "local responsibility by the membership, believing that the prosecution should originate in the local county societies," Jun 1934:28-29, 44.

Jurisdiction of the Judicial Council: On report of the Judicial Council, the House of Delegates adopted a report which reads in part as follows, June 1935:29–30, 40–41:

. . . The Council further states, "Public confidence in our avowed declarations for medical control over things medical cannot be successfully cultivated or maintained unless we exclude or remove from the ranks of our organized profession those who ignore our ethical code, especially as it applies to the true professional spirit in our relations with each and every patient . . . It will be recalled," the Council continues, "that last year the House of Delegates amended its *Principles of Medical Ethics* so clearly that there can be no misunderstanding of the conditions mentioned but the present method of procedure of preferring charges makes the pronouncement ineffective." Your committee, therefore, deems it advisable to extend the origination of charges in certain situations manifestly too great for county societies to handle to the state association and possibly in rare instances to the national organization. Your committee agrees with the Judicial Council that when the House of Delegates sees fit to extend such jurisdiction in matters of discipline, the Council should have the duties and powers then enjoined on it but should not at any time be expected to function in an ex parte capacity.

The House of Delegates adopted the following *Bylaws* amendments to effectuate suggestions contained in the above report. May 1936:44–45, 56, 66, 67; June 1937:54, 65:

(1) Add the words in italics to chapter IX, section 1 so that the second sentence reads in part as follows: "This power shall extend to and include (1) all questions involving Fellowship in the Scientific Assembly or the obligations, rights and privileges of Fellowship; (2) all controversies arising under this Constitution and Bylaws *and under the Principles of Medical Ethics* to which the American Medical Association is a party: . . ."

(2) Add the following paragraph to chapter IX, section 1: "The Judicial Council shall have authority in its discretion from time to time to request the President to appoint investigating juries to which it may refer complaints or evidence of unethical conduct which in its judgment are of greater than local concern. Such investigating juries, if probable cause for action be shown, shall report with formal charges to the President who, under chapter V, section 1, of the *Bylaws*, shall appoint a prosecutor who, in the name and on the behalf of the American Medical Association, shall prosecute the charges against the accused before the Judicial Council. The Council shall have the power to acquit, admonish, suspend, or expel the accused."

Procedure in Conduct of Trials: The Judicial Council submitted a report which clarified procedure in the conduct of trials, based on charges against members of component and constituent organizations, and recommended coordination of the governing bylaws of state associations and their component societies. May 1936:36, 37, 38.

Appeal Procedure: The House of Delegates amended chapter IX, section 1 of the *Bylaws*, adding the following sentence to the second paragraph, June 1937: 40, 53, 64, 65:

The period of time within which appeal to the Judicial Council may be taken shall be limited to the six months following the date of decision by the constituted authority of a constituent association.

Short Cuts to Discipline: The Judicial Council submitted the following report, June 1936:48, 64:

The attempt is being made in some societies to regulate some undesirable situation by amendment of the *Bylaws*, by the adoption of resolutions or by the establishment of rules of conduct directed to the specific undesirable practice existing at the moment. In such instances, small regard is paid to the established *Constitution and Bylaws* and short cuts to disciplinary action are sought, usually by making loss of membership automatic on violation of the newly adopted bylaw, resolution, or rule of conduct. In previous reports, the Judicial Council has called attention to the undesirability of basing disciplinary action on such specific rules or resolutions and especially when the general broad principles of conduct set out in the *Principles of Medical Ethics* are adequate to cover the situation.

Finality of State Action: The Judicial Council submitted the following report, June 1938:49:

The constitutions and bylaws of some constituent associations provide that the action of the Council or other authoritative body of the state association in matters of discipline over its members is final. The Judicial Council calls attention to the incorrectness of this statement which might and probably has been prejudicial to the rights of some members under disciplinary action. The only interpretation of the statement that can be made is that the action of the state authority is final so far as the state association is concerned. Notwithstanding this statement in the constitutions and bylaws, the accused has the right of appeal to the Judicial Council of the American Medical Association by virtue of chapter IX, section 1, of the *Bylaws* of the American Medical Association which reads in part as follows:

> "The judicial power of the Association shall be vested in the Judicial Council, whose decision shall be final. This power shall extend to and include . . . In all cases which arise (c) between a member or members and the component society to which said member or members belong, . . . the Judicial Council shall have appellate jurisdiction in question of law and procedure but not of fact," and also "The Judicial Council shall have jurisdiction on all questions of ethics and in the interpretation of the laws of the organization."

It is the opinion of the Council that wherever a statement of finality of the action of the state authority is made, the wording should be amended by the addition of the words "except as provided in the *Bylaws* of the American Medical Association" or some similar phrase.

Original Jurisdiction: The Judicial Council reported: (1) that the *Principles of Medical Ethics* "are not laws to govern but are principles to guide correct

conduct"; (2) that "the Judicial Council cannot pass judgement in advance on a situation which later may come under its review on appeal," as the Council "cannot be an attorney for the societies and later a judge over their actions"; (3) that the Council "cannot be familiar with local laws, customs and needs" and many inquiries coming to the Council should have been directed to state associations."

The House of Delegates adopted the following report:

Your reference committee concurs in the opinion of the Judicial Council that controversial matters that may arise in any local society should be reviewed by the grievance committee of the local society concerned and then by the properly constituted state agency before being referred to the Judicial Council, June 1941:42, 62.

Jurisdiction of the Judicial Council: On complaints regarding the "violation of medical ethics by individual physicians in the relationships between medical men," the Judicial Council reported as follows, June 1947:40, 89, 90:

In some of these complaints, it would seem that corrective or punitive measures are expected from the Judicial Council. The Council is not a legislating body. That function rests in the House of Delegates. The Judicial Council is a court to interpret the laws and ethics of the medical profession and to adjudicate those matters brought to it from the state associations under the *Constitution and Bylaws*. The responsibility for correction of a condition must be left to the state associations. Only when the situation involved becomes of general rather than local concern may the Judicial Council interfere. In such cases it has the power to request the President to appoint an investigating jury to consider the complaint.

Appeal Procedure: The House of Delegates concurred in recommendations of the Judicial Council regarding appeal procedures and referred the following section of the Council report to the Council on Constitution and Bylaws for implementation, Dec. 1951:44, 78, 79.

The Council would like to emphasize the details of the procedure to be followed in effecting appeals authorized under chapter X, section 4 (1) of the *Bylaws*. This emphasis is thought to be advisable at this time in order that delays in consideration of appeal cases be reduced to a minimum. The attention of members is redirected to the fact that in considering cases properly appealable, the Council may consider only questions of law and procedure, not of fact. Before the Council may assume jurisdiction of a case, evidence must be submitted that the aggrieved member has exhausted all procedures available to him under the provisions of the constitutions and bylaws of the component and constituent associations of which he is a member. In effecting an appeal, the aggrieved member must file with the Chairman of the Council six copies of an appeal statement, or brief, setting forth clearly the basis advanced by the member as his reason why the Council should assume jurisdiction and take action. A copy of this statement or brief must be forwarded at the same time to

the appropriate officer of the constituent association from the decision of which the appeal is taken. The present *Bylaws* provide that an appeal can be taken at any time within six months "immediately following the date of decision by the constituted authority of a constituent association."

The Council feels that it would serve to expedite appeal procedure if the *Bylaws* were amended to require that the appeal be effected within a period of sixty days rather than six months. The Council also feels that justice will be better served if, on an appeal being perfected, the decision of the constituent association were stayed pending the final decision of the Council. The Council hopes to have published in THE JOURNAL in an early issue a detailed statement relative to procedures to be followed in appeals to the Council.

Judicial Council Records: The House of Delegates adopted the following resolution from Texas, June 1952:34, 54:

Resolved, That the House of Delegates request the Board of Trustees to take the necessary action to see that permanent bound records of all actions of the Judicial Council be maintained in the Office of the Secretary of the American Medical Association for guidance of constituent societies seeking precedence and interpretation; and be it further

Resolved, That such rulings and interpretations of the Judicial Council as would be helpful to the membership of the American Medical Association at large be made available to them through THE JOURNAL of the American Medical Association at the discretion of the Editor.

Pursuant to the above action, the Judicial Council submitted the following report which was adopted by the House of Delegates, Dec. 1952:12, 47, 102, 103:

Your committee begs to convey to the House that the Board of Trustees has received a report from the Judicial Council to the effect that the recommendation contained in the resolution can be complied with, that the Council should see the material before it is published, that the Editor may select that which is to appear in THE JOURNAL, and that some method of future procedure will be worked out to the satisfaction of the Editor and the Council.

Jurisdiction of the Judicial Council: On resolution from the Section on Gastroenterology and Proctology requesting a *Bylaws* amendment to give the Judicial Council appellate jurisdiction in question of fact as well as of law and procedure, the House of Delegates voted that the present wording of the section of appellate jurisdiction should be retained, June 1952:40, 55; Dec. 1952:88, 101, 102.

Jurisdiction of the Judicial Council: The House of Delegates amended chapter XI, section 10(A), second paragraph, first sentence of the *Bylaws*, adding the word "original" and deleting the words "and chapter IV" so that the sentence reads as follows, Dec. 1952:88, 101, 102:

The Council shall have original jurisdiction in (a) all questions involving membership as provided in division one, chapter 1, section 1 of the *Bylaws* . . .

Repeated Questions to Judicial Council: On statement of the Judical Council regarding repeated questions which should be submitted to county and state representatives, the reference committee reported, and the House approved, that publication of decisions of the Council is being studied, and that the sending of this publication to medical societies should lead to a decrease in the number of questions asked of the Council, Dec. 1952:97, 110.

Discipline of Service, Affiliate, and Honorary Members: The House of Delegates approved an amendment to the *Bylaws* to provide "that the Judicial Council shall have original jurisdiction over members of the American Medical Association who are not members of their component county and constituent state medical societies."

The House approved addition of a new section 2, under chapter IV, which reads as follows, June 1953:33, 52, 53; Dec. 1953:76, 95:

Section 2. Service, Affiliate, or Honorary Members—The Judicial Council, after due notice and hearing, may censure, suspend, or expel any Service, Affiliate or Honorary member of the Association for an infraction of the *Constitution* or these *Bylaws*, or for a violation of the *Principles of Medical Ethics*.

Decisions and Opinions of the Judicial Council: The House of Delegates approved report of the Judicial Council recommending disapproval of resolution no. 19 from Colorado (Dec. 1953) for the following reasons, Dec. 1953:82, 94, 95; June 1954:28, 54, 55:

(1) The recommendation "that all decisions and opinions of the Judicial Council shall be reduced to writing and kept on file at the Association headquarters" is superogatory, because the Judicial Council has followed such practice for years.

(2) The provision "that all decisions and opinions of the Judicial Council shall be open to inspection by any member of the Association at the headquarters of the Association" is undesirable and perhaps impossible of execution, in view of practical considerations.

(3) The proposition that all parties in a dispute be given ample opportunity to be heard is in effect and has been for many years.

(4) The requirement that certain opinions of the Judicial Council must not be released until 60 days after the request for the opinion has been published in two consecutive issues of THE JOURNAL is open to serious objection: (a) the publication of such matters might result in a betrayal of the trust of participants in a controversy; (b) such an arrangement would interfere with or even prevent the possible solution of problems because of the unwillingness of individuals to submit information under such circumstances; (c) it is likely that such an arrangement might even lead to legal entanglement.

(5) The requirement that any member of the American Medical Association may present his views during hearings and "if any constituent or component society so requests, hearing shall be held by the Judicial Council at which any

recognized medical society which discusses it shall be heard by a representative of his choice" is already in force.

(6) The recommendation that Judicial Council decisions shall be final "unless rejected or modified by the House of Delegates" should be disapproved.

Decisions and Opinions of the Judicial Council: The House of Delegates disapproved resolution no. 35 from California, similar in content to resolution no. 19 from Colorado (Dec. 1953), proposing to amend judicial powers of the American Medical Association. June 1954:41, 54, 56.

Decisions and Opinions of the Judicial Council: On resolution no. 17 from Colorado, the House of Delegates adopted a report of the Council on Constitution and Bylaws which reads in part as follows, June 1954:43, 54; Nov.–Dec. 1954:74–75, 99, 100:

. . . INTENT OF RESOLUTIONS: What is the broad general objective embodied in all three of these resolutions?

A. The objective is to amend the *Bylaws* in such a manner as to require the Judicial Council to report to the House of Delegates, at each session, all interpretations of the *Principles of Medical Ethics* and all interpretations of the policies of the American Medical Association for examination by the House of Delegates.

B. Secondary to the main objective as stated above, resolution no. 47, like resolutions no. 19 and 35, prays that when an investigating jury is not requested in a given case, the Judicial Council be required to give each party concerned a hearing in the presence of the other; that each party be notified beforehand of the meeting which is to deal with his case; that no opinion by the Judicial Council be rendered until at least 60 days after request for such an opinion has been published in THE JOURNAL of the American Medical Association in two consecutive issues; and that any member of the American Medical Association or his representative may present his views in writing on a given matter to the Judicial Council, or that if a constituent or component medical society so wishes, it may request a hearing in a given matter at which a representative of such a society may present the views of that society.

ANALYSIS: Here there are only three main matters to be considered: (1) resolution no. 19, the progenitor of the other two resolutions, has been rejected by the House of Delegates; (2) resolution no. 35, which is virtually identical to resolution no. 47, has been rejected by the House of Delegates; (3) resolution no. 47, which is in effect a creature of resolutions no. 19 and 35, can hardly escape the same destiny accorded the previous two resolutions.

Never in any community where the course of justice has been unfettered has the judicial function been confused with the legislative function, nor can the consumation of justice and equity be achieved by the subordination of judicial procedure to the expediencies of the legislative process. No mechanism for the assurance of justice among men can long escape disaster if it is exposed to derangement by those who are charged with the drafting of measures exacted by contingencies in which the judicial process actually has little to do.

All these resolutions—no. 47, under consideration now, as well as the preceding ones—cannot be put into action without perverting the ancient and inviolable doctrine of separation of the judicial from the legislative in the democratic scene. Because these resolutions embody a principle that is offensive to reason, destructive to justice, and repugnant to sound parliamentary practice, they have been rejected in an act of wisdom by the House of Delegates. Resolution no. 47 should be accorded the same summary disposition. In fact, should the remote contingency arise in which resolution no. 47 might gain acceptance, the action of the House of Delegates in rejecting resolution no. 35 in June 1954, would have to be rescinded, for both resolutions are cut from the same fabric of indifference to both reason and justice.

Finally, the proposed resolution, like its predecessors, falls without hope of defense, because any member of the House of Delegates, by express stipulation of the *Bylaws*, has the privilege of reviewing the detailed work of the Judicial Council on his own time, and if he wishes to acquaint himself with any matter of interest to himself in the orderly procedures of the Judicial Council, he will encounter no barrier to his wish. Justice and reason were well served when resolutions no. 19 and 35 were rejected. The Council on Constitution and Bylaws recommends that the House of Delegates take the same action and voice its disapproval in respect to resolution no. 47.

Rules of Judicial Council: The House of Delegates adopted revised *Rules of the Judicial Council*, Nov.–Dec. 1954:55–56, 99–100, 100.

Appeal Procedure: The House of Delegates adopted a report which reads in part as follows, Nov.–Dec. 1955:74–75, 133, 134:

Your committee desires to commend the Council's conclusion that state associations have the right to supervise the actions of their component societies and that if the right of appeal to the state association is granted it must be presumed that the state has the right to act on the appeal as its judgment dictates. The committee desires also to stress with the Council that matters of discipline are matters for local resolution.

Membership of Judicial Council: The House of Delegates disapproved resolution no. 40 from Texas which recommended (1) increase in the number of members of the Judicial Council to nine; (2) change in the method of election so that members shall be elected by the House on nomination by the Board of Trustees in the same manner as with other standing committees, June 1956:60, 65, 66.

Short Cuts to Discipline: The Judicial Council submitted the following report, Nov. 1956:65, 66:

The Council would repeat comments previously made in its reports to this House concerning short cuts to discipline. Attempts are being made by some societies to regulate undesirable conduct or situations by hastily considered and adopted amendments to bylaws, by the adoption of resolutions, or the establishment of rules of conduct directed to a specific, undesirable practice existing at the

moment. Sometimes small regard is paid to the provisions of established constitutions and bylaws and short cuts to disciplinary action are sought, usually by making loss of membership automatic on violation of the newly adopted bylaw, resolution, or rule of conduct. Such procedures are undesirable for several reasons. They, in effect, represent power politics and government by minority. They usually stem from passion and prejudice rather than from reason. They fail to correct basic errors of judgment predicated on false premises. Most importantly they may occasion loss of membership in a county society, with consequent loss of membership in the constituent association and in the American Medical Association, for an action which although disapproved of locally, may be considered neither unethical or improper in other communities. Such procedure creates the impression that there is no uniformity of principles within medicine. The *Principles of Medical Ethics* are broad and are adequate to cover situations where loss of medical society membership may be indicated.

Attorney Advice in Legal Proceedings; Local Interpretation of Principles: The House of Delegates emphasized recommendation of the Judicial Council that "county and state societies seek the advice of their attorneys when appeals or legal proceedings may be anticipated because of some action contemplated or taken by medical organizations."

The House (1) urged delegates "to request local societies to send to the Judicial Council copies of opinions, interpretations, or discussions that are made by them on medical ethics, so that the Judicial Council may in turn review this material and make it available to other medical societies"; (2) recommended that the Judicial Council "exert even greater effort in the near future to compile and publish its opinions relating to the interpretation of medical ethics," Nov. 1956: 65–66, 66.

Jurisdiction of the Judicial Council: The Judicial Council submitted the following report, Dec. 1957:72, 73:

Some time ago, after an appeal to the Council had been decided, the unsuccessful party asked why the jurisdiction of the Council was limited to questions of law and procedure and did not extend to questions of fact.

The House of Delegates established the limitation of the jurisdiction of the Council, which does not differ greatly from jurisdiction of our civil appeal courts. Until the House changes the jurisdiction, the Council and members of the Association are bound by it.

The purpose of the limitation, essentially, is to prevent the appellate body from substituting its judgment on the facts for the judgment of the trier of the facts. The reason for this is that the trial body sees and hears the witnesses and their evidence. It determines the truth from that which has been physically before it. In the case of an appeal, which is heard on a record of what was said at the trial level, there is no opportunity to hear and see witnesses. The record is reviewed to make certain that the facts available to the trial body were material and sufficient to support the finding which it reached; to insure that required procedures were followed and that the law was applied properly.

Opinions and Interpretations of the Principles: The Judicial Council reported compilation of representative opinions and interpretations of the *Principles of Medical Ethics* to supplement the newly revised *Principles*, Dec. 1958:62.

EUGENICS

Study: The Bureau of Legal Medicine and Legislation suggested that a study of the field of eugenic asexualization be taken so that Association policy with respect to this matter may be determined, June 1928:21–22, 49.

Limitation of Conception for Eugenic Reasons: The House of Delegates accepted report of the Committee to Study Contraceptive Practices which contained a section reading as follows, May 1936:54, 55:

Our present knowledge regarding human heredity is so limited that there appears to be very little scientific basis to justify limitation of conception for eugenic reasons. However, it is recognized that there are a few congenitally transmissible diseases, for instance oxycephaly, Huntington's chorea, hereditary optic atrophy, otosclerosis, and familial cases of Friedreich's ataxia. There is conflicting evidence regarding the transmissibility of epilepsy and mental disorders.

No evidence was found which would indicate that wider dissemination of contraceptive information would tend to establish a better social and economic equilibrium in society. At present the part of our population with the best education and presumably the most competent socially and economically is not reproducing itself. Birth control propaganda is partially responsible for this condition.

EX OFFICIO

Right of Ex Officio Members to Vote: The House of Delegates adopted a report regarding voting rights of ex officio members of committees, which reads in part as follows, Dec. 1950:68, 69, 73; June 1951:30, 35, 36:

. . . An ex officio member, according to *Robert's Rules of Order* (revised) has the right to vote unless otherwise specifically prohibited. It is the opinion of your committee that any organization has the right to determine whether or not an ex officio member of a committee has or has not the right to vote . . .

EXECUTIVE VICE PRESIDENT AND ASSISTANT EXECUTIVE VICE PRESIDENT

Office Established: The delegates to the National Medical Convention in 1847 adopted a Plan of Organization for the American Medical Association which provided that the officers of the Association shall include two secretaries, May 1847:41–43, 57–58.

HOUSE OF DELEGATES — MINUTES

List of Officers and Members: The House of Delegates approved appending of a list of officers and permanent members of the Association to the *Proceedings* of the Association, May 1848:45.

Disclaimer: The House of Delegates approved printing of the following disclaimer at the beginning of the forthcoming copy of the *Transactions*, May 1851:39:

The American Medical Association, although formally accepting and publishing the reports of the various standing committees, holds itself wholly irresponsible for the opinions, theories, or criticisms contained therein, except when so decided by resolution.

Publication Cost: The House of Delegates adopted a resolution which stated (1) that it was unjust that expenses for publication of the *Transactions* above the amount of funds in the treasury be paid by members of the Committee on Publication; (2) that the Association did not expect the Committee on Publication to issue the volume of the *Transactions* for the present year unless it could be done with the funds and credit of the Association. May 1867:34–35.

Exchange With Medical Periodicals: The House of Delegates adopted a resolution which recommended that the Committee of Publication be empowered to exchange copies of the *Transactions* with all state medical societies and journals, with the Bureau of Medicine and Surgery of the Army and Navy, and with the Library of Congress. June 1874:47.

The Journal Supersedes Transactions: The House of Delegates approved, in 1882, publication of a weekly journal in place of the present *Transactions*. June 1880: 56–57, 68–69, 127–134; May 1881:33, 467–479; June 1882:32, 35–41.

Index to Transactions: The House of Delegates instructed the Secretary to have a subject index prepared for the complete series of the *Transactions*, May 1881:33.

Pamphlet Format: The House of Delegates resolved that there be published in pamphlet form, the minutes of the Association, together with its *Constitution, Bylaws* and *Code*, for distribution to each member of the Association at each succeeding meeting. June 1883: J.A.M.A. 1:7; May 1884: J.A.M.A. 2:574.

Official Record: The House of Delegates approved a recommendation that the minutes of all previous meetings as published in THE JOURNAL be considered the official record. May 1896: J.A.M.A. 26:984.

Stenographic Record: The House of Delegates adopted a resolution which (1) required the Permanent Secretary to bring to the annual meeting, Association

minutes of the previous years; (2) required the Permanent Secretary to have the stenographic record of the proceedings transcribed and ready for consideration and correction, each day before being adopted, June 1898: J.A.M.A. 31:125.

Recording of Minutes: The House of Delegates adopted a report of the Committee on Recording Minutes, which recommended (1) inclusion of names of House members in the minutes; (2) reading of minutes by the Secretary at the opening of each session; (3) publication of full and complete minutes by the Secretary in THE JOURNAL and in pamphlet form for distribution to House members; (4) keeping of minutes of meetings held after adjournment of the House; (5) filing of the original minutes in a permanent file, June 1905: J.A.M.A. 45:275, 284–285; June 1906:24.

Compilation of Policy Statements: The House of Delegates adopted a resolution from Illinois which instructed the Secretary to have published in the Handbook as an addendum, all resolutions that express an opinion or policy of the Association that have been adopted by the House of Delegates during the past five years, and that this addendum be added to from year to year as new resolutions are adopted, so that the members of the House may know what opinions and policies have been approved by this body, June 1919:51, 57.

Report by Delegates: The House of Delegates endorsed suggestion of the Speaker that delegates render a written report of actions of this House of Delegates to the associations they represent and to their component bodies, June 1921:2, 37, 38.

Compilation of Policy Statements: The House of Delegates concurred in recommendation of the Speaker that a compilation of the policies of this Association be undertaken by the Secretary, June 1923:2, 41, 42.

Transactions to Include Full Discussion: The House of Delegates disapproved a recommendation of the Speaker that all discussion voiced on the floor of the House be published in the *Transactions* for the information of the membership at large, June 1928:1–2, 47.

Report by Delegates: The House of Delegates approved a recommendation of the Speaker that delegates of the House tender to their state societies a full report of the transactions of the House of Delegates of the American Medical Association, May 1932:1–2, 41.

Index and Digest of Official Actions: The Bureau of Medical Economics reported compilation of an index and digest of official actions of the House of Delegates of the American Medical Association covering the years 1904–1941, June 1942:20.

Implementation of House Actions: The House of Delegates recommended that matters referred from the House for action, study, or recommendation be re-

ported on specifically in the *Proceedings* by the Secretary under a heading such as "Résume of Matters Referred from House of Delegates," June 1948:44, 95.

Digest of Official Actions: The Board of Trustees reported, with regard to resolution no. 3 from Iowa (November 1956) on publication of a digest of A.M.A. policies, that arrangements had already been made for the cataloging of Association policies. Nov. 1956:102-103; June 1957:10.

The Board of Trustees reported completion of the *Digest of Official Actions*, covering the years 1846–1958. Dec. 1958:60.

HOUSE OF DELEGATES — PROCEDURES

Rules of Order: The House of Delegates approved appointment of a committee "to prepare a system of rules for the government of this Association." May 1859-31-32.

Subcommittees of Arrangements: The House of Delegates adopted a motion to strike out from the Ordinances, a resolution (adopted in 1868) providing for appointment of subcommittees of arrangements in all large cities to obtain a reduction of fare for delegates to annual meetings. May 1868:39; June 1877:46.

Invocation—Abolishment: The House of Delegates disapproved a recommendation "that the custom of opening the sessions of the American Medical Association with prayer be abolished," May 1884: J.A.M.A. 2:576.

Business Conducted on Floor: The House of Delegates adopted a resolution which provided "that the business of general sessions shall be conducted from the *floor* of the House" rather than from the platform. May 1890: J.A.M.A. 14:834.

Advertising at Meetings; Official Program: The House of Delegates adopted a resolution which (1) prohibited the placing of books and other advertising sheets on the seats at all meetings of this Association; (2) provided for the procurement of a copyright of the official program so that "the financial rights of the Association may be protected by law," May 1890: J.A.M.A. 14:834.

Official Program: The House of Delegates adopted a resolution which instructed the Secretary to have printed the *Constitution and Bylaws* and the *Code of Ethics* in the regular official program each year. June 1898: J.A.M.A. 31:125.

Time of Meeting: The House of Delegates approved amendments to chapter VIII, section 3 of the *Bylaws* so that this section reads as follows, May 1903: J.A.M.A. 40:1375:

The House of Delegates shall meet at 10 o'clock on the day before that fixed as the first day of the annual session. It may adjourn from time to time as may be

necessary to complete its business, provided, that it shall not meet at hours that conflict with the general meetings of the Association.

Quorum: The House of Delegates approved amendments to chapter III, section 10 of the *Bylaws*, substituting the words *twenty-five* for the word *majority* so that twenty five of the voting members of the House of Delegates shall constitute a quorum. May 1903: J.A.M.A. 40:1375, 1377.

Board to Control Local Arrangements: The House of Delegates approved amendments to the *Constitution and Bylaws*, (1) abolishing the Committee on Arrangements (created 1876, *Transactions*, June 1876:56); (2) providing that the Board of Trustees shall have control of all arrangements for the annual sessions, provide meeting places, control all exhibits, and appoint a local committee of arrangements; (3) providing that the time and place of session may be changed by unanimous action of the Board of Trustees at any time prior to two months from the time selected for the session, July 1905: J.A.M.A. 45:274–275, 279; June 1906:22, 23, 27, 28.

Roll Call: The House of Delegates approved an amendment to the *Bylaws* to make the roll call the second item in the order of business of the House of Delegates, June 1907:2, 25, 26.

Order of Business: The House of Delegates approved amendments to the *Bylaws* so that the sections below reads as follows, June 1916:10, 67, 68:

(1) CHAPTER III, SECTION 1. REGULAR SESSIONS.—The House of Delegates shall meet annually on the Monday preceding the opening of and at the same place as, the Scientific Assembly of the Association.

(2) CHAPTER IV, SECTION 3. TIME OF ELECTION.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the fourth day of the annual session of the House of Delegates (the second day of the Scientific Assembly).

(3) CHAPTER X, SECTION 1. TIME OF GENERAL MEETING.—The general meeting shall be held on the evening of Tuesday of the week of the annual session . . .

Committee on Transportation and Place of Session Abolished: The House of Delegates approved amendments to chapter VII, sections 3 and 6 of the *Bylaws*, eliminating the Committee on Transportation and Place of Session (established May 1903, J.A.M.A. 40:1370, 1374–1375). June 1916:68, 71.

Committee of the Whole: The House of Delegates approved a recommendation "that the House of Delegates establish the precedent of going into a 'committee of the whole' for an hour or longer, if necessary, on the second day of our annual session . . . as its deliberations may deem expedient," June 1924:1, 40.

Quorum: The House of Delegates approved amendment to section 5, chapter II of the *Bylaws* so that "fifty of the voting members of the House of Delegates shall constitute a quorum," May 1927:55; June 1928:6, 46.

Reading Clerk: The House of Delegates approved a recommendation "that the position of Reading Clerk be created and that the Speaker shall make the appointment, provided that if any officer, delegate or committeeman desires to deliver his address in person, he shall be accorded that privilege," June 1930: 1–2, 36.

Entertainment: The House of Delegates adopted resolutions from Michigan, amended to read as follows, June 1930:30, 35:

Resolved, That this House of Delegates declare that the precedent governing entertainment functions is hereby and now terminated, and be it

Resolved, That at future annual sessions the only formal entertainment sponsored by this Association shall be the President's annual reception, the expense of which will be borne by this Association, and be it

Resolved, That the only obligation that shall rest on the local profession of any city in which this Association holds its annual session shall be to render such assistance through proper committees or individuals as will enable the Trustees and other officers to provide suitable hotel accommodations, meeting places, exhibit space and local information.

Sectional Caucuses: The House of Delegates rejected a resolution from Florida which disapproved sectional caucuses pertaining to matters that are to be acted on by the House of Delegates, "as the matter is already covered by a rule of the House," June 1930:6, 30, 31–32, 32.

Hotel Accommodations: The Board of Trustees instructed its committee to carry out the directives of a resolution from Virginia which requested arrangement of reasonable hotel accommodations for the general membership of the Association attending the annual session, June 1930:37, 40.

Social and Economic Problems in Open Session: The House of Delegates disapproved a suggestion from the Council on Scientific Assembly "that an open general meeting should be held at each annual session to hear the discussion of topics, nonscientific in character, in which rank and file of the profession may be particularly interested," June 1931:31, 37.

Reserve Seats: The House of Delegates approved a recommendation of the Speaker "that a section of the meeting place be reserved exclusively for members of the House of Delegates and officers of the Association, and that suitable provision be made for visitors and for representatives of the press who may wish to attend our sessions," July 1946:1, 59.

: to section 3, chapter II
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Schedule of Meetings of Subsidiary and Auxiliary Organizations: The House of Delegates approved a resolution which instructed the Editor to assemble and publish annually in the annual session number of THE JOURNAL, a condensed schedule of meetings of subsidiary and auxiliary organizations which convene in the convention city at the time of annual session, July 1946:54, 60.

Scientific Meeting for the General Practitioner: The House of Delegates concurred in suggestion of President-elect Bortz that the supplemental session be held in various parts of the country and that this session be preceded or followed by a scientific meeting devoted exclusively to the general practitioner, June 1947:5, 91, 92.

Standing Rules: On report of the Committee to Expedite Work of the House of Delegates pertaining to administrative matters, standing rules, and matters indicating a necessary change to the *Constitution and Bylaws*, the House of Delegates adopted the following recommendations, Jan. 1948:5–7, 15–17:

1. That it be a standing rule that the Speaker appoint reference committees two months in advance of a session and that the list of nominees be published one month in advance of a session.

2. That the Reference Committee on Credentials be divided into two groups, one group to examine delegates from states beginning with the letters from A-M and the other to examine those in the group from M-Z.

3. That there be no address by the President-elect.

4. That a standing rule be adopted to provide that the Reference Committee on Executive Session shall consider all matters referred to it in executive session, and shall report to the House of Delegates only when the House is in executive session.

5. That distinguished guests not be presented for addresses before the House of Delegates.

6. That there be no standing or conversation in the back of the room when the House of Delegates is in session.

7. That eight copies of resolutions introduced into the House be required.

8. That whenever practical, resolutions be sent to the central office of the American Medical Association for publication in THE JOURNAL in advance of the meeting of the House.

9. That there be two separate orders of business, one for the annual session and one for the interim session; that the Monday meeting of the House should recess by mid-afternoon to allow time for an executive session.

10. That the House not meet on Tuesday and the time be left open for reference committee meetings.

11. That the first order of business on Tuesday afternoon following the report of the Reference Committee on Credentials and the adoption of minutes shall be introduction of new business, to be followed by an executive session, which in turn shall be followed by unfinished business such as reports of reference committees.

12. That election of officers be retained as an order of business on Tuesday afternoon and that there be three ballot sheets, each a different color, (a) for the election of officers, (b) for the election of trustees and the place of annual session and (c) for the election of members of councils.

13. That no one insert his vote on the ballot until the names of all the nominees for each office have been submitted and that no delegate write the name of a nominee on his ballot until the names ot all the candidate are before the House.

14. That the proposed orders of business for the annual and interim sessions, as amended, be adopted.

Foreign Guests: The House of Delegates approved action of the Board of Trustees in appointing the Vice President of the Association "to organize and act as chairman of a committee of past presidents to entertain foreign guests at the annual and clinical sessions." Dec. 1950:7, 64, 65.

Professional Parliamentarian: The House of Delegates disapproved recommendation of the Speaker that a professional parliamentarian be employed for the House of Delegates, Dec. 1952:2, 98.

Address of President-elect: The House of Delegates concurred in recommendation of President Baker "that the rules of the House should be changed so that the President-elect will address the House at the annual session." Dec. 1952:5, 99, 101.

Your Role as a Delegate: The House of Delegates approved a recommendation that the booklet *Your Role as a Delegate to the American Medical Association* be mailed to each delegate prior to succeeding meetings of the House, June 1953:2, 46, 47.

Hotel Accomodations: The House of Delegates referred to the Board of Trustees, resolution no. 33 from Oklahoma which requested the Secretary of this Association to make definite provisions for the accommodation of elective officials of state associations at meetings of the American Medical Association and not to leave the matter to the discretion of the local committee on arrangements, June 1954:41, 56.

Parliamentary Procedure: The Council on Constitution and Bylaws recommended, and the House approved, that officers of this Association as well as members of state and local medical societies familiarize themselves with the *Standard Code of Parliamentary Procedure* by Alice F. Sturgis so that it may be discussed by this House at a later meeting, Dec. 1958:106, 107.

HOUSE OF DELEGATES — SESSIONS

Alternate Sessions in Washington, D. C.: The House of Delegates resolved that the clause in the *Bylaws*, which provides that every alternate meeting of the Association be held in Washington, D. C., be repealed, May 1870:51.

Four Day Session: On recommendation of the President, the House of Delegates approved extension of the length of annual sessions from three days to four days. June 1874:39, 40, 75–76.

Alternate Sessions in Washington, D. C.: The House of Delegates adopted a resolution which recommended that every second meeting again be held in Washington, D. C.. June 1882:55.

Special Sessions: The House of Delegates amended the *Bylaws* so that the first sentence of chapter III, section 2 reads as follows. May 1922:42, 45:

SPECIAL SESSIONS.—Special sessions of the House of Delegates shall be called by the Speaker, on written request of twenty-five or more delegates representing one third or more of the constituent associations; or on request of a majority of the Board of Trustees.

Ad Interim Sessions, Disapproved: The House of Delegates disapproved recommendations for creation of an ad interim meeting of the House of Delegates. May 1922:2–3, 39; June 1924:17; May 1925:33, 40; April 1926:34, 47; June 1930:3, 36.

Outside of the United States: The House of Delegates disapproved a resolution from Indiana which recommended an amendment to article 10 of the *Constitution* to provide that "a session may be held any place in the United States *or Canada*." May 1925:34, 47, 48; April 1926:27, 37.

Place: The House of Delegates amended the *Constitution* so that article 10 reads as follows. April 1926:2, 37, 44–45; May 1927:8, 50–51:

The House of Delegates and the Scientific Assembly shall meet annually at times and places to be fixed by the House of Delegates. Places desiring to entertain the House of Delegates and the Scientific Assembly in annual session shall submit that invitation in writing, together with such data as may be required, to the Board of Trustees, not less than sixty days prior to the annual session at which the selection of the place of meeting is to be made. The Board of Trustees shall investigate or cause to be investigated all such places from which said invitations have been received, and shall make report to the House of Delegates advising which, if any, of said places possess or may be expected to furnish, the necessary facilities and conveniences for entertaining the Association and accommodating its various activities. The time and place of any of these sessions may, however, be changed by the unanimous action of the Board of Trustees at any time not less than sixty days prior to the time selected for that session. A session may be held at any place in the United States.

Place: The House of Delegates adopted the following resolution from Indiana, May 1927:37, 52:

Resolved, That the annual sessions of this Association shall be held only in cities in which the facilities for properly caring for all the activities of the Asso-

ciation have been canvassed and approved by the Board of Trustees in advance of the time when decision as to meeting place is to be made; and be it further

Resolved, That to enable the House of Delegates to vote intelligently on this question, the Board of Trustees at each session shall present its approval of two or more cities which, on investigation by the Board, have been found to possess ample and adequate facilities for caring for the Association and all its activities in a satisfactory manner for the ensuing session; and be it further

Resolved, That the Board of Trustees shall have the authority to change the place for holding the annual session if an emergency arises or if for any reason it is deemed advisable by the Board to change from the selection made by the House of Delegates.

Date: On a resolution from Virginia which requested that dates of the annual sessions be arranged so that they do not conflict with commencement dates of medical schools, the Board of Trustees reported that in selecting the date of the annual session, the Board "is constantly mindful of the interests of Fellows of the Association." June 1928:41, 53.

Executive Sessions: The House of Delegates approved a recommendation "that the House of Delegates resolve itself into executive session at 2 P.M. on Tuesday of each annual meeting for the consideration of reports or problems referred to that session" and that this provision be added to the order of business, June 1930:1, 36.

Executive Sessions: The Speaker recommended, and the House approved, that the Secretary, the Chairman of the Board of Trustees, and the Speaker be authorized to formulate a program of pending questions that the year's activities and experience indicate as meriting executive consideration in order that the Tuesday afternoon executive session shall not aimlessly concern itself with irrelevant matters, May 1932:1, 41.

Executive Sessions: The House of Delegates adopted the following resolution, May 1936:2, 42, 47, 48:

Resolved, That the Speaker of the House of Delegates now in session be empowered, at his discretion, to refer any resolution to the Special Reference Committee on Executive Session; and be it further

Resolved, That the Speaker be empowered to declare an executive session whenever he deems one necessary.

Place: The House of Delegates approved a resolution from West Virginia which recommended that the House select the place of the annual session three years in advance of the date of meeting, June 1937:60, 68.

Executive Sessions: The House of Delegates approved a resolution from Tennessee which recommended that problems of a nature critical to the life of the

American Medical Association be referred by the Speaker of the House for consideration in executive session: that each delegate who offers a resolution be requested at the outset to state the subject thereof, and that the Speaker then rule, before such resolution shall be read, whether or not it be considered in executive session. June 1940:49.

Clinical Sessions: On recommendation of President-elect Lee, the House of Delegates authorized an ad interim session of the House of Delegates, Dec. 1943:6, 77.

Clinical Sessions: The House of Delegates amended the *Bylaws* so that chapter III, section 1 reads as follows, July 1946:33, 56:

SEC. 1. REGULAR SESSIONS.—The House of Delegates shall meet annually on the Monday preceding the opening of and at the same place as the Scientific Assembly of the Association. The House of Delegates shall meet also in supplemental sessions once during the interval between annual sessions, at such time and in such places as the Board of Trustees shall designate. Business that may properly come before an annual session may be considered at any supplemental session, subject to the provisions of the *Constitution*. The provisions of the *Bylaws* governing the conduct of business at an annual session, the duties of the Secretary and the meetings of the Board of Trustees shall apply to any supplemental session.

Executive Sessions: The House of Delegates adopted a revised *Constitution and Bylaws* in which the following section was included as chapter IX, section 3 (C), June 1947:2, 91, 92; June 1948:82, 88, 102, 106:

(C) EXECUTIVE SESSIONS.—The House of Delegates may convene in executive session at any time on a majority vote of its members. Only members of the House of Delegates as defined in article 6, section 2, of the *Constitution* shall be present at an executive session. The House, by a two thirds majority vote, may invite any other person who in its judgement might assist in the deliberations.

Open, Closed, or Executive Sessions: The House of Delegates amended the *Bylaws* so that chapter IX, section 3 (C) reads as follows, Nov.-Dec. 1948: 55–56, 56, 58, 59, 63–64:

(3) OPEN, CLOSED, OR EXECUTIVE SESSIONS.—Sessions of the House may be (1) open, (2) closed or (3) executive. (1) The House of Delegates may meet in open session to which any person may be admitted. By majority vote of the seated delegates, an open session may be moved into either a closed or an executive session. (2) A closed session shall be restricted to Fellows and members of this Association and to attachés of this Association, of constituent state medical associations, and of component county medical societies. (3) An executive session shall be limited to the members of the House of Delegates as defined in article 6, section 2 of the *Constitution* and to such administrative employees of this Association and of the House of Delegates necessary for the functioning of

the House. (4) The House of Delegates, in any session, by a two-thirds vote may extend an invitation to address the House of Delegates to any individual who, in its judgement might assist in its deliberations.

Clinical Sessions: The House of Delegates disapproved a resolution from Nebraska which recommended that the interim session be held in the month of December, the exact date to be fixed by the Board of Trustees. Jan. 1949:11, 16, 17.

Clinical Sessions: On request of the Board of Trustees for an expression of opinion, the House of Delegates approved continuation of the clinical session and recommended that the Board of Trustees and the Council on Scientific Assembly consult with officers of the Section on General Practice for advice regarding possible improvements in the scientific program. Dec. 1950:49, 64, 65.

Executive Sessions: On recommendation that the Committee on Constitution and Bylaws interpret and clarify the term "executive session," the House of Delegates adopted report of the Committee stating that chapter IX, section 3 (C) (3) of the *Bylaws*, as interpreted by the Committee, was definite in intent and that the committee was unable at this time to add anything which would provide further clarification. June 1951:30, 35, 36.

Closed Sessions: The House of Delegates amended the *Bylaws*, deleting the word "attachés" and inserting the words in italics so that chapter IX, section 3 (C) (2) will read as follows. Dec. 1951:61, 82, 83:

A closed session shall be restricted to Fellows and members of this Association and *to members of the staff of this Association,* of constituent state medical associations, and of component county medical societies.

Open, Closed, or Executive Sessions: The House of Delegates approved a recommendation that the following sentence in italics be transferred to chapter IX, section 2 (B) and that chapter IX, sections 3 (C), (D) and (E) read as follows. Dec. 1952:87–88, 101, 102:

The House of Delegates, in any session by a two-thirds vote may extend an invitation to address the House to any person who in its judgement, might assist in its deliberation.

(C) Open—The House of Delegates may meet in open session to which any person may be admitted. By majority vote of the seated delegates, an open session may be moved into either a closed or an executive session.

(D) Closed.—A closed session shall be restricted to members of this Association, and to members of the staff of this Association, of constituent state medical associations and of component county medical societies.

(E) Executive.—An executive session shall be limited to the members of the House of Delegates as defined in article VI, section 2 of the *Constitution* and to such administrative employees of this Association and of the House of Delegates necessary for the functioning of the House.

Regional Meetings. The House of Delegates adopted the following report with regard to resolution no. 16 from Georgia recommending a series of small regional two-day meetings to supplement semi-annual meetings of the Association, June 1956:57, 64:

. . . The Trustees, the Law Department, the Public Relations Department, and others confirm the fact that the American Medical Association is eager to offer assistance in furnishing speakers, material, and other support for any county, state, or regional meeting, if asked.

Your reference committee favors meetings of this type, but recommends that no action be taken for the reasons detailed.

Discontinuation of Clinical Session: On resolution no. 13 from Illinois which recommended discontinuance of the interim session, the reference committee recommended, and the House approved, "that the Board of Trustees consider the advisability of holding an interim meeting of the House of Delegates in Chicago each November or December and an interim scientific session in November or December of each year in different parts of the United States."

The House of Delegates approved the following with regard to the report of the Board of Trustees, Nov. 1956:108–109; June 1957:14–15:

. . . Your committee feels that the value of the interim session has been demonstrated in public relations values and in areas of scientific activity. Your committee feels that the initial intent of the interim session was to carry the work of the Association to less populous areas of the nation where conduct of the annual session is not practical. It is obvious that this policy enables many members to avail themselves of these scientific, postgraduate benefits without extensive travel. Concurrently conducted scientific sessions with meetings of the House of Delegates stimulates attendance of those who contribute to deliberations of the House. The modest and proportionately small additional costs involved represent funds, in the opinion of your committee, wisely expended. Your committee, therefore, concurs heartily with the Board that the House of Delegates meeting and the scientific clinical session should be held at the same time and place, and it is recommended that the present practice be continued without change.

HOUSE OF DELEGATES — SPECIAL AND STANDING COMMITTEES

See also names of Councils, ex. Medical Service, Council on

Abolishment of Standing Committees: The House of Delegates tabled a recommendation that the standing committees on medical education, medical literature, climatology and epidemic diseases be abolished, and that instead, there be delivered, addresses on medicine, surgery, and obstetrics and diseases of women, May 1872:66; May 1873:36.

Appointment of Members: The House of Delegates referred to the Judicial Council, a resolution which provided "that in the recommendation and appoint-

ment of committees, preference should be given to delegates present to those in nonattendance," June 1874:28.

Relationship to the Board of Trustees: On address of President Burrell, the House of Delegates adopted the following report, June 1909:1, 42:

In order that the Association may become more closely knit together and its various energies be coordinated, it is advised that all committees, whether constituted by the House of Delegates or by any of the sections, be required to act with the advice and under direction of the Board of Trustees in the intervals between the sessions of the House of Delegates and that the defined policies of all committees and of the sections of the Association shall be approved by the Board of Trustees before being issued to the public as in the name of or under the auspices of the Association. In order that this action may become a part of the law of the Association, the committee offers the following amendments to the *Constitution and Bylaws*:

(1) Chapter IX, section 1 (page 16): add to this section the following words: *during the intervals between the sessions of the House of Delegates, the Board of Trustees shall supervise the action of committees constituted by action of the House.*

(2) Chapter X, section 1 (page 18): add to this section the following words: *any of these committees, acting during the intervals between the sessions of the House of Delegates shall be subject to the Board of Trustees.*

Appointment of Members: The House of Delegates approved a *Bylaws* amendment to provide that "vacancies occuring in any standing committees during the interval between annual sessions of the Association shall be filled by the President," June 1919:1, 40.

Appointment of Members: The House of Delegates approved the following amendment to chapter VII, section 1 of the *Bylaws*, June 1916:68:

(1) strike out the following words: *these committees shall be nominated by the President and elected by the House of Delegates, unless otherwise provided for in these Bylaws.*

(2) substitute in their place, the following words: *The standing committees shall be nominated by the President and elected by the House of Delegates, unless otherwise provided for in these Bylaws. Reference committees and special committees shall be nominated by the chairman of the House of Delegates and elected by the House of Delegates unless otherwise provided for in the Bylaws.*

Recall of Members: The House of Delegates approved deletion of the following sentence from chapter VII, section 2 of the *Bylaws*, June 1921:32, 36:

The House of Delegates may recall the election of any officer or appointment of any member of a committee or council at any session by two-thirds vote of the members of the House of Delegates, present and voting, provided that no motion for recall shall be voted on until the day following that on which it is introduced.

Clarification of Bylaws Re Committees: The House of Delegates approved an amendment to division three, chapter X, section 4, paragraph A of the *Bylaws*, deleting the words in italics from the following sentence: (A) the following *Councils of the American Medical Association* are the Standing Committees of the House . . .

The House amended the following paragraphs of chapter X, section 4 of the *Bylaws*, adding the words in italics so that the amended portions will read as follows:

> (C) OFFICERS.—The Council *and Committees* shall organize and elect their own officers . . .
> (D) EXPENDITURES.—Each Council *and Committee* shall submit to the Board of Trustees a budget . . .
> (E) RULES AND REGULATIONS.—Each Council *and Committee* may make its own rules . . .
> (F) COMMITTEES.—Each Council *and Committee* shall have the authority to appoint committees subject to the approval of the Board of Trustees for any purpose within the functions of the Council or *Committee*.
> (G) HEADQUARTERS.—The Association headquarters shall be the headquarters of all Councils *and Committees*.
> (H) REPORTS.—Each Council *and Committee* shall submit a report of its work . . . ,

Dec. 1950:44, 67, 68.

Clarification of Bylaws Re Committees: The House of Delegates approved the following amendments to the Bylaws. Dec. 1951:61, 61–62, 82, 83:

(1) Chapter X, section 1(A): add the word in italics:

> (A) Standing Committees (*Council*)

(2) Chapter X, section 4 to read as follows:

> Sec. 4. STANDING COMMITTEES (COUNCILS).—

(3) Chapter X, section 4(F): substitute for the word *subcommittee* the words *special committees* so that the section will read as follows:

> (F) COMMITTEES.—Each Council shall have the authority to appoint special committees subject to the approval of the Board of Trustees for any purpose within the functions of the Council or Committee.

Organizational Structure of Standing Committees: The House of Delegates adopted as amended, report of a committee appointed "to review the organizational structure of standing committees of the House of Delegates," which included the following recommendations, June 1951:13, 34, 35; Dec. 1951:68–69, 78, 79:

1. That this House of Delegates express its appreciation to the Board of Trustees for the general excellence of the program being developed under its direction, and that it direct the Board of Trustees to conduct the affairs of the Association and coordinate all activities of standing committees as provided in the *Constitution and Bylaws*, especially chapter X, section 3 of the *Bylaws*.

2. That differences of opinion that may arise among standing committees concerning the scope of their respective areas of activity be resolved by the Board of Trustees.

3. That the programs of the standing committees be given adequate publicity in THE JOURNAL by the submission of informative reports from the standing committees concerned.

4. That any Trustee member of a standing committee of the House of Delegates be ex officio without vote.

5. That a limitation similar to that imposed on the Board of Trustees by the *Bylaws* be placed on the terms of office of members of standing committees of the House of Delegates.

Terms of Office: The House of Delegates adopted the following *Bylaws* amendment, limiting the terms of office of members of standing committees, June 1952:28, 47–48, 49–50:

Add to chapter X, section 4, a new subdivision (B) as follows: *No member of any standing committee (council) shall serve for more than two consecutive terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless he has served three or more years.*

Appointment of Members: On recommendation of the Council on Constitution and Bylaws "that members of standing committees of the House of Delegates be elected by the House of Delegates on nominations made by the Board of Trustees in a uniform manner for each standing committee," the House of Delegates took the following action, June 1953:26–27, 33, 52, 53:

(1) Chapter XI, section 2(A): disapproved deletion of the words in italics in the following sentence:

> The Judicial Council shall consist of five Active or Service Members elected by the House of Delegates *on nomination of the President* . . .

(2) Chapter XI, section 2(B) Council on Scientific Assembly: approved deletion of the words in italics in the following sentence:

> All members shall be elected by the House of Delegates *on nomination by the Board of Trustees* . . .

(3) Chapter XI, section 2(C) Council on Medical Education and Hospitals: approved deletion of the words in italics in the following sentence:

> Members of the Council shall be elected by the House of Delegates *on nomination by the Board of Trustees* . . .

(4) Chapter XI, section 2(D) Council on Medical Service: approved deletion of the words *each of whom shall serve for a term* and addition of the words in italics in the second sentence; approved deletion of the entire last sentence which reads: *At each annual session the Board of Trustees shall present to the House of Delegates three nominations for each vacancy, and the House of Delegates shall elect from these.* This paragraph as amended will read as follows:

> (D) THE COUNCIL ON MEDICAL SERVICE shall include six Active or Service Members. *All members shall be elected by the House of Delegates for terms* of five years each so arranged that at one annual session the terms of two members expire and at four annual sessions the term of one member expires. In addition, the President, the immediate past president, and a member of the Board of Trustees selected by the Board shall be members of the Council, except that the President and the Trustee member shall be ex officio members without vote.

(5) Chapter XI, section 2(E): Approved deletion of the words in italics in the following sentence:

> The Council on Constitution and Bylaws shall consist of five Active or Service Members elected by the House of Delegates *on nomination by the Board of Trustees* . . .

(6) Chapter XI, section 2(F): Changed the present subsection (F) to (G) without modification and inserted the following new subsection (F):

> At each annual session, the Board of Trustees shall present to the House of Delegates two or more nominations for each vacancy in the Standing Committees (Councils) of the House of Delegates except for the judicial Council, and further nominations may be made from the floor of the House of Delegates, except for the Judicial Council.

Appointment of Members: The House of Delegates disapproved the following resolution from Louisiana (no. 36), as "this resolution would restrict the Board of Trustees in its work," June 1956: J.A.M.A. 162:663:

Resolved, That the Board of Trustees be requested to secure the approval of the appropriate executive committee of the state society concerned before a member is presented to the House of Delegates of the American Medical Association in nomination for election to a council.

Executive Vice President—Office Created: The House of Delegates approved the following *Bylaws* amendments subsequent to creation of the office of Executive Vice President. *Delete the words in bold face and substitute the words in italics*, June 1958:38–39, 39–40:

CHAPTER XI.—STANDING COMMITTEES (COUNCILS) OF THE HOUSE OF DELEGATES

SECTION 1. **Names. (A) Judicial Council; (B) Council on Medical Education and Hospitals; (C) Council on Medical Service, and (D) Council on Constitution and Bylaws.** *Designation and Administration.—The Judicial Council, the Council on Medical Education and Hospitals, the Council on Medical Service and the Council on Constitution and Bylaws shall be the standing committees of the House of Delegates subject to the administrative direction of the Executive Vice President.*

SECTION 2. Membership.—(D) The Council on Constitution and Bylaws shall consist of five Active or Service Members elected by the House of Delegates for terms of five years, so arranged that at each annual session the term of one member expires. The President, **Secretary, Assistant Secretary,** *Executive Vice President, Assistant Executive Vice President*, a member of the Board of Trustees selected by the Board and the Speaker and Vice Speaker of the House of Delegates shall be ex officio members of this Council without the right to vote.

SECTION 4. OFFICERS.—The Councils and Committees shall organize and elect their own officers except that **the Secretary of the Association shall be the Secretary of the Judicial Council and that**, on nomination by the respective Councils, the Board of Trustees shall elect a secretary of the Council on Medical Educa-

tion and Hospitals and a secretary of the Council on Medical Service and shall fix their salaries.

SECTION 2. REPORTS.—Each Council and Committee shall submit an annual report of its work to the House of Delegates at the interim session. All such reports, when possible, shall be transmitted to the Secretary *Executive Vice President* of the Association before being presented at the interim session. The Secretary *Executive Vice President* shall provide copies for distribution to the members of the House of Delegates and arrange for their publication in The Journal of the American Medical Association. Only urgent special reports shall be submitted at the annual session.

Nominations—Announcement: The House of Delegates adopted resolution no. 7 from California, Dec. 1958:120:

Resolved, That the Board of Trustees make known its nominations to committees elected by the House at the first meeting of the House of Delegates that the House may become familiar with the candidates for whom they vote.

HUNTER, JOHN

Memorial: The House of Delegates approved appointment of a committee to collect funds for a project of the British Medical Association in memory of John Hunter, May 1859:31; June 1860:31, 37–38, 42.

Hunter Prizes: The delegate from Delaware submitted a resolution which recommended investment of funds left over from the Hunter Memorial so that "when the interest accruing upon this investment shall prove sufficient, it shall be used in awarding prizes, to be called Hunter Prizes to the authors of meritorious essays on surgical subjects." June 1863:22.

Hunter Prizes: The House of Delegates rescinded the resolution passed in 1863 relative to the establishment of Hunter Prizes, and recommended that the money be transferred to the Treasurer of the Association to be used by him for general expenses. June 1865:56.

HYDROPHOBIA

Study: The House of Delegates approved appointment of a committee to study hydrophobia and its occurrence during different seasons. May 1854:30–31; May 1855:46–47.

Study: The House of Delegates adopted a resolution which recommended that a copy of the statistical part of the report of the Committee on Hydrophobia and the Connection of the Year With its Prevalence be transmitted to the governor of each state with the request that this subject be brought before the state legislatures. May 1856:24–25, 233–336.

LEGISLATION

Committee on Medical Legislation: The House of Delegates referred to the Committee on Publication, a report submitted by a committee appointed to consider "the best mode of rendering the medical patronage of the national government tributary to the honor and improvement of the profession." May 1856:35, 531–551.

Committee on Medical Legislation: The House of Delegates approved, in 1899, establishment of a standing committee on legislation which "shall report annually to this Association its action during the previous year and shall recommend to the Association such action regarding pending legislation as it shall deem proper." June 1898: J.A.M.A. 31:84, 85, 95; June 1899: J.A.M.A. 32:1337–1338, 1372; June 1900: J.A.M.A. 34:1559.

Organization of Medical Profession: The House of Delegates approved creation of an auxiliary committee to the Committee on Medical Legislation to be composed of one member from each state and territorial society represented in this Association and one member of the Army, Navy, and Marine Hospital service. June 1900: J.A.M.A. 34:1558; June 1901: J.A.M.A. 36:1635–1636, 1717–1718; June 1902: J.A.M.A. 38:1657, 1658.

Organization of Medical Profession: The Committee on Legislation reported (1) organization of a National Congressional and Legislative Committee composed of representatives from each county society; (2) organization of a national legislative council composed of representatives from each state; (3) compilation of a list of local political leaders of every organized or recognized political party in the United States. The Committee recommended that the entire profession bring itself to bear in securing members of the medical profession to become members of Congress.

The Committee recommended, and the House approved, that a Bureau of Medical Legislation be established at headquarters. June 1904:4–6; June 1905: J.A.M.A. 45:259, 261–262, 277.

Enlarged Legislative Policy: The House of Delegates requested the Board of Trustees to provide such aid to the Bureau of Medical Legislation as would enable it to carry through the enlarged legislative policy proposed, not restricted to questions of a national concern, but embracing the public interests of the medical societies and of the profession in all the states and municipalities of the nation. June 1907:19, 28, 30.

Organization of Medical Profession: The House of Delegates recommended, for greater efficiency, that the chairmen of state legislative committees be appointed members of the National Legislative Council and that members of the auxiliary state committees constitute the National Auxiliary Committee. June 1908:14, 37.

Council on Health and Public Instruction: The House of Delegates approved merging of the Standing Committee on Medical Legislation with the Council on Health and Public Instruction. June 1911:7, 36.

Council on Medical Legislation Proposed: The House of Delegates referred to the Board of Trustees, a recommendation that the legislative work of this Association be transferred from the Council on Health and Public Instruction to a council on medical legislation. June 1912:2, 47.

Legislative and Legal Bureau Approved: The House of Delegates approved establishment of a central bureau for the consideration of all legislative matters pertaining to medicine, relieving the Council on Health and Public Instruction of these duties. May 1922:3, 18, 35, 39.

Council on Health and Public Instruction: The House of Delegates approved a *Bylaws* amendment "to relieve the Council on Health and Public Instruction of responsibility for legislation." June 1923:38, 40–41, 41.

Washington Representative: The House of Delegates approved a recommendation of the Reference Committee on Legislation and Public Relations that a full-time representative in Washington be appointed by this Association. May 1925:47.

On request for reconsideration of the action which approved appointment of a full-time Washington representative (May 1925), the House of Delegates advised the Board of Trustees to provide for a representative of this Association in Washington during legislative sessions of Congress, April 1926:19, 38.

The Board of Trustees reported assignment of a member of the staff of the Bureau of Legal Medicine and Legislation to full-time duty at Washington during sessions of Congress, May 1927:22.

Director of Bureau of Legal Medicine and Legislation: The House of Delegates approved a *Bylaws* amendment, changing the title of the administrative head of the Bureau of Legal Medicine and Legislation from "Executive Secretary" to "Director." July 1929:24, 35, 36.

Committee on Legislative Activities: The House of Delegates approved the following resolution from Minnesota. June 1930:31, 36–37, 37:

Resolved, That the Board of Trustees appoint annually a committee of five, representing various sections of the country, the personnel of said committee to be composed of men who have had experience on state legislative committees, and that said committee is to study these problems and to cooperate with the Bureau of Legal Medicine and Legislation and make such recommendations as they consider necessary to the House of Delegates and in the interim to the Board of Trustees.

On report of the Bureau of Legal Medicine, the House of Delegates approved a recommendation "that state committees be established whose duties are to keep their legislators, both state and national, properly informed on matters pertaining to medicine," June 1931:4–5, 35, 36.

The House of Delegates approved a report of the Committee on Legislative Activities which recommended creation of a "national legislative committee to function continuously with the Board of Trustees and the Bureau of Legal Medicine and Legislation," June 1931:40–41.

The House of Delegates voted to delete from report of the reference committee a statement of the Board of Trustees which disapproved (1) subordination of the Bureau of Legal Medicine and Legislation to the Committee on Legislative Activities; (2) a budget request from the Committee; and (3) compensation for members of the Committee, May 1932:20, 24, 36, 42–44, 45–47, 48.

Washington Office: The House of Delegates disapproved a resolution from Dr. Charles Riggs of the U.S. Navy, which recommended establishment of a permanent Association office at Washington, D.C., June 1933:49–50, 52.

The House of Delegates referred to the Board of Trustees, a resolution from West Virginia which recommended provision of a permanent representative of the American Medical Association in Washington, Feb. 1935:7, 9.

The Council on Medical Service and Public Relations reported opening of an Association office in Washington, D.C., on April 3, 1944, June 1944:60, 85, 86.

Social and Economic Activities: The House of Delegates returned to Michigan State Medical Society for clarification and more specific recommendations, a resolution which recommended "that the House of Delegates of the American Medical Association proceed to change and amend the organizational and incorporational setup of the American Medical Association so as to permit of economic and political activities being carried on by the American Medical Association." June 1944:69, 83, 84.

United Public Health League: The House of Delegates disapproved a resolution from California which provided that the American Medical Association "endorses the United Public Health League as a vehicle for meeting the demands of the rank and file membership of the Association in the economic and political fields." June 1944:71, 84, 85.

State Committees on Legislation: The House of Delegates expressed accord with a report of the Council on Medical Service and Public Relations which reads in part as follows, Dec. 1945:57, 86, 87:

. . . That each state association be invited to appoint a special national legislative committee, consisting of at least five men composed of the president, secretary and three other members, in those states which do not now have active legislative committees. The function of this committee will be to determine the

opinions and wishes of the profession and to keep the Council office and the Washington Office informed of the attitude of the senators and congressmen of their respective states. A two-way flow of information is thus encouraged . . .

A.M.A. Staff—Stand on Legislation: The House of Delegates adopted the following resolution from Georgia. June 1948:71, 77, 92, 93; Nov.–Dec. 1948:3:

Resolved, That it is contrary to the policy of this House that headquarters staff personnel so consulted or appointed shall become advocates either for or against legislative matters pending before this House.

Washington Office: The House of Delegates approved expansion of the Washington Office as rapidly as is practicable. June 1948:76–77, 96; Nov.–Dec. 1948: 51, 72.

Coordination Committee on Legislation: On report of the Washington Office, the House of Delegates approved the following report. Dec. 1949:10–11, 68:

". . . Since the Washington Office is now under the direction of the Board of Trustees instead of, as formerly, under the Council on Medical Service, in order to promote more effectively the activity of this office and implement its work, your reference committee recommends that the Board of Trustees appoint a committee of not less than seven members from the Trustees and general membership. The committee's function should be the facilitating of the activities on legislative matters and the dissemination and distribution of legislative information throughout the various states . . .

Washington Office: The House of Delegates approved report of the Reference Committee on Legislation and Public Relations which recommended that the Legislative Committee and the Board of Trustees take appropriate action to strengthen the Washington Office. June 1950:10, 44, 45, 53, 54.

Legislation Not Related Directly to Medicine: The House of Delegates adopted the following report of the Coordination Committee on Legislation. June 1950: 10, 53, 54:

. . . The committee is of the opinion that, as a general principle, the American Medical Association should not take a position favoring or opposing legislation which does not bear directly on medicine, but is equally strongly of the opinion that it would be unwise for the House to place restrictions on the discretionary powers of the Board of Trustees and Legislative Committee.

Washington Office: The House of Delegates adopted, as amended, a resolution from Wisconsin which authorized the Board of Trustees to consider purchase of suitable property in Washington, D. C., at an opportune time, to serve as permanent headquarters for the Washington Office of this Association. Dec. 1951:70, 78, 79; June 1952:15, 41.

Washington Letter: The Washington Office announced merger of the *Capitol Clinic* and the *Legislative Bulletin* to form the *American Medical Association Washington Letter*, Dec. 1953: 16, 89, 90.

Attitudes of State Societies: The House of Delegates approved a recommendation of the Reference Committee on Legislation and Public Relations "that in order to furnish further advisory sources for the Committee on Legislation, some mechanism be developed to obtain the attitude of each state medical society on pending federal legislation." Nov.-Dec. 1954: 95.

Washington Letter: The House of Delegates concurred in opinion of the Board of Trustees that the mailing list of the *Washington Letter* be not expanded, June 1955: 13, 52.

Legislative Newsletter: The House of Delegates approved resolution no. 19 from Oregon which recommended development of more effective means for informing members about national legislation and socioeconomic factors affecting medical practice, Nov.-Dec. 1954: 86, 93, 94.

In accordance with the above resolution, the Board of Trustees reported (1) that the Committee on Legislation had been authorized to prepare a legislative newsletter for distribution to key legislative personnel of state medical societies; (2) that communications from state associations had been invited to indicate positions adopted with respect to national legislation and to suggest means of improving the Association's procedure for obtaining views and recommendations of state medical societies, June 1955: 16, 54, 56.

Law Department: The House of Delegates approved transfer of functions of the Bureau of Legal Medicine and Legislation to a newly created Law Department, Nov.-Dec. 1954: 10, 23, 91, 93.

Washington Office: The House of Delegates referred to the Board of Trustees, resolution no. 48 from the Section on Military Medicine which recommended increase of personnel in the Washington Office, June 1955: 44, 58, 59.

Regional Legislative Conferences: On report of the Committee on Legislation regarding regional legislative conferences held for the purpose of establishing closer and more effective liaison with state and local medical societies, the House of Delegates adopted a report which suggested "that the work of the "Committee could be even more effective if a representative of the Committee could appear before the House of Delegates and representative members of each state society to discuss legislative matters on a national level." June 1956: 20, 67.

Washington Office Legislative Analysis Service: The Washington Office reported inauguration of the Washington Office Legislative Analysis Service, designed to

supply exact and detailed information under a legalistic format to a relatively small mailing list. Nov. 1956:26.

State Legislative Key Men: The House of Delegates approved the following section of a report submitted by the Task Force on Socioeconomic Problems, June 1957:23:

In the legislative field the Task Force recommended in November that consideration be given by the Committee on Legislation of the Association to a plan whereby legislative contacts could be more effectively implemented throughout the states. With this in mind the Committee on Legislation submitted a revised method of operation to the Board of Trustees, which was adopted. The specific recommendations which have already been carried out are (1) the appointment of a key legislative man in each state to work with the state medical association and the members of the Committee on Legislation; (2) the establishment by the Woman's Auxiliary of a similar arrangement by the appointment of legislative key women; and (3) the employment of additional research personnel for the staff of the Committee.

The Task Force recommends to the Board than an effort be made to increase the liaison between the Association and the individual congressmen and senators. Specifically, the Task Force recommends that the state associations be encouraged to send committees or groups of representatives to Washington to confer with their individual congressmen. If such action is taken by a state association, it is urged that a representative of the A.M.A. Washington Office be included in the discussions.

The Committee on Legislation reported a revised mechanism for appointment by the Board of Trustees, of legislative key men from each state, Dec. 1957: 18-19.

Legislative Key Women: The Committee on Legislation reported that "legislative key women" have been appointed in almost every state by the Woman's Auxiliary; that the Committee voted to extend an invitation to the chairman of the Committee on Legislation of the Woman's Auxiliary to attend meetings of the A.M.A. Committee, June 1957:23; Dec. 1957:19, 21, 107, 108.

Survey of the A.M.A. Legislative Program: The House of Delegates adopted resolution no. 13 from California, amended to read as follows, June 1958:52-53:

Resolved, That the Board of Trustees of the American Medical Association, through the General Manager, is hereby requested immediately to survey and re-evaluate the functions and effectiveness of the over-all A.M.A. legislative system, including the Washington Office, in the light of present day needs of the government, public and medical profession alike for effective liaison between government and medicine on all matters affecting the public's health and adequate, prompt and accurate transmittal to the full membership of the A.M.A. of information on all current public issues in which the physician has a direct interest; and be it further

Resolved, That the Board of Trustees implement, as rapidly as possible, all changes and additions that its survey discloses are desirable to achieve the basic purpose of this resolution: namely, effective public and government relations.

LEPROSY

Experimental Station: The House of Delegates adopted a resolution which urged on federal authorities the establishment of an experimental station, including hospital and laboratories, at the leper settlement in the island of Molokai, Hawaii, for the investigation and study of leprosy, looking especially toward cure of the disease, June 1904:19, 20.

Legislation to Effect Control: The House of Delegates adopted a resolution from the Section on Dermatology which recommended enactment of legislation providing for the comprehensive care of lepers and control of leprosy by the federal government, June 1914:48, 49, 50.

National Leprosarium: The House of Delegates approved and referred to the Council on Health and Public Instruction with power to act, a resolution from the Section on Preventive Medicine and Public Health (1) requesting the American Public Health Association to call a conference to discuss every phase of the problem of leprosy; (2) requesting the board charged with the responsibility of selecting a site for a national leprosarium to convene at the earliest possible moment and arrive at a decision; (3) urging the Surgeon General of the U.S. Public Health Service immediately thereafter to establish said national leprosarium as provided by Congress, April 1920:49–50.

LIBRARIANS, MEDICAL RECORD

Approval of Schools: The House of Delegates approved a recommendation that the Council on Medical Education and Hospitals undertake standardization, inspection, approval, and listing of schools for the training of medical record librarians, June 1942:56, 58.

Approval of Schools: The House of Delegates approved *Essentials of an Acceptable School for Medical Record Librarians*, June 1943:61, 63, 72; Dec. 1945:47, 71; Dec. 1949:49–50, 67, 68; June 1952:30–31, 45, 46.

Medical Record Technicians: The House of Delegates approved *Essentials for the Training of Medical Record Technicians*, (Medical Record Technicians work "under the supervision of a qualified medical record librarian or a medical record committee [and] perform technical tasks associated with the maintenance and custody of medical records"), June 1953:29–30, 49, 50; Dec. 1953:63, 97, 98.

Hospital Staff Meetings: The House of Delegates adopted the following report with regard to resolution no. 29 from California, June 1957:51:

This resolution requests the Joint Commission on the Accreditation of Hospitals to revise its standards regarding active staff attendance requirements to conform with the Stover report.[1] The Bulletin of the Joint Commission on Accreditation of Hospitals, March 1957, contains a new statement which reads as follows:

> Active staff attendance shall average at each meeting at least 30 per cent of the active staff who are not excused by the executive committee for just cause. Each active staff member shall attend 50 per cent of staff meetings unless excused by the executive committee for just cause. There was some concern on the part of the introducer of this resolution as to what constitutes just cause. The Joint Commission on Accreditation of Hospitals assured the reference committee that unless these excuses were overutilized, determination be left to the executive committee of the hospital. Your reference committee therefore recommends that this resolution be disapproved.

MEMBERSHIP

Membership Defined: The delegates to the National Medical Convention held in 1847 adopted a *Plan of Organization* for the American Medical Association which provided: "The members of this Institution shall collectively represent and have cognizance of the common interests of the medical profession in every part of the United States; and shall hold their appointment to membership either as delegates from local institutions, as members by invitation, or as permanent members." May 1847:41–45, 56.

Exclusion of Empiricists: The delegation from New Hampshire submitted a communication which stated that no delegate should be admitted to membership in this Association "from a medical society which numbers among its members any person or persons who adopt as their system of practice, any form of empiricism," May 1854:20.

Persons Expelled from Local Societies; Education Requirements: The House of Delegates approved an amendment to the *Plan of Organization* to provide "that no individual who shall be under sentence of expulsion or suspension from any state or local medical society of which he may have been a member, shall be received as a delegate to this body or be allowed any of the privileges of a member until he shall have been relieved of said sentence."

The House disapproved a resolution "to prohibit the admission as a delegate or recognition as a member of any person who is not a graduate of some reputable medical college," May 1858:30–31, 42; May 1859:34–35.

Persons Expelled from the A.M.A.: The House of Delegates approved addition of the following sentence to article II of the *Plan of Organization*, May 1859:37:

1. The Stover report concluded as follows: "Staff meetings required by the Joint Commission are acceptable, but attendance requirements should be set up locally and not by the Commission."

No one expelled from this Association shall at any time thereafter be received as a delegate or member, unless by three-fourths vote of the members present at the meeting to which he is sent, or at which he is proposed.

County Society Membership Requirement: The House of Delegates indefinitely postponed action on resolutions to abolish "membership by invitation" and to restrict delegates to members of local medical societies, May 1869:28; May 1870:39.

Authors of Sensational Medical Works: The House of Delegates resolved that membership be refused to authors of "so-called medical works of a character decidedly injurious to the morals of the young," which have been written for the purpose of notoriety and advertised for sale, unless such advertisements are withdrawn at once, May 1870:30.

Race Restrictions: The House of Delegates tabled a resolution which provided "that no distinction of race or color shall exclude from the Association persons claiming admission and duly accredited thereto," May 1870:65–67.

State Society Members to be Permanent Members: The House of Delegates adopted a majority report opposing the following recommendations of President Bowditch: (1) that every regular member of a state society become a permanent member of this Association; (2) that delegates shall be apportioned on the basis of one delegate for twenty regular resident members instead of one for every ten, June 1877:35, 36, 51–52, 105–106; June 1878:48–52.

Members by Application: The House of Delegates amended regulation II of the *Plan of Organization* to provide for the admittance of "members by application," May 1881:51; May 1884: J.A.M.A. 2:573.

Dentists: The House of Delegates adopted a resolution which provided that regular graduates of dental schools with standards comparable to the best class of medical colleges, "be recognized as members of the regular profession of medicine and eligible to membership in this Association on the same conditions and subject to the same regulations as other members," June 1887: J.A.M.A. 8:722.

Members by Application: On recommendations regarding an increase in revenue by an increase in permanent paying membership and formation of branches of this Association, the House of Delegates adopted a report which recommended (1) that no radical changes be made in the *Plan of Organization* and that branches of the Association be not established; (2) that instead, an amendment be made to the section on members by application, enabling "all of the members of recognized state and local societies *under adequate safeguards* to become *de facto permanent members* without attending an annual meeting." Thus members by application would "have their names upon the roll and have all the rights and privileges accorded to permanent members, and shall retain their

membership on the same terms," May 1886: J.A.M.A. 6:510, 606; June 1887: J.A.M.A. 8:711–716, 717; May 1888: J.A.M.A. 10:693–694.

Permanent Members Equal in Rights to Delegates: The House of Delegates tabled an amendment to the *Constitution* to make "permanent members equal in all rights to delegates." May 1890: J.A.M.A. 14:837; May 1891: J.A.M.A. 16:715.

Education Requirements: The House of Delegates indefinitely postponed action on an amendment to provide that after July 1, 1897, no one would be admitted to membership in the American Medical Association "who has not studied medicine four years, and attended four annual courses of lectures of at least six months' duration." June 1892: J.A.M.A. 18:811; June 1894: J.A.M.A. 22:952; May 1895: J.A.M.A. 24:761, 762, 763.

Life Membership: The House of Delegates approved a suggestion that members of the Association who have been on the list for forty years and over should be made life members and receive THE JOURNAL free of cost. May 1896: J.A.M.A. 26:985.

Education Requirements: The House of Delegates referred to the Judicial Council, a decision of the Executive Committee that the action taken by the House in 1898 was unconstitutional. This action restricted from membership, anyone who, after January 1, 1899, conferred or received a degree on any conditions below the published standard of the Association of American Medical Colleges. June 1898: J.A.M.A. 31:83, 92; June 1899: J.A.M.A. 32:1009–1110, 1193–1194, 1333, 1338.

Education Requirements: The House of Delegates amended article II of the *Constitution*, adding to the qualifications of membership in those societies eligible to send delegates to the Association, the provision that they shall not have received into membership "any one who may after 1901 have received the degree of doctor of medicine on less than four years of graded instruction or an equivalent requirement." June 1899: J.A.M.A. 32:1373; June 1900: J.A.M.A. 34:1359.

Associate Members: The House of Delegates amended section 3 of the *Constitution*, substituting the words in italics for the words "not physicians," June 1902: J.A.M.A. 38:1637:

Representative teachers and students of the allied sciences, *unregistered or unlicensed practitioners* may become Associate members by vote of the House of Delegates.

Dentists: The House of Delegates amended article III of the *Constitution* to provide that dentists who hold the degree of D.D.S. may be admitted as Dental members. June 1902: J.A.M.A. 38:1658; May 1903: J.A.M.A. 40:1375, 1377, 1378.

Verification of Qualifications; Transfer: The House of Delegates adopted the following recommendations: (1) that the Secretary complete verification of the membership list and obtain information on members regarding qualification; (2) that present members be requested to furnish satisfactory evidence of membership qualification as required by our laws on or before January 1, 1903; (3) that after March 1903, all those not eligible be dropped from the roll of members; (4) that the word "local" in line 9, section 3, chapter I, the *Bylaws*, shall be construed, in this connection, to apply to the state organization, or one of its recognized branches of the state in which the person holds his legal residence; (5) that a member moving from one county or state to another may continue to hold his membership in the Association for a period not to exceed two years, without joining an affiliated society in his new place of residence, provided, however, that during this time he retains his original membership in the county or state society from which he moved. June 1902: J.A.M.A. 38:1660.

U. S. Indian Service: The Secretary reported a communication requesting that the rules regulating membership of officers of the Army, the Navy, and the U. S. Marine Service should also apply to the U. S. Indian Service. May 1903: J.A.M.A. 40:1371.

Pharmacists: The House of Delegates approved addition of a section 7 to article III of the *Constitution* to provide that "reputable pharmacists may be admitted as Pharmaceutic members on recommendation of officers of the Section on Materia Medica, Pharmacy and Therapeutics, subject to a majority vote of members of the Section." May 1903: J.A.M.A. 40:1375, 1377, 1378.

Associate Members: The House of Delegates amended the *Bylaws* to specify clearly that associate membership applied "only to those who are not eligible to regular membership." The section, as amended, reads as follows. June 1906:4; June 1907:2, 25, 26:

Section 3.—Associate Members.—Representative teachers, students of sciences allied to medicine, resident in the United States, and not eligible to regular membership, may become Associate members of this Association on recommendation of the officers of a section and on election by the House of Delegates. Such members shall be designated as Associate members.

Dentists and Pharmacists: The House of Delegates amended chapter III, sections 1 and 2 of the *Bylaws* on admission of Dental and Pharmaceutical members, adding the phrase, *and confirmation of the House of Delegates*. June 1907: 31, 32.

Uniform Regulation: The House of Delegates adopted a report of the Committee on Uniform Regulation of Membership which included the following recommendations approved by a conference of state society secretaries. June 1908:4, 33–34, 34; June 1909:34–39, 46, 47; June 1910:25–27, 47–49, 50, 51–56, 58–59; June 1911:3, 37, 44; 13–14, 40, 41; June 1912:11, 42–43, 45; June 1913:31–32, 54; June 1914:38–39, 50, 51:

(1) that the fiscal year coincide with the calendar year in all parts of the organization; (2) that constituent associations adopt provisions making dues in county societies payable January 1 of each year and requiring county secretaries to report to state secretaries all members in good standing together with their per capita assessment for the current year not later than March 31; (3) that the pro-rating of dues be made optional with each local society; (4) that a uniform system of blanks for county and state societies is desirable as soon as practicable; (5) that an admission fee for membership be made optional with each society; (6) that the House of Delegates consider the advisability of issuing charters to constituent state associations; (7) that a uniform system of membership transfer was desirable, but could not be established until there was greater uniformity in other details of organization.

Retired Members: The House of Delegates disapproved an amendment to the *Bylaws* to provide that a member "who has been in good standing with the American Medical Association for twenty years and who has been placed on the retired list of his state association, shall on his request, be placed by the Secretary of the American Medical Association on the list of retired members of this Association and be exempt from the payment of dues," June 1908:12, 36.

Associate Members: On recommendation of the Secretary, the House of Delegates approved an amendment to the *Bylaws* adopted in the past year, (1) to include again provision for Associate membership for teachers and students of allied sciences; (2) to define Associate membership, June 1911:2, 37.

Journal Subscription: The House of Delegates referred to the Council on Constitution and Bylaws, a recommendation that the *Bylaws* be amended so that members in the same family or firm receiving duplicate copies of THE JOURNAL should have a choice of specialty journal, June 1911:4, 37.

Retired Service Members: The House of Delegates amended chapter I, section 2 of the *Bylaws*, adding the words in italics, June 1912:11, 46:

Commissioned medical officers of the United States Army, United States Navy, and the United States Public Health and Marine-Hospital Service shall be members of this Association so long as they are engaged actively in their respective service *and thereafter if they have been retired on account of age or physical disability* . . .

Fellowship Created: The House of Delegates approved amendments to the *Constitution and Bylaws* to provide for two classifications of membership: (1) membership—any physician joining a county medical society of a constituent state or territorial body logically becomes a member of the American Medical Association; 2. Fellowship—members who pay dues for support of THE JOURNAL and the scientific work and the scientific session of this Association, June 1911:40; June 1912:26–27, 45, 46, June 1913:10–11, 38, 50.

Transfer: The House of Delegates voted to make a standing rule, the following resolution from Tennessee regarding the new section in the *Bylaws* on transfer of membership, adopted in June 1912. June 1912:11, 46; June 1913:55; June 1915:2, 60, 61:

Resolved, That nothing in this section shall be construed as exempting any member of the American Medical Association from compliance with the requirements of the civil laws of the state or district into which he may have removed.

Affiliate Fellowship: The House of Delegates approved an amendment to the *Bylaws* to establish Affiliate Fellowship for aged Fellows, June 1914:11, 44.

Residents Near State Lines: The House of Delegates approved insertion of the following sentence in section 3, chapter VIII of the *Bylaws*, June 1915:11, 60, 61:

And provided further, that members of a constituent state association who are located for the purpose of practicing medicine in a state adjacent to that through the association of which they hold membership in the American Medical Association, may be continued as members of the American Medical Association, provided the council of the medical association of the state in which they are practicing medicine waives jurisdiction over the membership of the individual member who holds his connection with the organization through a neighboring constituent state medical association.

Associate Fellowship: The House of Delegates disapproved a recommendation that the *Bylaws* be amended to provide that "no person can become an Associate Fellow who can become a member of the American Medical Association in the regular way," June 1916:68, 71; June 1917:67, 68.

Dentists: The House of Delegates approved action of the Section on Stomatology in requiring applicants for Associate Fellowships holding the degree of D.D.S. or its equivalent, to be endorsed by the executive committee of the Section, June 1917:70.

American Physicians in Foreign Countries: The House of Delegates approved according of Associate Fellowships to American physicians engaged in missionary and similar work located in foreign countries, May 1922:7, 42, 45.

Transfer: The House of Delegates amended the *Bylaws*, adding to chapter XI, section 3 the phrase in italics, May 1922:35, 51:

A Fellow who changes the location at which he practices medicine, from the state whose constituent association he holds membership in the American Medical Association to another state in which there is a constituent association is eligible to membership in the component society of his new location on the presentation of a transfer card and an official statement that his dues have been paid in full in the society in which he holds membership, *provided that no evidence which would otherwise disqualify him for membership arise.*

Retired Service Fellows: The House of Delegates amended section 2, chapter XI of the *Bylaws*, adding the words in italics, June 1924:22, 40:

Commissioned officers of the United States Army, United States Navy, and the United States Public Health Service shall be Fellows of this Association so long as they are engaged actively in their respective service, and thereafter if they have been retired on account of age or physical disability *or, after long and honorable service under an Act of Congress.*

Membership Contingent Upon Payment of Assessments: The House of Delegates adopted the following report, June 1924:22, 40:

In respect to membership contingent upon the payment of a large assessment, it is conceived that a well meaning member may be excluded unjustly from inordinate demands. A member so excluded should and does have the right to appeal to the state council for relief, and then in turn to the Judicial Council of the American Medical Association.

Retired Physicians: The House of Delegates disapproved "creation of an auxiliary membership to include physicians in good standing who have retired from practice but are interested to the extent of paying the dues," June 1924:45, 51.

Dentists: The House of Delegates approved an amendment to chapter IV, section 5 of the *Bylaws*, substituting the words *Section on Laryngology, Otology and Rhinology* for the words *Section on Stomatology* so that applications from dentists for Associate Fellowship in this Association shall be acted on by the Section on Laryngology, Otology and Rhinology. May 1925:32, 32–33, 39, 40, 45–46, 47, 48, 49–50.

Veterans Bureau Physicians: On a request that physicians connected with the Veterans Bureau be admitted to Fellowship on the same basis as physicians in the Army, the Navy, and the Public Health Service, the House of Delegates adopted a report stating that "it would be unwise to accept any physicians to membership or Fellowship in the American Medical Association except through regular channels as prescribed in the *Constitution and Bylaws*," May 1925: 60–61; April 1926:28; May 1927:38, 45, 48, 49.

Education Requirements: The House of Delegates approved an amendment to the *Bylaws*, proposed by the Judicial Council, "to provide that no person who is not a doctor of medicine shall be permitted to become a Fellow of the Association," June 1930:24, 33, 39, 40.

Membership Limited to One Constituent Society: On recommendation of the Judicial Council that all constituent associations be requested to amend their organic laws so that no member shall hold membership in more than one component or constituent society, the House of Delegates adopted a report of the reference committee stating that the *Bylaws* of this Association concerning

ional memberships were sufficiently definite in their provisions and that strict observance of these provisions should be insisted upon. May 1932:7, 25, 34.

Transfer: The Judicial Council defined the term "eligible" as applied to applicants for membership and clarified the significance of "transfer cards." May 1932:25.

Veterans Bureau: The House of Delegates disapproved a resolution from New Hampshire which provided that "physicians who are employed by the United States government as full time physicians in service other than commissioned officers of the United States Army, United States Navy, and U.S. Public Health Service shall be Fellows while so employed by the government, provided such physicians subscribe to THE JOURNAL." June 1933:87.

Education Requirements: The House of Delegates adopted the following resolution from the Judicial Council, June 1934:56, 58:

Resolved, That the *Bylaws*, chapter XI, section 2, be amended by adding at the end of the section: "In exceptional cases a member holding a degree equal in requirement to that of M.D., but not graduated at a recognized school, who formerly was a Fellow or who has established a high standard of professional attainment, may be admitted as a Fellow by the Judicial Council if in its judgment such action is desirable.

Component Society Membership Required: The House of Delegates adopted the following resolution. June 1935:29, 41, 60, 62.

Resolved, That in order to equalize the privileges and duties of all members of the American Medical Association and in order to attain a fair distribution of delegates in this House based on the number of members of component societies forming each constituent association, the first sentence of section 1, chapter XI of the *Bylaws* be amended to read: "Membership in this Association shall continue only so long as the individual is a member of a component society of the constituent association through which he holds membership."

Residents Near State Lines: The House of Delegates endorsed and recommended for earnest consideration by constituent state societies, suggestion of the Secretary "that physicians residing near state lines may be given the privilege of affiliating themselves with the component societies of immediately adjacent counties in other states." May 1936:7, 63.

Members Convicted of Felony: The Judicial Council recommended that the *Bylaws* be amended to provide that "conviction of a felony shall automatically remove a member's name from the membership roll for a period of not less than one year after the termination of punishment for the offense." May 1936:44, 56, 66, 67; June 1937:53.

Negro Physicians: The House of Delegates adopted reports of the Board of Trustees stating (1) that on request of the National Medical Association, the

Board was working out a method for listing Negro physicians in the American Medical Directory in a manner which would not be objectionable to them; (2) "that every component county medical society has the right of self-government in local matters, including membership, by which arrangement many Negro physicians now hold membership in the American Medical Association"; (3) that respecting governmentally directed health projects, the Board of Trustees emphatically depreciated discrimination against any competent and qualified physician because of race, color, creed, or sex, which interfered with his right as a physician to serve those who desire to consult him."

The House disapproved a resolution from New York urging the House to declare its belief that membership in component societies of this Association should not be denied to any person on the basis of race, creed or color, as "the resolution implies that the county medical society should not, in effect, have the right of selection of its own members." May 1939:74, 82; 80, 81, 86, 87, 90.

Education Requirements: The House of Delegates approved an amendment to the *Constitution* to provide that members of the American Medical Association must hold the title of doctor of medicine or bachelor of medicine, May 1939:87; June 1940:8, 53.

Uniform Membership Regulations: On report of Judicial Council, the House of Delegates recommended that the Council "as a guide to the state association, draw up recommendations as to the proper basis of membership and define the status of the various classes of membership in such associations."

The House recommended "that the representation in this body be based on the number of active members in each society," June 1941:42, 62.

Lay Executive Secretaries of Constituent Societies: The House of Delegates disapproved a resolution from Colorado which recommended election of lay secretaries and executive secretaries of constituent associations and component societies to Associate Fellowship, June 1942:65, 69–70, 70.

Veterans Administration: The House of Delegates approved recommendations (1) that the Veterans Administration be given representation in the House of Delegates; (2) that members of the permanent medical corps of the Veterans Administration receive the same consideration as that given to medical officers of the Army, the Navy, and the Public Health Service, with the provision that Fellowship will continue only as long as they remain members of the permanent corps; (3) that such Fellows shall not receive THE JOURNAL or other publications of the American Medical Association except by personal subscription, June 1944:58, 70, 75; Dec. 1945:8, 39–40, 82; Dec. 1946:25–26, 42, 43, 48.

Honorary Members: The House of Delegates approved an amendment to chapter XII, section 7 of the *Bylaws* to provide for conferring of Honorary Fellowship on certain distinguished foreign guests, June 1947:43–44, 65.

Negro Physicians: On a resolution from the National Physicians Association, the House of Delegates adopted the following report, June 1944:49, 82–83, 183–84:

It feels that the Negro physicians of this country should be offered every possible opportunity to improve their medical qualifications. It would urge component societies to extend all aid that is practical to the Negro physicians in their communities to the end that the quality of service rendered by them to their people may be steadily improved. It is recognized, however, that the decision as to membership in the component county medical societies or on hospital staffs is outside the jurisdiction of the American Medical Association and is a matter of local concern.

Drive for New Membership: The House of Delegates requested the Board of Trustees to initiate a drive for new members extending through the constituent associations to the component societies. June 1948:43, 95.

Active Membership: The House of Delegates approved an amendment to *Constitution* so that article 5, section 1, paragraph (A) reads as follows, June 1948: 71, 81:

A. Active Members. Active membership shall be limited to those members of constituent associations who (1) hold the degree of doctor of medicine or bachelor of medicine and (2) are entitled to exercise the rights of Active membership in their constituent associations, including the right to vote and hold office, as determined by their constituent associations, subject to the provisions of the *Bylaws*.

Race or Religion Restrictions: The House of Delegates disapproved a resolution from New York which recommended a change in the *Constitution* of the American Medical Association to provide that no component society "shall exclude any qualified physician from its membership by reason of race, creed, or color," as "the component society is the sole judge as to whom it elects to membership, provided the applicant shall meet the medical requirements for membership." June 1948:72, 93, 94; June 1949:29, 42.

Transfer: The House of Delegates amended the *Bylaws* to provide that when a member has moved to another jurisdiction, "unless he has transferred his membership within six months after such change of practice, the Secretary shall remove his name from the roster of members," June 1949:31, 48, 49.

U. S. Air Force: The House of Delegates adopted an amendment to the *Constitution and Bylaws* to provide Service Fellow status for medical officers of the U. S. Air Force, June 1949:33, 48–49, 49, 50; Dec. 1949:21, 69, 70.

Race or Religion Restrictions: The House of Delegates adopted a resolution from Virginia which recommended "that constituent and component societies having restrictive membership provisions based on race, study this question . . . with a

view to taking such steps as they may elect to eliminate such restrictive provisions," June 1950:41, 55, 56.

The House of Delegates disapproved a resolution from New York which recommended collection and organization of "all pertinent information and experience bearing on possible restrictions to membership based on race or religion." June 1951:22, 39.

Fellowship Abolished: The House of Delegates adopted changes in the *Constitution and Bylaws* to establish a single membership classification, June 1951:26, 27–28, 29, 33, 35; Dec. 1951:8, 85; 58–60, 81; June 1952:25–28, 40–47, 48–49.

Retired and Emeritus Members: The House of Delegates disapproved a resolution from Illinois which recommended "classes of membership for both retired and emeritus members with relief from payment of dues in the American Medical Association," as the present *Constitution and Bylaws* already provides for categories similar to emeritus and retired membership, June 1951:27, 33, 35; Dec. 1951:62, 82, 83–84.

Active and Associate Members: The House of Delegates approved rewording of division one, chapter 1 of the *Bylaws* to read as follows:

Members in good standing of the constituent associations of the American Medical Association are eligible for either Active membership or Associate membership in the American Medical Association, provided they possess the qualifications set forth in article 5 of the *Constitution* and after they have been certified officially for enrolment by the secretaries of their constituent associations to the Secretary of the American Medical Association.

The House approved deletion of the last sentence of this chapter which pertained to the revision of the *Constitution and Bylaws* in 1947 and was now obsolete, June 1951:29–30, 34, 36.

Reactivation of Fellowship: The House of Delegates disapproved reactivation of the Fellowship status in recognition of those doctors who annually contribute to the American Medical Education Foundation, Dec. 1951:85, 86; June 1952:10, 41.

Restrictions Based on Race or Religion: The House of Delegates adopted a resolution from New York which recommended that the House reiterate the resolutions adopted in June 1950 and send a copy of this resolution to each constituent association, June 1952:35, 54.

Negro Physicians: The House of Delegates rejected a resolution from North Carolina which recommended recognition of the Old North State Medical Society as an affiliate of the Medical Society of the State of North Carolina and also of the American Medical Association, June 1952:34, 54; Dec. 1952:11–12, 102, 103.

Active and Associate Members: The House of Delegates amended chapter I, section 1 of the *Bylaws*, adding the words in italics. Dec. 1952:88, 101, 102:

. . . member in good standing of a constituent association of the American Medical Association is eligible for either Active membership or Associate membership in the American Medical Association after he has been certified for enrolment by the secretary of the constituent association *in the jurisdiction of which he conducts his professional activities* to the Secretary of the American Medical Association, provided he possesses the qualifications set forth in article V of the Constitution, and provided he is approved for membership by the Judicial Council . . .

Affiliate Members: The House of Delegates amended chapter I, section 4 of the *Bylaws*, adding the words in italics. Dec. 1952:88, 101, 102:

. . . Affiliate members shall not be required to pay membership dues and shall enjoy the privileges of the Scientific Assembly without the right to vote or hold office, *but shall not receive any publication of the American Medical Association except by subscription.*

Honorary Members: The House of Delegates amended chapter I, section 5 of the *Bylaws*, adding the words in italics. Dec. 1952:88, 101, 102:

. . . Honorary members shall enjoy the privileges of the Scientific Assembly without the right to vote or hold office, shall not be required to pay membership dues *and shall not receive any publication of the American Medical Association except by subscription.*

One Type of A.M.A. Membership: The House of Delegates approved addition of the following new section at the end of chapter I of the *Bylaws*. June 1953:26, 52, 53:

Section 6. Limitation to One Type of Membership.—A member shall hold only one type of membership in the American Medical Association at any one time.

Uniform Membership Regulation: The House of Delegates adopted a resolution which approved the plan outlined in the November 28 issue of THE JOURNAL, entitled *Development of Uniformity in Membership Regulations Between Constituent Associations and the A.M.A.* and authorized distribution of reprints to constituent and component societies with the suggestion that definite efforts be made toward the standardization of membership classifications in constituent and component medical societies. Dec. 1953:77, 95, 96; 82, 83, 94–95, 95.

Transfer: The House of Delegates approved an amendment to chapter II, section 2, third line of the *Bylaws*, adding the words in italics, so that this section reads as follows:

Should an Active or Associate member remove his practice to another jurisdiction he shall apply for *a continuance of his* membership through the constituent association in the jurisdiction to which he has moved his practice.

The House approved an amendment to the *Bylaws* to provide that an Active or Associate member does not necessarily lose his American Medical Association membership when he is precluded by the laws of a constituent association from transferring his membership within six months. The words *six months* were substituted by the words *two years* so that the second sentence in chapter II, section 2 reads as follows:

Unless he has transferred his membership within *two years* after such change of practice, the Secretary of the American Medical Association shall remove his name from the roster of members. June 1954:29, 54, 55.

Discontinuation of Free Service Membership: On resolution no. 3 from Colorado which recommended that the Board of Trustees consider discontinuation of free service membership to physicians in the armed forces and the Veterans Administration, the House of Delegates adopted a report which reads in part as follows, June 1954:35, 54; Nov.–Dec. 1954:51, 99, 100:

. . . It is the belief of the Board, after studying the results of the surveys, that the present system should not be changed since it would immediately result in a large loss of membership due to the inability of many physicians in the armed forces and the Veterans Administration to qualify for one reason or another for membership in a county medical society. Furthermore, the surveys indicate that the vast majority of the present service members desire that the system be retained without change. For these reasons the Board of Trustees recommends that the resolution be not adopted.

Security Risk Cases: The House of Delegates concurred in recommendation of the Board of Trustees that resolution no. 9 from Mississippi, which recommended withholding of membership in this Association from physicians discharged from the armed forces for security reasons, be disposed of in accordance with the following provisions of chapter VIII, section 1 of the *Principles of Medical Ethics*, June 1954:37, 56, 57; Nov.–Dec. 1954:51, 99, 100:

Physicians as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity.

Interns, Residents, and Fellows: The House of Delegates adopted resolution no. 42 from Illinois which recommended that the House "go on record as endorsing a type of membership, either with no membership fee or a nominal fee, for physicians who are graduates of approved schools and who are serving internships, residencies, or fellowships in approved hospitals," June 1954:42, 54; Nov.–Dec. 1954:9.

Negro Physicians: The House of Delegates disapproved resolution no. 44 from North Carolina which requested that the Old North State Medical Society be recognized as an "affiliate constituent" of the North Carolina Medical Society and also of the American Medical Association, as there is no provision in our *Constitution* for an affiliate constituent. June 1954:43, 54.

Service Membership for Armed Forces and USPHS Reservists; Indian Service: The House of Delegates referred to the Board of Trustees, resolution no. 8 from the U.S. Public Health Service which requested that "reserve medical officers of the Public Health Service as such, be extended service memberships in the American Medical Association on the same basis as said memberships are extended to reserve medical officers on duty in the military services," June 1954: 15, 34.

In June 1956, the Section on Military Medicine submitted resolution no. 1 which called for admission to Service membership, of reserve officers of the various defense forces and the Public Health Service who are on extended active duty, June 1956:51–55, 69.

The Council on Constitution and Bylaws recommended, and the House approved, amendments to provide (1) admission to service membership of reserve officers of the various defense forces and the Public Health Service who are on extended active duty; (2) deletion of that section relating to medical officers in the Indian Service, in view of discontinuance of that Service. Article V, section 2 and chapter I, section 2, as amended, read as follows, Nov. 1956:8, 94, 95; June 1957:25; June 1958:34–35:

Article V. Section 2. Service Members.—Service membership shall be limited to regular commissioned medical officers and commissioned medical officers of the reserve components on extended active duty with the United States Army, the United States Navy, the United States Air Force and the United States Public Health Service and the permanent medical officers of the Veterans Administration, subject to the provisions of the *Bylaws*.

Chapter I. Section 2. Service Members.—Regular commissioned medical officers and commissioned medical officers of the reserve components on extended active duty with the United States Army, the United States Navy, the United States Air Force or the United States Public Health Service, who have been nominated by the Surgeons General of the respective services, and the permanent medical officers of the Veterans Administration, who have been nominated by the Chief Medical Director, may become Service members on approval of the Judicial Council. Such members shall have the same rights and privileges as Active members but shall not be required to pay dues and shall not receive any publication of the American Medical Association except by subscription. Service members shall retain membership as long as they are on active duty, and thereafter if they have been retired in accordance with federal law and do not engage in active practice.

Drive for New Membership: The House of Delegates approved and referred to the Board of Trustees for what action it may take, resolution no. 42 from New York which recommended that this Association "augment its efforts to stimulate new memberships in the American Medical Association by an increased, determined, cooperative effort with the various state and county medical associations." June 1956:60, 64.

Transfer: The House of Delegates amended chapter II, section 2 of the *Bylaws* to read as follows, Nov.1956:94, 95:

Section 2. Transfer.—Should an Active or Associate member remove his practice to another jurisdiction, he may continue his membership in the American Medical Association by applying for membership in the constituent association in the jurisdiction to which he has moved his practice. Unless his application has been favorably acted upon within two years after such change of practice, the Secretary of the American Medical Association shall remove his name from the roster of members.

Membership in Rhode Island: The House of Delegates voted that no action be taken on resolution no. 7 from Rhode Island which protested the critical report on physician membership of this state in the American Medical Association, cited in the report of the Reference Committee on Reports of Board of Trustees and Secretary, as an unfortunate misunderstanding had resulted from the usage of different baselines of comparison, June 1957:44.

Limitation of Service Membership to Career Officers: The House of Delegates referred to the Council on Constitution and Bylaws for further study, resolution no. 7 from Colorado, Dec. 1957:111:

Resolved, That the House of Delegates reiterates its adherence to the principle that membership in this Association should originate with membership in a component county medical society, and instructs the Council on Constitution and Bylaws to prepare the necessary amendments to return Service membership to the original concept of its applicability only to the career officers of the armed forces of the United States; and be it further

Resolved, That pending implementation of these amendments, the Board of Trustees and the General Officers are instructed to resolve existing conflicts within the *Constitution and Bylaws* related to this subject matter in favor of dues-exempt Active membership through component societies and constituent associations rather than in favor of direct Service membership.

The Council on Constitution and Bylaws recommended "that Veterans Administration physicians be eliminated from eligibility for Service membership." The House of Delegates adopted the following substitute report for the report of the Council, June 1958:35–36:

(a) That eligibility of full-time Veterans Administration personnel for Service membership should be determined by strict adherence to the present provisions of division one, chapter I, section 2 of the *Bylaws*. This section requires certification by the Chief Medical Director of the Veterans Administration, rather than by the medical director or resident manager of any individual Veterans Administration hospital. Such strict adherence to the *Bylaws* will provide a reliable checklist for the use of the A.M.A. Membership Department in the same manner as such lists are now provided by the surgeons general of the armed forces;

(b) That the entire matter of Service membership be re-referred to the Council

on Constitution and Bylaws for further study with the request that the Council develop some alternative method of determining eligibility for Service membership which will be equally applicable to all Service memberships.

The House of Delegates adopted a resolution submitted by the Council on Constitution and Bylaws, amended to read as follows, Dec. 1958:106–107, 107–108.

Resolved, That the House of Delegates of the American Medical Association urge all component societies to make every effort to provide a type of membership for armed forces, Public Health Service, and Veterans Administration physicians which will enable them to become Active members of constituent societies and of the American Medical Association.

Service Physicians' Participation in Local Medical Societies: The House of Delegates adopted resolution no. 29 from Georgia, amended to read as follows, Dec. 1957:115:

Resolved, That membership in the American Medical Association of physicians engaged in federal medical services be reconsidered by the Council on Constitution and Bylaws; that this Council be requested to seek means of increasing active participation of physicians in this classification and in local medical societies; and be it further

Resolved, That the Council on National Defense, through its Committee on Military Affairs, assist in the accomplishment of this objective and report back to the House of Delegates of the A.M.A. in 1958; and be it further

Resolved, That the surgeons general of the Army, Navy, Air Force, and Public Health Service, Veterans Administration and other allied branches be requested to participate in this program and that special recognition or credit be granted to physicians in federal medical services who participate actively in local medical societies.

The Council on Medical Service reported, and the House approved, "that because of the variance in local and state society rules and regulations and the frequent change of assignments of medical officers of the several federal medical services, there is no simple or practical solution which can be recommended at this time." The House further recommended that delegates stimulate interest in this participation in their own state and county societies by the best locally accepted plan, June 1958:22.

State Association Stamps on A.M.A. Cards: The House of Delegates referred to the Executive Vice President without comment and for such action as he deems feasible, resolution no. 62 from South Carolina which recommended use of the South Carolina Medical Association official stamp on American Medical Association membership cards of those who have paid their state dues, in order that one card may signify both memberships, June 1958:58.

Service Physicians—Active Membership: The House of Delegates adopted the following resolution, Dec. 1958:106–107, 109:

Whereas, It is the policy of the Association as indicated in its *Constitution and Bylaws* to condition Active membership upon membership in a constituent association; and

Whereas, Service membership is a departure from this principle and should be granted only in unusual circumstances, such as ineligibility for local county society membership; and

Whereas, It is sometimes impossible for physicians in the armed forces, Public Health Service, or Veterans Administration to obtain membership in constituent associations because of certain component society residence or practice requirements; therefore be it

Resolved, That the House of Delegates of the American Medical Association urge all component societies to make every effort to provide a type of membership for armed forces, Public Health Service, and Veterans Administration physicians which will enable them to become Active members of constituent societies and of the American Medical Association.

MENTAL HEALTH

Insanity in the U.S.: The House of Delegates approved appointment of a committee to study the subject of insanity in the United States, May 1857:32.

Medical Jurisprudence: The House of Delegates accepted and referred to the Committee on Publication, a report on the medical jurisprudence of insanity and the testimony of skilled witnesses in the courts of justice, including a classification of insanity, May 1856:42; May 1858:38, 473–524.

Medical Jurisprudence: The House of Delegates referred to the Committee on Publication, a paper on "moral insanity in its relations to medical jurisprudence." May 1858:41, 721–746.

Physicians for Mental Hospitals: The House of Delegates adopted a resolution which recommended "that there should be attached to every public hospital for the insane, one or more consulting physicians, who may be consulted at the discretion of the superintendant, such a measure being alike for the interest of the hospital, its medical officers, and its patients," June 1861:42–44, 123–133.

Association of Medical Superintendants of Insane Asylums: The House of Delegates resolved that a delegate be sent annually to the "Association of Medical Superintendants of Insane Asylums" to urge upon that association the advantage of a more intimate union with the American Medical Association, June 1865: 41, 762.

Medical Jurisprudence: The House of Delegates adopted the following resolution from report of the delegate from this Association to the Association of Superintendants of American Asylums for the Insane, May 1866:42, 395–406:

Industrial Records: The Council on Industrial Health reported reactivation of the Committee on Industrial Medical Records, Dec. 1958:33.

OFFICERS OF THE AMERICAN MEDICAL ASSOCIATION — NOMINATION, ELECTION, TENURE OF OFFICE

Installation: The House of Delegates approved insertion of the following sentence after the first paragraph of the 4th article of the *Plan of Organization*, June 1863:37; June 1864:50:

The President and Vice President shall assume the functions of their respective offices at the beginning of the annual meeting next succeeding their election; other officers shall take office immediately upon their election.

Nomination: The House of Delegates tabled an amendment to the *Constitution* to provide that officers of the Association "shall be nominated by the Judicial Council," May 1873:53-54; June 1874:36-37.

Attendance at Meeting Required for Election: The House of Delegates amended the *Bylaws* to provide that in "the election of officers and the appointment of committees by this Association and its President, [candidates] shall be confined to members and delegates present at the meeting, except in the Committee on Arrangements." June 1878:57; May 1879:32; June 1880:66; May 1881:38.

Nomination: The House of Delegates tabled the following amendment to article IV, section 1 of the *Constitution*, June 1878:59; May 1879:32:

The several state, Army, and Navy delegations, including delegates and permanent members, shall, on the first day of the annual meeting of this Association, at a meeting publicly called for that purpose, nominate candidates for the several offices of President, Vice Presidents, and chairmen for the several sections, and shall choose one of their number to act on the Nominating Committee of the Association, with power to cast as many votes in that Nominating Committee as there are members of the delegation of which he is a member. Candidates for the several offices above named to be reported to the Association shall be selected from the names reported to the Committee of the several state delegations.

Attendance at Meeting Required for Election: The House of Delegates amended section XIII of the *Bylaws* to provide "that none but members present shall be elected President, Vice President, Secretary or Treasurer of the Association, Chairman or secretary of sections," June 1882:55; June 1883: J.A.M.A. 1:2.

Nomination: The House of Delegates tabled a resolution which provided "that it is not expedient for the Nominating Committee to nominate its own members for any of the offices of the Association," May 1884: J.A.M.A. 2:575.

Treasurer: The House of Delegates approved a recommendation "that the *Constitution* be amended in that portion relating to the necessity of electing to

office only those who are present at a meeting, so that the Treasurer be not thus included." June 1894: J.A.M.A. 22:943, 953.

Nomination and Election Procedure: The House of Delegates amended the *Bylaws* deleting the section entitled "Committees on Nominations" and substituting the following paragraph. June 1902: J.A.M.A. 38:1657; May 1903: J.A.M.A. 40:1373:

Nominations for officers shall be by informal ballot in the House of Delegates, unless otherwise ordered, by a majority of the delegates present when such nominations are made. Twenty votes will be necessary to nominate them, and after the nominations are made, the balloting shall continue until some nominee has received a majority of the votes present. After the second formal ballot the nominee receiving the lowest number of votes shall be dropped, and so on in each successive ballot until an election is had.

Solicitation of Votes: The House of Delegates adopted the following resolution. June 1902: J.A.M.A. 38:1661:

Resolved, That it is the sense of the House of Delegates of the American Medical Association that the solicitation of votes for office is not in keeping with the dignity of the medical profession, nor in harmony with the spirit of this Association and that such solicitation shall be considered a disqualification for election to any office in the gift of the Association.

President and Vice President—Eligibility: The House of Delegates amended article 8, section 4 of the *Constitution* to provide that no member of the House of Delegates shall be eligible for the office of President or Vice President. May 1903: J.A.M.A. 40:1375.

Nomination: The House of Delegates amended chapter VII, section 1 of the *Bylaws* to read as follows. June 1904:21; July 1905: J.A.M.A. 45:258, 278:

Nominations for office, except that of the Treasurer, shall be made orally, but no nominating speech shall exceed two minutes in length. Any nominee receiving a majority of the votes cast shall be declared elected. The Treasurer shall be nominated by the Board of Trustees.

Vice Presidents—Sequence: The House of Delegates amended chapter VII, section 2 of the *Bylaws*, substituting the word *ranking* for the word *first* so that this section reads as follows. July 1905: J.A.M.A. 45:275, 279:

Section 2. Vice Presidents: The Vice Presidents shall assist the President in the performance of his duties; during his absence, or at his request, one of them shall officiate in his place. In case of the death, resignation, or removal of the president, the vacancy shall be filled by the *ranking* Vice President.

The House disapproved a *Bylaws* amendment to designate first, second, third or fourth Vice President in balloting.

Board of Trustees—Election: The House of Delegates adopted a resolution which provided (1) that Trustees of this Association shall be nominated orally and elected by ballot of the House of Delegates in separate order; (2) that at least two nominations shall be made to fill each vacancy in the Board of Trustees, June 1906:2, 3, 25.

Balloting: The House of Delegates disapproved a *Bylaws* amendment to provide that "in balloting for all elective officers and for the place of meeting of the Association, each member of the House shall cast his own ballot." June 1907: 19, 26–27.

Recall of Officers: The House of Delegates approved addition of the following sentence to chapter IX, section 2 of the *Bylaws*, June 1912:45, 54:

The House of Delegates may recall the election of any officer or the appointment of any member of a committee or council at any session by a two-thirds vote of the members present and voting, provided that no motion for recall shall be acted on till the day following that on which it is introduced.

President and Trustees—Eligibility: The House of Delegates approved addition of the following sentence to chapter IV, section 2 of the Bylaws: No member of the House of Delegates shall be eligible to the office of President or Vice President, nor shall a member of the Board of Trustees be eligible for election to any other elective office, the term of which runs concurrently with the term for which the said Trustees has been elected.

The House approved addition of the following to article X, section 2 of the *Constitution*: "No Trustee shall be eligible to any other elective office, the term of which runs concurrently with the term for which the said Trustee has been elected." June 1916:11–12, 68; June 1917:62, 63.

Time of Election: The House of Delegates amended chapter IV, section 3 of the *Bylaws*, adding the words in italics, June 1918:25, 27:

Sec. 3. Time of Election.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the afternoon of the fourth day of the annual session of the House of Delegates (the second day of the Scientific Assembly), *provided, however, that the House of Delegates may change the time of election by action taken at a meeting at least one day in advance of that to which the election is to be changed, and provided further that the motion to change the time of election shall be supported by three-fourths of the delegates present and voting.*

Election—One Nominee: The House of Delegates amended chapter IV, section 2 of the *Bylaws* (method of holding elections), adding the following sentence, June 1919:31, 53:

Provided, however, when there is only one nominee for office, a majority vote without ballot may elect him.

President and Vice President—Nomination: The House of Delegates recommended for consideration next year, a suggestion of the Speaker that, inasmuch as the House is the executive of the Scientific Assembly, including the election of its officers, each section of the Scientific Assembly should indicate by nomination to the House, those whom they would approve for the presidency and vice presidency. April 1920:2, 51.

Trustees—Tenure of Office: The House of Delegates approved an amendment to the *Constitution* to extend the term of the Trustees to five years and to provide that no Trustee shall serve more than two consecutive terms. June 1923:14–15, 41; June 1924:9–10, 36, 37–38.

President and Vice President—Nomination: The House of Delegates disapproved addition of the following sentence after the first sentence of chapter IV, section 9, of the *Bylaws*, June 1924:51; May 1925:8, 39:

At some time between the first and fourth day of the annual session of the House of Delegates, the chairmen and the secretaries of the various sections of the Scientific Assembly and the members of the Council on Scientific Assembly shall meet at the call of the Chairman of the Scientific Assembly and shall prepare and present to the House of Delegates, at their meeting on the fourth day of the annual session, three nominees for the office of President-elect and two nominees for the office of Vice President, and nominees so presented shall be the only ones eligible for election.

General Officers Defined: The House of Delegates amended section 1, article 6 of the *Constitution*, inserting the words in italics so that this section will read as follows. May 1925:8, 39:

The general officers of the Association shall be a President, a *President-elect*, a Vice President, a Secretary, a Treasurer, a Speaker and a Vice Speaker of the House of Delegates, and nine Trustees.

Memorials: The House of Delegates approved a recommendation that some suitable memorial be devised for those who die during their terms of service as officers of the American Medical Association. May 1932:39.

Reference Committee on Nominations: The House of Delegates disapproved appointment of a reference committee on nominations. June 1934:2, 44.

Solicitation of Votes: On a resolution requesting opinion on a standing rule which provides disqualification of candidates for solicitation of votes, the Judicial Council reported, and the House approved: (1) that the rule adopted in 1902 "has never been rescinded and is still in the same force and effect as it has been since its adoption"; (2) that the "Council considers the standing rule on solicitation of votes to be illegal and of no force and effect. This being so, there can be no violation. There being no violation, the supposed person mentioned in the resolution is legally eligible for nomination or election. The Judicial

Council believes that, if the House desires to have our laws disqualify for nomination on a basis of reprehensible solicitation, adequate legislation and phraseology can be found." June 1935:34, 41, 42.

President—Eligibility and Installation: The House of Delegates approved the following amendments to the *Bylaws*, June 1937:40, 53, 65:

1. Chapter IV, section 1, last sentence to read: "No member of the House of Delegates nor general officer of the Association shall be eligible for election to the office of President-elect or Vice President."

2. Chapter IV, section 8 to read: "Installation as President.—The President-elect shall be installed as and assume the duties of President at the opening general meeting of the Scientific Assembly of the annual session following that at which he was elected."

President—Succession in Office: The House of Delegates adopted the following resolution from the Judicial Council, June 1937:40, 53, 69; June 1938:7, 58, 60, 64, 65:

Whereas, The *Constitution and Bylaws* refer to the election annually of a President and President-elect when in fact only a President-elect is elected; and

Whereas, No provision is made in the *Constitution and Bylaws* for a succession in office in case of death or disability of the President-elect; be it

Resolved, That article 6, section 2 of the *Constitution* be amended to read: (a) The President-elect shall be elected annually. He shall serve as President-elect until the annual session of the Association next ensuing after his election and shall become President on his installation in the course of that session, serving thereafter as President until the next following annual session and the installation of his successor. If the President-elect dies, resigns or, in the judgment of the Board of Trustees, confirmed by the House of Delegates, is permanently disqualified for the performance of the duties of his office by any just cause, the Vice President shall become President-elect and in due course succeed to the presidency, with all of the prerogatives and duties pertaining to that office, as fully as if elected to it in the first instance: Provided, however, that the President-elect who is elected at the annual session of the Association in 1937 shall, notwithstanding his election as such for the period of one year only, be installed as President in the course of the session in 1938 and continue as such until the session in 1939 and the installation of his successor.

(b) a Vice President, a Secretary, a Treasurer, and a Speaker and Vice Speaker of the House of Delegates shall be elected each to serve for one year or until his successor is elected and installed: Provided, however, that in event of the death, resignation or removal, or of the permanent disability of the President-elect as determined by the Board of Trustees, the Vice President shall succeed to the office of President-elect and in due course to the office of President notwithstanding the fact that he was in the first instance elected as Vice President for one year only.

Balloting: On recommendation of the Speaker, the House of Delegates requested that the Secretary prepare a ballot and ballot box for use in the election to be held at this session, so that the delegates may determine by actual trial whether or not they wish to make this a permanent procedure. July 1946:1, 59.

Time of Election: The House of Delegates amended chapter XIV, section 2 (A) of the *Bylaws* to read as follows. Nov. 1956: J.A.M.A. 163:45, 47, 198:

(A) Time.– Officers of the Association shall be elected by the House on the fourth day of the annual session. The House may set the time or hour of such election by adopting an appropriate motion. The Reference Committee on Rules and Order of Business at each annual session shall consider this matter and shall make recommendations to the House.

Tenure of Office When Annual Session Postponed: The House of Delegates concurred in a recommendation of the Judicial Council that the inadequacy of the *Constitution and Bylaws* in providing protection of the tenure of office of various officers and committees in event of the postponement of the annual session, be given immediate attention by the Reference Committee on Amendments to the Constitution and Bylaws. July 1946:33–34, 37.

President—Eligibility: The House of Delegates amended chapter IV, section 1 of the *Bylaws*, deleting the words in bold face, Dec. 1946:47:

Section 1. Nominations.—Nominations for office shall be made orally, but a nominating speech must not exceed two minutes. The Treasurer shall be nominated by the Board of Trustees. **No member of the House of Delegates nor general officer of the Association shall be eligible for election to the office of President-elect or Vice President.**

President—Eligibility: The House of Delegates disapproved a resolution from Illinois which recommended amendments to the *Constitution and Bylaws* to provide that general officers shall not be eligible for election as President-elect, Dec. 1949:62, 69, 70.

Elections—Announcement: The House of Delegates adopted a resolution from the Section on Preventive and Industrial Medicine and Public Health which provided that announcement of the results of balloting by members for the House shall be reported to the Speaker by the tellers immediately after the votes have been tallied, and then reported by the Speaker to the members of the House. June 1950:34–35, 43.

OFFICERS OF THE AMERICAN MEDICAL ASSOCIATION — REIMBURSEMENT

President and President-elect: On recommendation that the President and the President-elect be reimbursed for traveling expenses, the Board of Trustees reported that "it has been and is the policy of the Board of Trustees to pay the expenses incurred by any representative of the Association in attendance at any occasion as an official representative of the Association." June 1928:51, 53.

President and President-elect: The House of Delegates voted that the establishment of a fixed amount to be given the President and President-elect in lieu of the present system of reimbursement for all legitimate expenses occuring while on duty, "does not appear entirely satisfactory in that occasions may arise when this stipend might prove inappropriate or even inadequate to meet the exigencies of official activities." June 1931:3, 35, 36.

Trustees and General Officers: The House of Delegates adopted the following report with regard to a resolution from Colorado. Dec. 1949:59, 72:

. . . After careful deliberation your committee feels that it would be impossible to compensate these men (trustees and general officers) for the time taken from their individual practices. Your committee has been assured that any effort to do this would in no way enhance the number of meetings or the functioning of the Board. It does feel, however, that all members of councils and committees as well as of the Board of Trustees and the general officers should be completely compensated for all expenses involved in serving the American Medical Association. Your committee, therefore, recommends that the Secretary be directed to review the actual expenses incurred in attending various meetings from data now on hand and that such adjustments be made as may be necessary to make the daily expense allowance equal to or slightly in excess of the actual expenses incurred.

President and President-elect: The House of Delegates approved Board decision "to authorize an honorarium of $50 a day for the President and President-elect for every day they are away from their homes on official Association business, in addition to the regular per diem and travel allowance which they are now receiving." Dec. 1951:69, 78, 79; June 1952:15, 41.

Travel Insurance: The House of Delegates approved action of the Board of Trustees in securing travel insurance of $25,000 per person to cover the delegates and alternates as well as members of the councils and committees of the House of Delegates and of the Board while traveling on official business of the Association. Dec. 1958:90.

OFFICES, MEDICAL

Standards: The House of Delegates approved and referred to the Council on Health and Public Instruction for favorable action, a resolution from Louisiana which recommended a score card for doctors' and dentists' offices requiring that they be brought up to certain standards. June 1912:55, 57.

OPHTHALMOLOGY

Ophthalmology—Teaching: The House of Delegates referred to the Committee on Medical Education, a resolution which recommended that the faculties of medical colleges create chairs of ophthalmology. June 1863:40.

Campaign to Promote Use: The House of Delegates disapproved resolution no. 67 from Texas, June 1957:59:

Resolved, That out of respect for and in deference to the members of this Association it is the request of this House of Delegates that the American Medical Association should first obtain membership approval, given by way of the duly-elected representatives of their component societies, prior to engaging in any medical service program of great national impact.

Campaign to Promote Use: The Board of Trustees recommended, and the House approved, that there be continued activity at all levels directed toward educating the public to secure the minimum of three polio vaccine injections, Dec. 1958:57.

POLITICAL PARTIES

Nonsupport: The House of Delegates adopted the following resolution from District of Columbia, June 1952:37, 50, 51:

Resolved, By the House of Delegates that the American Medical Association does not support any political party or any candidate for public office.

POST OFFICE REGULATIONS

First Class Delivery Schedules: The House of Delegates disapproved a resolution from Pennsylvania which urged prompt restoration of previous first class delivery and collection schedules in the Post Office Department, as this matter is not pertinent to the affairs of the House of Delegates of the American Medical Association, Dec. 1950:53, 72.

POSTGRADUATE MEDICAL EDUCATION

Four-Year Course: The House of Delegates approved development of a four-year course of postgraduate study to be adapted to the needs of the average county society, June 1907:19–20, 33, 35; June 1908:32–33, 34; June 1909:47.

Survey: The House of Delegates adopted a report of the Council on Medical Education regarding completion of its survey of postgraduate medical schools in this country and a study of the problems of graduate medical education, June 1913:47; June 1914:19–20, 42–43; June 1915:53–54, 59, 60.

Survey: The Council on Medical Education and Hospitals reported on opportunities for graduate and postgraduate medical studies in this country and in Europe, June 1919:4, 53, 54, 58; April 1920:32–33, 38.

A.M.A. Program: The House of Delegates approved action of the Board of Trustees in holding in abeyance, plans for graduate extension work to be

State Society Programs—A.M.A. Support: The House of Delegates took no action on the following resolution from Michigan, Dec. 1946:27:

Resolved, That the delegates of the Michigan State Medical Society to the American Medical Association be instructed to initiate a study of policy by which the American Medical Association could contribute a portion of the cost of such a program of health education carried on by any state medical society.

Bureau of Health Education: The House of Delegates disapproved a resolution from New Jersey which recommended a change in name of the Bureau of Health Education to Bureau of Child Health Education, June 1948:74, 97–98, 98.

Physician—Media of Public Information: The House of Delegates approved revision of section 5, chapter I of the *Principles of Medical Ethics* changing the title of this section from *Educational Information Not Advertising* to *Relationship of the Physician to Media of Public Information*, Dec. 1953:77, 99, 100.

Television: The Bureau of Health Education reported a survey on the use of films and live programs on television by local medical societies, Nov.–Dec. 1954: 39, 88–89, 89.

Authoritative Articles in Lay Magazines: The House of Delegates requested the Bureau of Health Education to explore "the possibility of publishing informative articles by capable medical authors and authorities in lay magazines," Nov.–Dec. 1954:89.

PUBLIC RELATIONS

Responsibilities of the Medical Profession: The House of Delegates tabled a resolution which recommended that "medical men enlighten the public mind with regard to the duties and responsibility of the medical profession and their just claims to the confidence of the public," May 1849:46.

A.M.A. as Spokesman for Organized Medicine: The House of Delegates adopted the following substitute for a resolution from Michigan, June 1931:32, 41, 42:

Whereas, From time to time, members of the American Medical Association, holding membership in various medical societies, organized for scientific advancement, have initiated in such bodies resolutions defining medical policies and opinions on questions of medical economics and social relations . . .

Resolved, That the House of Delegates of the American Medical Association urge all members of the Association to initiate such resolutions in their county or state societies or in the House of Delegates of the American Medical Association, and that an effort be made, through the periodicals of the Association, to inform the membership, and also all organs of public expression, that the

American Medical Association is the one body, in organized medicine, entitled to speak for the vast majority of the physicians of this country.

A.M.A. as Spokesman for Organized Medicine: The House of Delegates endorsed resolutions from Pennsylvania and from Wisconsin which declared that all opinions made to the public on general, social, legislative and economic relationships of medical practice should be made only through approved channels of the American Medical Association. June 1933:21, 52, 55.

Public Relations Department Disapproved: The House of Delegates disapproved a resolution from Michigan which proposed creation of a public relations department and a resolution from California which requested appointment of a professional public relations counsel. June 1937:54, 67, 68; June 1938:55, 57, 64, 65, 76, 78.

Personal Opinions of Officers and Members: The House of Delegates concurred in opinion of President-elect Rock Sleyster that "officers and members should refrain from expressing opinions not approved by the American Medical Association, unless they make it clear that it is their personal opinion and not the policy of the organization"; that "much misunderstanding in the bodies of organized medicine is caused by statements of individuals who are believed by the public to speak authoritatively but who, in fact, speak only for themselves." May 1939:5, 77, 78.

Council on Medical Service and Public Relations: The House of Delegates approved establishment of a Council on Medical Service and Public Relations, June 1943:68, 69, 70, 71, 83, 83–84, 84–85, 85.

Public Attitude Toward the Medical Profession: The House of Delegates disapproved request from California for a survey of the public's attitude toward the medical profession. June 1944:70–71, 84, 85.

Speakers' Bureaus: The House of Delegates approved a resolution from Indiana which requested (1) that the Board of Trustees secure men capable of serving as a speakers' bureau on a state basis; (2) that personnel be secured also to work with the Secretary of the Association in maintaining contacts with constituent state societies. June 1944:81, 90.

State Public Relations Programs: The House of Delegates approved a resolution from Ohio which (1) recommended creation of a well-financed public relations program in every state medical society; (2) instructed the Council on Medical Service and Public Relations to offer sustained leadership to state medical associations in their public relations programs. Dec. 1945:72–73, 90.

A.M.A. Program: The Council on Medical Service and Public Relations submitted to the House of Delegates, a report from a special committee on public

relations which had participated in its October 1945 conference. The Committee (1) emphasized the importance of programs in two areas of public relations: the profession and the public; (2) recommended that the Board give consideration to utilization of professional public opinion counsels; (3) stated that "the task of public relations would be rendered much easier if those concerned could be put in possession of a constructive program [for medical care] which they could promote to the public rather than in a position of continuous defense against programs coming from other sources."

The House of Delegates adopted the following report with regard to the report of the Council:

Your reference committee . . . desires to emphasize the importance of utilizing all dignified approachments to the public by which the public may have a clear knowledge of the work of organized medicine. Community health conferences have proved valuable in numerous sections of the country. The utilization of public relations counsels on a national, state and county level is approved. Dec. 1945:56, 83, 87.

Survey of A.M.A. Public Relations (Rich Report): The Board of Trustees employed a public relations firm "to make a survey of and to make recommendations for the future conduct of the Association's public relations."

FIRST REPORT: The Board submitted, and the House approved, the following recommendations with regard to the first part of the report from the public relations consultants (Rich report), July 1946:67–69:

1. Stress the scientific activities of the Association through THE JOURNAL and through an expanded *Hygeia*, this to be under the supervision of the Editor.

2. Expansion and revitalization of the Bureau of Medical Economics, with the employment of competent economists.

3. The constitution of a new division of public relations under the immediate supervision of the General Manager and the general supervision of the Board of Trustees, with an executive assistant who is a public relations expert with adequate personnel at its head to coordinate all public relations activities of the Association other than scientific.

4. With the coordination of all public relations activities in this office, the Council on Medical Service and Public Relations should have its name changed to the Council on Medical Service.

SECOND REPORT: The House of Delegates adopted the following recommendations of the special committee appointed to consider the second part of the Rich report, Dec. 1946:13–14, 22, 27, 28, 33–38, 47, 49, 50:

1. Dramatization of the progress of scientific medicine, development of the story of organized medicine, revitalization of *Hygeia*.

2. Employment of an economist of high caliber to head the Bureau of Medical Economics who shall give opportunity in his department in THE JOURNAL and in *Hygeia* for the expression of diverse viewpoints.

3. Employment of an executive assistant to the General Manager who shall be in charge of coordinating public relations activities of the Association.

4. Approval of three essential goals of public relations for this Association: a) find the truth; b) put the people first; c) become adequate.

5. Objective study of the relationship of lay participation to the successful development and operation of voluntary health insurance plans and, "unless there shall prove to be conclusive evidence to the contrary, the present requirements for total medical care be revised promptly."

6. Identification by each council and bureau of all legitimate organizations having cognate interests and development of specific plans for establishing practical cooperative relationships with them.

7. Development of two distinct parts of the work of the Bureau of Health Education: public education and school health program and improvement of the Bureau's publications.

8. Assistance by the Bureau of Legal Medicine and Legislation "in the development of legislation in accordance with principles established by the House of Delegates."

9. Broadening work of the Council on Industrial Health with labor, management and consumer groups.

10. Necessity of having an executive assistant to the General Manager responsible for the public relations and publicity of all the scientific councils and bureaus.

11. Approval of the following fundamental principles:
To build up desirable public relations there are three essentials for the American Medical Association as for any other organization: positive and constructive policies; effective, adequate and coordinated action; balanced and efficient promotional and interpretive facilities.

12. Establishment of a national house organ.

13. Discontinuation of the present Bureau of Public Relations, utilization of various media for publicity (as indicated in report of the special committee).

14. Employment of a person to conduct a centralized service of pamphlet production.

15. Employment, subject to cost and demonstrated need, of a competent promotional specialist.

16. Initiation and activation of a Speakers' Bureau.

National Physicians Committee: That portion of the Rich report pertaining to the National Physicians Committee was considered separately. The special committee submitted and the House approved, the following recommendations. June 1947: 73–74:

1. Accusations of financial transactions of "unsavory character" have not been substantiated by fact.

2. With regard to the question of interlocking trusteeship, your committee has, in its December report, expressed its views: "This committee recognized: that

each member of the American Medical Association is primarily a citizen with the inalienable right to join any organization." As a result of its recent study the committee reiterates this statement.

3. In view of the presently incomplete development of the public relations program of the American Medical Association, there is still a very definite need for continuation of the National Physicians Committee and other organizations established for similar purpose.

4. Even with a fully developed public relations program by the American Medical Association, along lines as presently planned, there will, in all probability, still be a place for the National Physicians Committee for many years to come.

5. Your committee recommends that the House of Delegates of the American Medical Association repeat its commendation of two previous occasions on the accomplishments of the National Physicians Committee and resolve a vote of confidence in the managing board of that organization.

6. Last December this committee recommended to the House of Delegates that "in line with the new program in the process of accomplishment this committee feels that the American Medical Association should and must do its own public relations and legislative work." It reiterates that recommendation at this time and further recommends appropriation of adequate funds for implementation of a definite program under the guidance of a public relations consultant who will work harmoniously with all American Medical Association agencies.

7. To accomplish this last recommendation, your committee further recommends that adequate changes be made in the Public Relations Department.

SURVEY OF PUBLIC'S ATTITUDE TOWARD THE PROFESSION: The special committee submitted, as a supplement to its report on public relations, report on a survey of "opinions of the public and of physicians after a century of the American Medical Association," June 1947:74–79.

Speakers' Bureaus: On report of the Council on Medical Service regarding institution of a "briefing" course at Association headquarters on organization of county society speakers' bureaus, the House of Delegates importuned all state medical societies to establish speakers' bureaus and to cooperate closely with activities of the Council in this regard, Dec. 1946:18, 45, 46.

Speakers' Bureaus: On address of President-elect Bortz, the House of Delegates recommended (1) that the Council on Medical Service assist in establishment of a speakers' training program in every county medical society; (2) that the Council bring all of its pamphlets up to date; (3) that a number of basic speeches be prepared for distribution through the speakers' bureaus, June 1947: 6, 92.

Secretary's Letter: The Secretary reported inauguration of a weekly "informal newsletter, signed by the Secretary and General Manager, containing brief

reports of work in progress and contemplated at Association headquarters by the several councils, bureaus, and departments," June 1947:9, 93, 94.

Bureau of Public Relations Re-established: On resolutions from California and from Georgia, the House of Delegates adopted a substitute resolution which provided "that the Board of Trustees set up whatever machinery may be necessary to re-establish a bureau of public relations." June 1947:68, 79, 89, 90, 99.

Press Releases: The House of Delegates disapproved a resolution from New York which recommended that advance press items either be discontinued altogether or be released after actual receipt of THE JOURNAL by the medical profession. The House recommended that, since information is frequently given to the press before it is available to the practicing physician, information which is released to the press as new be simultaneously channeled to the profession. June 1947: 74–79.

Information from Headquarters Office: The Board of Trustees voted "that all messages to state and county societies shall emanate from the Office of the Secretary and General Manager and that all bulletins issued by independent offices in the Headquarters shall constitute portions of the Secretary's News Letter." Nov.–Dec. 1948:26.

Expansion of Public Relations Activities: The House of Delegates approved action of the Board of Trustees in appointing (1) a field director of public relations; (2) an advisory committee to the Department of Public Relations, composed of executive secretaries or public relations directors of constituent medical associations; (3) an interdepartmental public relations committee for the purpose of coordinating all public relations activities of the headquarters staff, Dec. 1950: 41, 64, 65; June 1951:9, 31.

Publicity re A.M.A. Activities: The House of Delegates urged all state societies to present *You and Your A.M.A.* programs and adopted the following policy submitted by the Board of Trustees:

The development of any programs designed to inform the medical profession or the public of the over-all activities of the American Medical Association is a responsibility of the Board of Trustees and will be carried out through the Secretary and General Manager. Suitable arrangements shall be made by the Secretary and General Manager to secure participation by all councils, committees and departments to assure that their specific programs are properly and adequately presented to both the profession and the public. June 1951:17–18, 44; Dec. 1951:9, 80.

Scientific Section: The House of Delegates disapproved formation of a section on public relations and recommended to the Board of Trustees that continued efforts be made to increase participation in public relations by physicians. June 1951:26, 32, 45.

Slogans to Publicize American Medicine: On a resolution from New York which requested preparation of slogans to publicize American medicine, the Board of Trustees reported, and the House approved, that the Bureau of Public Relations had prepared 26 slogans, June 1951:27, 32, 33; Dec. 1951:43, 80, 81.

PR Department—Expansion: The House of Delegates approved the following recommendation, Nov.–Dec. 1954:15–17, 94, 95:

That the House of Delegates approve the carefully planned expansion program of the Public Relations Department which is taking place from year to year, within budgetary limits, commend this scientific approach to adequate coverage of the Association in this field, and recommend its continuance at as rapid a pace as conditions justify.

Headquarters Survey Report: A special committee "to determine the need for survey of organizational mechanism of American Medical Association" (English Committee) was appointed by action of the House at the Clinical Meeting of 1955. On that portion of the Headquarters Survey Report dealing with public relations, the House of Delegates adopted the following report, June 1955:23, 59:

. . . The committee finds that the Public Relations Department has an adequate budget and is developing its specialized techniques in a sound manner. It approves under certain circumstances the employment of outside research foundations. The committee is in accord with the statement that the only public relations program of any permanent value is the private and public relations of the individual doctor. Nevertheless, we must expect and respect the rights of others to disagree with us.

Division of Communications: Pursuant to recommendations of the Heller report and the Hyland Committee, the Board of Trustees reported, and the House approved, reorganization of the Association staff into seven divisions, including a Communications Division and a Field Division, Dec. 1958:60–61.

QUININE

Cinchona Tree in the United States: The House of Delegates approved appointment of a committee "to memorialize Congress relative to the cultivation of the cinchona tree in the United States," May 1867:37–40; May 1868:43, 149–150; May 1870:63, 151–160; 63, 409–422.

The Committee on Cultivation of the Cinchona Tree reported a memorial to Congress requesting appointment of a commission to determine an area of the United States which would be suitable for production of the cinchona tree, May 1872:63–65; June 1874:25–26, 97, 139–140.

Tariff: The House of Delegates adopted a resolution which recommended that this Association "approve passage of the Morrison bill providing for the repeal of the tariff on quinine, and insist that said bill shall become a law," May 1877:46–47.

Public Health Activities: The House of Delegates approved recommendation of the Speaker that there was no longer "need for the Red Cross to enter into the field of medicine or community clinic activities," June 1923:3, 41, 42.

REED, CHARLES A. L.

Senatorial Candidacy Endorsed: The House of Delegates adopted the following resolution, June 1908:41:

Resolved, That this House of Delegates, without any reference to political affiliation, heartily commends the candidacy of Dr. Charles A. L. Reed for United States Senator.

REED, WALTER

Memorial: The House of Delegates approved appointment of a committee on memorial to Major Walter Reed, May 1903: J.A.M.A. 40:1370, 1375; June 1904:23; July 1905: J.A.M.A. 45:258.

The House of Delegates approved discharge of this committee on completion of its project, June 1906:21–22.

REESE, DAVID M.

Recommendation of an Expelled Member: The House of Delegates accepted a statement of apology from Dr. David M. Reese, one of the Association vice presidents, for certifying "to the professional qualifications of an expelled member of this body" for Blockley Hospital, Philadelphia, May 1858:26–27, 33–34.

REFERENCE COMMITTEES

Establishment: On recommendation of President Billings, the House of Delegates approved creation of reference committees in place of the Business Committee, June 1904:1–2, 14.

Amendments to the Constitution and Bylaws: The House of Delegates amended the *Bylaws* to provide that members of the Judicial Council shall be members, *ex officio*, of the Committee on Amendments to the Constitution and Bylaws, June 1914:44.

Appointment of Members: The House of Delegates amended the *Bylaws* to provide that "reference committees and special committees shall be nominated by the Chairman[1] of the House of Delegates and elected by the House of Delegates unless otherwise provided for in the *Bylaws*," June 1916:68.

1. The Chairman of the House of Delegates was designated as "Speaker of the House of Delegates" in 1917.

Legislation and Public Relations: The House of Delegates approved a *Bylaws* amendment changing the title of the Reference Committee on Legislation and Political Action to Reference Committee on Legislation and Public Relations, June 1919:52, 57, 58.

Establishment of New Committees: The House of Delegates adopted the following amendment to chapter VII, section 1 of the *Bylaws*, June 1923:3, 41, 42, 49:

The Speaker of the House of Delegates may appoint from the members of the House such additional committees as he may deem expedient in advance of the annual meeting to expedite the business of the House of Delegates. All such committees shall be subject to the approval of the House of Delegates.

Legislation and Public Relations: The House of Delegates amended chapter X, section 4 (4) of the *Bylaws*, deleting the words, "The members of the Council on Health and Public Instruction shall be members, ex officio, of this committee" and substituting the words, "The Executive Secretary of the Bureau of Legal Medicine and Legislation shall be ex officio member of this committee," June 1923:45, 49.

Appointment of Members: On address of the Speaker, the House of Delegates adopted the following resolution, May 1925:1, 4, 60:

Resolved, That the members of reference committees of this House be appointed at least thirty days in advance of the annual session at which they are to serve, that they be notified by mail concerning such appointment, and that they in turn signify as accurately as possible intention as to attendance so that in case of failure to serve the vacancies may be filled immediately by the Speaker of the House.

Limitation of Membership: Dr. William Allen Pusey suggested, in his presidential address, that reference committee membership be limited to members of this House.

The House of Delegates voted that there was no urgent reason to change the character of membership in certain councils, bureaus, or reference committees, inasmuch as the ex officio members have only the privilege of discussion and not of voting, May 1925:4, 60.

Rules and Order of Business: The House of Delegates disapproved recommendations of the Speaker: (1) that the Committee on Rules and Order of Business be abolished; (2) that a reference committee on medical economics be created, June 1934:1-2, 44.

Appointment of Members: The House of Delegates disapproved a resolution from New York which recommended that the Speaker notify members of their appointments as members of reference committees at least two weeks before a meeting of the House, July 1946:53, 64.

Board of Trustees and Judicial Council as Reference Committees: The House of Delegates voted that no action be taken on resolutions from Colorado and Utah disapproving reference of matters to the Board of Trustees and to the Judicial Council as reference committees and recommending that only those committees which are exclusively composed of elected delegates be utilized. Dec. 1946:26, 27, 40.

Notification of Meetings: The House of Delegates adopted the following resolution from North Carolina, June 1947:95, 104:

Resolved, That at future sessions of the House of Delegates of the American Medical Association a central bulletin board containing information including names of committees and hours and places of meetings be established, and that its location be announced by the Speaker of the House of Delegates.

Appointment of Members: The Speaker recommended, and the House approved, that the Secretary again notify constituent associations of the House action which provides that all reference committees shall be appointed sixty days prior to the convening of sessions and that names of appointees shall be published thirty days prior to the session, June 1948:1, 81, 82.

Amendments to the Constitution and Bylaws: The House of Delegates adopted a revised *Constitution and Bylaws* in which the following sentence was deleted from the section relating to the Reference Committee on Amendments to the Constitution and Bylaws, June 1948:90:

The members of the Judicial Council shall be members, ex officio, of this committee.

Insurance and Medical Service: On recommendation of the Speaker, the House of Delegates amended the *Bylaws* to establish a Reference Committee on Insurance and Medical Service, Dec. 1949:3, 69.

Medical Military Affairs: The House of Delegates adopted a *Bylaws* amendment to establish a Reference Committee on Medical Military Affairs, June 1951:2, 34, 35.

Miscellaneous Business: The House of Delegates disapproved a resolution from New York which recommended (1) creation of additional committees to handle miscellaneous business and a committee to help the Speaker assign topics; (2) reapportionment of all reference committees, June 1951:41, 45.

Appointment of Members: In his address to the House, the Speaker stated that delegates who were members of councils or standing committees would probably not be appointed to reference committees.

The House of Delegates made no recommendation, as the matter was considered entirely within the province of the Speaker of the House, Dec. 1952:2, 98, 101.

Organization: The House of Delegates amended chapter XII, section 3 of the *Bylaws* so that this section reads as follows, June 1953:26, 52, 53:

Section 3. Organization.—(A) Each reference committee shall convene whenever necessary. It shall consider business referred to it and shall report to the House of Delegates when called on by the Speaker. A majority of the members of each committee shall constitute a quorum.

Minority Reports: The House of Delegates approved addition of the following paragraph to chapter XII, section 2 of the *Bylaws*, June 1953:26, 52, 53:

(B) Minority Reports.—A member of a reference committee who wishes to make a minority report must refrain from signing the majority committee report and must make his intentions known to the other members of the reference committee while it is in executive session and prior to the presentation of the majority report to the House of Delegates.

Hygiene, Public Health and Industrial Health: The House of Delegates approved combination of the Reference Committees on Hygiene and Public Health and on Industrial Health to form the Reference Committee on Hygiene, Public Health and Industrial Health, Dec. 1953:77, 95, 95–96.

Alphabetical Listing: The House of Delegates amended chapter XII, section 4(A) through (M) of the *Bylaws*, rearranging the listing of reference committees so they appear in alphabetical order, Nov.–Dec. 1955:116, 128.

Amendments to the Constitution and Bylaws: The House of Delegates amended chapter XII, section 4(G) of the *Bylaws* by adding the following words in italics, Nov.–Dec. 1955:116, 128:

Amendments to the Constitution and Bylaws to which shall be referred all proposed amendments to the Constitution or Bylaws *and matters pertaining to the Principles of Medical Ethics of the American Medical Association.*

Board of Trustees: Subsequent to creation of the Office of Executive Vice President, the House of Delegates approved change in name of the "Reference Committee on Reports of Board of Trustees and Secretary" to "Reference Committee on Reports of Board of Trustees," June 1958:39, 39–40.

RELIGION

Relationship to Medical Profession: The House of Delegates adopted a report which stated that it was inexpedient to publish in the *Transactions* a paper entitled *Religion, an Element in Medicine, or Duties and Obligations of the Profession*, May 1854:36, 40; May 1855:49–52.

RESEARCH, MEDICAL

Committee on Medical Literature: The delegation to the national medical convention, held in 1847, adopted a *Plan of Organization* for the proposed American Medical Association which included provision for a Committee on Medical Literature, to be appointed at every annual meeting, to "prepare an annual report on the general character of the periodical medical publications of the

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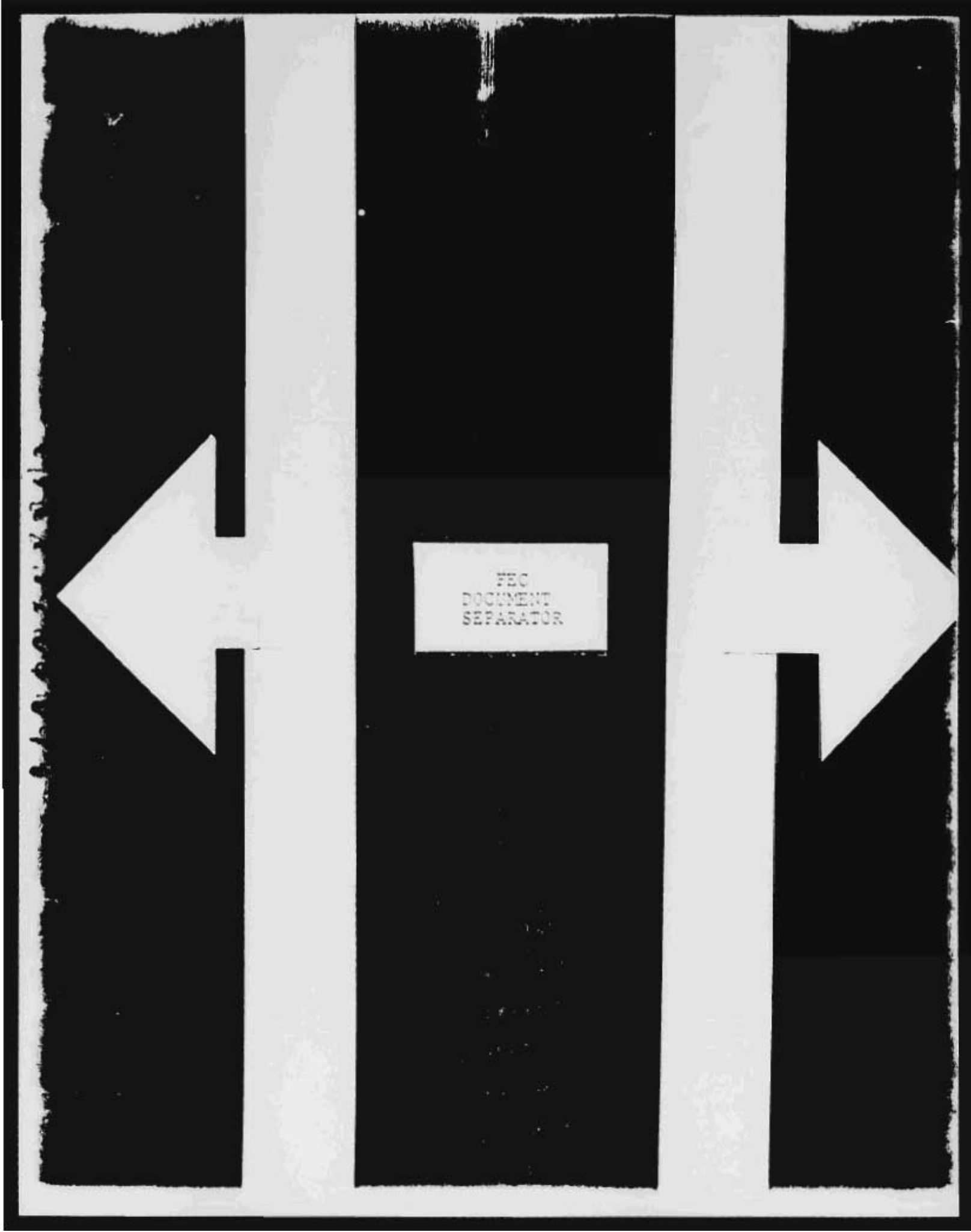
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1959-1968 Digest of Official Actions

AMERICAN MEDICAL ASSOCIATION

ERNEST B. HOWARD, M.D.

EXECUTIVE VICE PRESIDENT

INTRODUCTION . . .

Volume II of the Digest of Official Actions of the American Medical Association House of Delegates covers a ten year span, 1959 to 1968. Volume I covers the period between 1846 and 1958.

This Digest of Official Actions of the American Medical Association is not intended to provide a detailed report of official actions. Rather it summarizes these actions and refers to the official Proceedings of the House where the complete record is reported. Actions are arranged chronologically under the classifications and include all actions taken during 1959-1968.

In explanation of the references: The House of Delegates meets twice each year in June and November or December. The reference June 65:102-105 refers the reader to the June 1965 Proceedings where on pages 102 to 108 the specific action will be found. Where the reference is reported as A-65 or C-65, the "A" refers to the Annual Convention in June and "C" refers to the Clinical Convention in November or December.

Customarily, the Association does not rescind its actions on specific subjects. The most recent actions of the House constitute current policies of the American Medical Association. The purpose of Volume II is to provide a basic reference tool which will serve as a guide to the policies established from 1959 to 1968.

ERNEST B. HOWARD, M.D.
EXECUTIVE VICE PRESIDENT

usual channels of distribution to constituent associations, component societies, and other appropriate groups, Dec. 1968:109–110.

AMERICAN ASSOCIATION OF PROFESSIONS

Formation: The House of Delegates took no action on resolution no. 29 which recommended that the Board of Trustees "interest itself in the movement represented by such state organizations as Michigan Association of Professions and particularly in the further development of American Association of Professions toward the end that when AAP is finally completed organizationally, it will be so constituted that the profession of medicine can participate in the functioning, the support and the benefits of this association," but agreed that the Board should be aware of the existence of this organization. June 1962:109–110.

Formation of State Associations: The House of Delegates adopted resolution no. 50 which urged the constituent medical societies to take a leadership role in the formation of state associations of the professions to provide a vehicle for interprofessional cooperation in those areas where united activity of the various professions can be of great benefit, and requested the Board of Trustees to consider the potential advantages of aiding in development of the American Association of Professions, June 1965:118.

AMERICAN FARM BUREAU

Commendation: The House adopted a resolution congratulating and commending "The American Farm Bureau Federation and its state constituents for their unalterable opposition to the extension of government controls in agriculture and to government encroachment in business, industry, and the professions," further recommending that copies of the resolution be forwarded to the American Farm Bureau for dissemination to its state constituents and such other distribution as may seem desirable, June 1963:159.

AMERICAN MEDICAL ASSOCIATION—ORGANIZATION AND ADMINISTRATION

Objectives: The House of Delegates adopted a recommendation of Council on Constitution and Bylaws pursuant to House action in December, 1958 (111–116), that no change be made in Article II of the *Constitution* to include an understanding of the socioeconomic and political conditions which facilitate the attainment of the objectives of the Association.

The House urged physicians to participate in community activities and socio-economic matters in their own communities, June 1959:53, 55.

Scientific Activities: On address of President Gunnar Gundersen the House viewed "with favor the new Advisory Committee on Scientific Activities," appointed "to take an objective look at the present and future scientific activities of the AMA," and advise on which activities should be continued, which dropped, new activities to be undertaken and better ways to coordinate the activities. June 1959:8–9, 10.

The Board of Trustees appointed the ad hoc Advisory Committee, Dec. 1959: 10, 24, 80, 98–99, 109.

Washington Office Reorganization: The Washington Office reported reorganization with a new concept of operation, Dec. 1959:111–113.

Hawaii and Alaska Medical Associations: The House adopted resolution no. 47, congratulating and welcoming the states of Hawaii and Alaska and their state medical associations as members of AMA, Dec. 1959:222.

New Divisions: The Executive Vice President announced that the Division of Socio-Economic Activities was divided into a Division of Environmental Medicine and a Division of Legal and Socio-Economic Activities, Nov.–Dec. 1960:53, 89–90.

Investment Policy Guides: The Board of Trustees presented policies and practices adopted as guides to sound financial management, Nov.–Dec. 1960: 106–107.

Ten-Point Program: The House of Delegates endorsed the AMA's positive 10-point program for 1961 under categories of: (1) costs of medical care; (2) voluntary health insurance and prepayment; (3) help to the needy and near-needy aged; (4) health of the aged; (5) mental health; (6) physician supply; (7) continuing education and research; (8) international health; (9) preservation of the freedom of patients and physicians; and (10) health and safety education, June 1961:42–44.

Constituent Associations: The House adopted resolution no. 29 recommending amendment to AMA *Constitution* to provide for inclusion of commonwealth associations in Article III, Nov. 1961:211; amendment adopted, June 1962:35.

Environmental Health Department: The Board announced establishment of a Department of Environmental Health, Nov. 1962:26, 28.

Table of Organization: The House com
and his staff for their report, especial
"makes it much easier for the componen
quarters," Dec. 1963:60–63, 71.

Address of President Donovan F. War
endorsement and confidence in the five
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(3) improving the communications thr
medicine's public relations, (4) educati
ical progress, and (5) insuring that no
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adopt resolution no. 4 proposing the f
study the functions, expenditures and
1964:144–145.

Committee on Study, Policy and Plann
to the Board of Trustees resolution no.
the AMA of a permanent advisory com
whose duty it is to study economic, ph
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medical care, with consideration of th
the public and the medical profession, J

Remarks of the Executive Vice Preside
for information the remarks of F. J. L.
activities of the Association, Nov.–Dec.

Pamphlets: The Board of Trustees
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1965:32.

Planning and Development: The Boa
of a Committee on Planning and Deve
(1) to review and study current plannin
for planning and development and (2)
anisms and organizational arrangemen
and development for the future. The n
five members of the Board, the Chairm
Medical Education and Legislative Ac
gates and two members of the House
adopted the Board report and instruc

Table of Organization: The House commended the Executive Vice President and his staff for their report, especially the Table of Organization, which "makes it much easier for the component medical societies to find aid at headquarters." Dec. 1963:60–63, 71.

Address of President Donovan F. Ward: The House of Delegates expressed endorsement and confidence in the five-point program outlined by President Donovan F. Ward which dealt with (1) closer liaison between AMA and all specialty groups, (2) strengthening of the concept of the family doctor, (3) improving the communications throughout the profession and fortifying medicine's public relations, (4) educating the public on the benefits of medical progress, and (5) insuring that no one shall be denied medical care because of inability to pay, Nov.–Dec. 1964:5.

Ad Hoc Study Committee on Costs: The House of Delegates voted not to adopt resolution no. 4 proposing the formation of an ad hoc committee to study the functions, expenditures and sources of AMA income, Nov.–Dec. 1964:144–145.

Committee on Study, Policy and Planning: The House of Delegates referred to the Board of Trustees resolution no. 1 calling for the establishment within the AMA of a permanent advisory committee on study, policy and planning, whose duty it is to study economic, philosophical, political, social and scientific trends of the day as they bear upon public health, medical practice and medical care, with consideration of the effects which these may have upon the public and the medical profession, June 1965:75.

Remarks of the Executive Vice President: The House of Delegates accepted for information the remarks of F. J. L. Blasingame, M.D., reporting on the activities of the Association, Nov.–Dec. 1965:8–14.

Pamphlets: The Board of Trustees reported to the House its reaffirmation of the October 1964 policy regarding the distribution of pamphlets, Nov.–Dec. 1965:32.

Planning and Development: The Board of Trustees reported appointment of a Committee on Planning and Development with two broad assignments: (1) to review and study current planning procedures and techniques in AMA for planning and development and (2) to study and recommend new mechanisms and organizational arrangements to achieve more effective planning and development for the future. The membership of this committee includes five members of the Board, the Chairmen of the Councils on Medical Service, Medical Education and Legislative Activities, Speaker of the House of Delegates and two members of the House selected by the Speaker. The House adopted the Board report and instructed the Committee to submit recom-

mendations to the Board for consideration by the House of Delegates in June 1966. Nov.–Dec. 1965:103–104.

Implementation: The House accepted for information Report GC of the Board of Trustees which informed the House of the progress being made by the Study Committee on Planning and Development. The House did not adopt resolution no. 26 (A–66:121), calling for the establishment of a more definitive role for each program emanating from the AMA, because it felt this was being accomplished by the Study Committee on Planning and Development. June 1966:66–68, 121. Nov. 1966:110.

Role of Medicine in Society: The House of Delegates referred to the Study Committee on Planning and Development resolutions nos. 4, 46 and 47 since all three resolutions dealt with the same general area of concern about future activities of the Association. Nov.–Dec. 1965:179–180.

Training and Development of Leadership: The House of Delegates adopted, and referred to the Board of Trustees for consideration, resolution no. 38 calling for continued efforts in the training and development of volunteer and staff leadership, and that the Board of Trustees conduct a leadership conference to determine the needs of state and county medical societies. June 1966: 130.

Communications with County Societies: The House of Delegates referred to the Board of Trustees, for study and appropriate action, resolution no. 88 stating that one method of distribution of information relative to the development and maintenance of the highest quality of medical care, as well as programs and actions of the AMA House of Delegates and Board of Trustees, be accomplished by designation of a specific section in the *AMA News* of particular interest to the county society level for consideration and action, and as a forum for inter-county communication. June 1966:153.

Implementation: The Board reported that news of county society activities would continue to be an important part of the *AMA News*, but recommended that no special section be set aside for county society communication. The House adopted the recommendation of the Board. Nov. 1966:89–90.

Information Handbook for AMA Members: The House of Delegates adopted resolution no. 98 directing the appropriate AMA staff to prepare and make available to AMA members a handbook to include, but not necessarily limited to, AMA *Constitution and Bylaws*, short history of the AMA, organization of the House of Delegates, Board of Trustees, councils and committees of the House, committees of the Board, AMA staff and departments, and relations of AMA to society. June 1966:157.

Committee on Planning and Development: The House of Delegates adopted a report of the Board of Trustees which announced the establishment of a permanent Committee on Planning and Development composed of seven active members of the AMA, and contained the following summarized conclusions:

1. The American Medical Association can improve its effectiveness by placing more emphasis on planning.

2. The responsibility for planning should not be separated from the responsibility for managing the affairs of the Association.

3. The planning process must be tailored to fit the uniqueness of the American Medical Association.

4. The House of Delegates, the Board of Trustees, all councils and committees, and the Executive Vice President and his staff must make a significant commitment of time and other resources in order to make the Association's planning efforts more productive.

5. A concerted effort should be made to blend into the Association's planning efforts the knowledge and insights of many disciplines, including medicine, sociology, economics, law and any others which would bring more enlightenment to bear upon the problems facing the Association.

6. The Association must recognize that its present organizational structure does present severe limitations and may have to be modified at some future time. June 1967:56–60.

AMA Unity: The House of Delegates referred to the Board of Trustees resolution no. 13 which stated that:

1. A clear distinction be drawn between policy making function and the executive functions so that councils, committees, officers and staff will have clearly and carefully defined authority to act in a unified, consistent and coordinated manner.

2. Improved communications, essential to presenting a unified front against further governmental intervention and control, be established with the members and the local and state societies.

3. The President of the American Medical Association be, and is hereby, directed to appoint an ad hoc committee of the House consisting of five delegates and a sixth member, who shall be the Executive Vice President, to prepare and to report for House approval at the Clinical Session 1967 recommendations for practical restructuring of the AMA table of organization and authority which will assure effective leadership operating within policies established by this House, enhance AMA responsiveness to the edicts of its membership, and unify presentation of its policies to Congress and the public. June 1967:97–98.

AMA Aims: The House of Delegates referred to the Board of Trustees resolution no. 72 which stated that AMA should restudy its aims and aspirations, June 1967:123.

Implementation: The House of Delegates approved in principle the following purposes and responsibilities of the AMA, as submitted by the Board of Trustees:

It is the responsibility of the American Medical Association, as the representative of the American medical profession, to continue to foster the advancement of medical science and the health of the American people.

Its continuing purposes are to meet this responsibility through the following means:

1. By encouraging the further development of medical knowledge, skills, techniques and drugs; and by maintaining the highest standards of practice and health care.

2. By creating incentives to attract increasing numbers of capable people into medicine and the other health-care professions.

3. By advancing and expanding the education of physicians and other groups in the health-care field.

4. By motivating skilled physicians who have the art of teaching to apply themselves to developing new generations of excellent practitioners.

5. By fostering programs that will encourage medical and health personnel to serve voluntarily in the areas of need for medical care.

6. By developing techniques and practices that will moderate the costs of good medical and health care.

7. By seeking out and fostering means of making all health-care facilities—physicians' offices, hospitals, laboratories, clinics and others—as efficient and economical as good medical practice and attention to human values will permit.

8. By combining the utilization of the latest knowledge for prevention and treatment with the vital healing force of the physician's knowledge of and devotion to his patient.

9. By maintaining the impetus of dedicated men and women in providing excellent health care by preserving the incentives and effectiveness of unshackled medical practice.

10. By maintaining the highest level of ethics and professional standards among all members of the medical profession.

11. By continuing to provide leadership and guidance to the medical profession of the world in meeting the health needs of changing populations, Nov. 1967:120–121.

Fiscal Notes: The House of Delegates did not adopt resolution no. 31 which recommended that any resolution which would involve the expenditure of funds shall be accompanied by a fiscal note. Nov. 1967:201.

Conference of County Society Leaders: The House of Delegates adopted resolution no. 39 which called for the Board of Trustees to incorporate in future meetings of the AMA mechanics by which county medical society problems may be presented and discussed. Nov. 1967:205.

Implementation: The House adopted a report of the Board which announced that such a national conference would be held Aug. 21, 1968, as a part of the 1968 AMA Institute program. June 1968:63–64.

Financial Statement and Status of AMA: The House of Delegates accepted for information reports of the Board of Trustees containing the financial statement and the financial status of the AMA, with the request that this information be brought to the attention of all members of the Association. June 1968: 45–46, 86.

Financial Economies: The House of Delegates adopted substitute resolution no. 17 which reiterated support for the continuation of the existing practice of holding the clinical conventions of the House of Delegates in conjunction with the scientific meetings developed by the Council on Scientific Assembly, and encouraged reduction of the expenditures of the Association by:

(1) Requesting the Board of Trustees to continue to take action to reduce, to the extent possible, the extraneous activities financed in whole or in part by the AMA at all meetings of the House of Delegates, the several councils, committees, seminars and other meetings.

(2) Requesting the Board of Trustees to continue to make recommendations as to the consolidation or even abolishment of councils and committees whose reason for creation may no longer exist, or for whose mission the AMA has served as a catalytic developer and for which other agencies have now recognized the responsibility and are able to assume the financial obligation of the program. June 1968:158.

Physician Participation in Organized Medicine: The House of Delegates adopted a substitute resolution, in lieu of resolutions nos. 41 and 52, which requested the Board of Trustees to reconsider and correct the wording of its action on the Interspecialty Committee Report on "Physician Participation in Organized Medicine," and recognized the value and effective strength of the county medical society as the foundation of organized medicine. June 1968:178.

In December 1968, the Board of Trustees revised the controversial portion of the Interspecialty Committee statement on county medical society meetings referred to in substitute resolution no. 41 (A-68) as follows: "A number of local medical societies have noticed a declining attendance at society meetings. A probable contributing factor is the heavy demand on physicians' time, created by required meetings related to hospital staff membership and privilege."

Study by Cresap, McCormick and Paget: The House of Delegates accepted Report V of the Board of Trustees which called attention to the management survey being conducted on the operations of the AMA by the firm of Cresap, McCormick and Paget. The House requested that it be informed promptly of the results of this study. Dec. 1968:135.

Division of Public Affairs: The House of Delegates adopted a substitute resolution, in lieu of resolutions 25, 33 and 60, which requested that (1) the Board of Trustees continue to observe closely the activities of the Division of Public Affairs since this Division is newly formed with newly defined functions and activities; (2) the House receive in advance a comprehensive report on the management survey and its implementation from the Board of Trustees prior to the 1969 Annual Convention; and (3) in the interim, the Board of Trustees keep members of the House fully informed of developments with respect to the management survey as expeditiously as may be feasible, Dec. 1968:187.

AMA NEWS

Origin: The Communications Division reported that the *AMA News*, a biweekly newspaper, was issued for the first time on Sept. 22, 1958, Dec. 1959: 91-92, 109.

ARMED FORCES

Honoring Deceased Members of the Armed Forces: The House of Delegates voted that, because of existing processes for such observances, resolution no. 109 be not adopted. The resolution called on the AMA to request the President of the United States to honor deceased members of our armed services by designating one day of each week when all United States flags would be flown at half mast, June 1967:143.

Physician Leadership in Blood Banking and Uses: The House of Delegates adopted resolution no. 62 which commended the AMA Committee on Blood for their many excellent activities and efforts to enhance blood banking and blood uses, and in promoting physician leadership and guidance in this important facet of medical service; and urged each state and county medical society, and all physicians, to assume an active leadership role providing guidance and direction in the blood affairs of the community, Nov. 1966:227.

Blood Insurance Program: The House of Delegates adopted substitute resolution no. 38 reaffirming its policy opposing in principle the payment for whole blood and red blood cells through insurance, June 1967:110.

Definition of Blood as a Medical Service: The House of Delegates adopted resolution no. 21 which (1) endorsed the concept that the procurement, processing, distribution or use of human blood and other human tissues is the rendering of medical services by all who participate therein, not the selling of a commodity; (2) reaffirmed the position that, beyond assurances that all such participants shall be responsible to exercise the highest standards of professional judgment and procedure, the results of medical services cannot be guaranteed; and (3) directed the Board of Trustees to support legislative action at the federal level to implement this concept and position and to urge the constituent medical societies to support similar action in their respective jurisdictions, Nov. 1967:194.

Change in Status of Committee on Blood: The House of Delegates referred back to the Board of Trustees a report which requested approval of council status for the Committee on Blood, with the suggestion that consideration be given to the consolidation of the study of all scientific and biomedical aspects of human tissue transplants, including blood, for the purpose of recommending policy in this area for the AMA, June 1968:32.

BOARD OF TRUSTEES

Board Reorganization: The Board of Trustees reported that it had "divided itself into three new committees: the Committee on Scientific Activities, the Committee on Socio-Economic Activities and the Committee on Miscellaneous Activities. The objective of these committees is to review the current programs of all committees and councils of the Association. This review will include the committees of the House of Delegates, whose activities during intervals between sessions of the House are under the direction of the Board of Trustees as provided in Chapter 10, Section 3, of the *Bylaws*," June 1959: 31; Dec. 1959:8.

General Principles: The Board reported adoption of the following policies for its standing councils and committees: (1) That the term of service be one

ar subject to reappointment for a maximum of 10 years, retroactive to Jan. 1953; 2) that the membership be "frozen" for the remainder of the year 1959; 3) that a panel of competent eligible individuals be developed, who could serve on a committee or council effectively; that such panel be derived from the committee or council concerned, state and county societies and other sources. Dec. 1959:10, 24.

The House approved the following general principles for standing committees and councils of the Board: (1) Standing committees of the Board shall be designated as councils only on approval of the House of Delegates; this principle does not, however, preclude the authority of the Board to discontinue any of its councils at any time. (2) Each council shall elect annually its own officers. The chairman may not serve more than three consecutive terms, retroactive to Jan. 1, 1959. (3) A council which desires to appoint a committee shall notify its establishment and shall submit nominations for membership on that committee, including the chairman, for consideration by the Board. (4) In principle a man should not be a member of more than one council of the Board. 5) The Board of Trustees shall designate the chairman of each standing, special and ad hoc committee of the Board. (6) AMA staff personnel shall not be members of the editorial boards of AMA scientific publications and councils and committees of the Association. It was understood, however, that this rule did not apply to ex officio staff members, without vote, on councils and committees by virtue of the *Constitution and Bylaws* of the Association. Nov.–Dec. 1960:12, 13.

Standing Committees and Councils: The Board reported adoption of the following general principles pertaining to the procurement of information on nominees for standing committees and councils:

Except where a position is required to be occupied by a member of the Board of Trustees, the Nominating Committee shall procure and provide the Board with a statement which shall include a summary biography of the nominee, his general qualifications, a list of the memberships and offices which he holds in professional organizations, and his direct and indirect affiliations with educational institutions and commercial firms. To the extent, if any, that the foregoing may indicate a possible conflict with the objectives, purposes and policies of the American Medical Association or the council or committee involved, the Nominating Committee shall provide the Board with its evaluation as to the ability of the nominee to serve the primary interests of the American Medical Association. Nov. 1961:18, 30.

Responsibilities: The House adopted substitute resolution no. 96 directing the Speaker of the House of Delegates to appoint an ad hoc committee consisting of five elected members of the House of Delegates to study and review the responsibilities of the Board of Trustees and to recommend whether or not the present Board of Trustees should be enlarged and whether any

change should be made in the terms of office of trustees as presently stated in the Association's *Constitution and Bylaws*; this ad hoc committee to report to the House of Delegates in Denver in November 1961. June 1961:200.

PROGRESS REPORT: Nov. 1961:12–13.

The House concurred with the following recommendations of the ad hoc committee:

I. *Responsibilities of the Board of Trustees:* The responsibilities of the Board of Trustees as presently stated in the *Constitution and Bylaws* (particularly the *Constitution* Article VIII and the *Bylaws* Chapter XVI) are proper and should not be changed.

II. *Membership of the Board of Trustees:* The Board of Trustees be enlarged by the addition of: (a) 3 elected members, and (b) the immediate Past President of the Association so that the Board of Trustees will consist of 15 voting members, 12 elected members, the President, the President-Elect, and the immediate Past President; (c) the Vice-President, the Speaker and Vice Speaker of the House of Delegates should continue as at present to attend all meetings of the Board (including executive sessions) with right of discussion but without right to vote; (d) the committee recommends that as at present representation on the Board not be on a fixed regional or geographic basis.

III. *Terms of Office:* (a) that the terms of office of elected trustees be 3 years and that a trustee shall not serve for more than 3 terms on the Board (a total of 9 years); (b) that a trustee elected to serve an unexpired term shall not be regarded as having served a term unless he has served two or more years; (c) that a trustee elected for one 5 year term prior to adoption of the above recommendation shall be eligible for re-election for one term of 3 years. If in addition to such a 5 year term, he has served 3 or more years of an unexpired term he shall not be eligible for re-election; (d) that the present staggering of terms be continued so that eventually 4 trustees shall be elected annually, each to serve a term of 3 years.

IV. No action be taken at the present time regarding the establishment of a nominating committee for officers of the Association and members of the Board of Trustees. June 1962:85–86;

Amendments to Constitution and Bylaws implementing above recommendations, June 1962:35–36; Nov. 1962:126–127; June 1963:53–54.

Reports of Action: In response to a House recommendation that the Board devise a system to inform the House of Delegates of its activities between sessions, the Board reported its action "authorizing current reports of its actions to the delegates, alternate delegates, members of AMA councils and committees and state medical societies," the first report being distributed in October 1962. June 62:83, 84; Nov. 1962:28; Dec. 1963:23, 29; commendation of the Board and the Executive Office: Dec. 1963:183–184.

General Principles: The Board reported the following addition to existing general principles for its councils and committees, and that joint meetings of the Board with AMA councils and Chief Editors of the specialty journals had been held: Nov. 1962:26, 28:

Physician-members of councils, committees, and editorial boards shall be members of the American Medical Association, if they are eligible for such membership.

Where practical, subcommittees of councils or committees of the Board shall be composed of not more than five members, one or more of whom shall be a member of the parent council or committee. Nov. 1962:26, 28.

New Committees: The Board announced appointment of committees on (1) executive sections, (2) international health, (3) nuclear medicine, (4) Joint Commission on Accreditation of Hospitals, (5) current medical terminology, and (6) medicine and religion. Nov. 1962:26-27, 28.

Expenditure of Funds: The House took no action on resolution no. 6 regarding resolutions requesting new programs by the AMA which would involve expenditures of substantial funds. The House noted that the intent of resolution no. 6 is already covered in Chapter XVI, Section 4 (A) of the AMA By-laws. June 1963:132-133.

Principles and Guide: The following rules were approved for Board of Trustees' councils and committees, the first being a revision of an existing principle: (1) Physician members of councils, committees and editorial boards should hold the type of membership in the American Medical Association for which they are eligible; (2) for determination of a term, the length of service for a two-year term shall be one year or more and for a one-year term, six months, if appointed to fill a vacancy.

The Board approved a guide for councils and committees for transmittal to their members. The purpose of the guide is to help acquaint members of councils, committees, and editorial boards with the history, purpose, organization, and administration of the Association. It outlines the composition and operation of the House of Delegates, Board of Trustees, editorial boards, councils and committees and the policies in effect relative to them. Dec. 1963:29.

New Committees: The Board announced the appointment of the following new committees: (1) Joint Commission on Medicine and Pharmacy, co-sponsored with the American Pharmaceutical Association and the National Association of Retail Druggists, to explore the interprofessional relationships of the two professions. (2) Committee on Environmental Health, to be responsible for medicine's interest in the relationship of man to his surroundings, particularly in those areas which pertain to the control of transmissible disease; air, water, and soil pollution; ionizing and other radiation affecting

the public; health problems related to population growth; and urbanization and technological developments bearing on the ecology of man. (3) Committee to study Social Security and Workmen's Compensation, which later, after discussion with representatives of the Council on Medical Service and its Committee on Federal Medical Services, was discharged with thanks, the Council on Medical Service to continue its study of Social Security disability benefits and the Council on Occupational Health its review of workmen's compensation. (4) Committee on Osteopathy and Medicine representing the Council on Medical Education and Hospitals, the Judicial Council, and the Council on Scientific Assembly, to keep developments in the osteopathic and medical fields under constant review, to recommend appropriate actions for the American Medical Association, and to assist state societies. Dec. 1963:29.

Commendation: The House of Delegates adopted resolution no. 23 expressing approval of informing AMA members and the constituent medical associations of the forward looking programs of the AMA by the distribution of summaries of major actions and discussions of each meeting of the Board and urging the continuance of this valuable service, and commending the Board of Trustees and the Executive Office. Dec. 1963:153–154.

New Committees: The Board of Trustees announced the authorization of the following new committees:

Commission on Medical Practice to study and recommend methods for the better distribution of knowledge and skills by the medical profession to provide more adequate availability of personal physicians.

Committee on Human Reproduction to review the policy of AMA on contraceptive practices and to prepare statements on this and other subjects related to human reproduction.

Committee on Quackery; Committee on Exercise and Physical Fitness.

Subcommittee on Classification of Sports Injuries of the Committee on Medical Aspects of Sports to develop standard nomenclature relating to degree and type of injury in sports so that meaningful records and statistics concerning sports injuries and their cause and prevention can be maintained.

Committee on Continuing Professional Education Programs of Voluntary Health Agencies of the Council on Voluntary Health Agencies, composed of one representative from each of several national voluntary health agencies, the Councils on Medical Education, Postgraduate Programs and Voluntary Health Agencies, and three members at large.

Commission on Research to study federal support of medical research, Nov.–Dec. 1964:27.

Committee on Occupational Toxicology; Committee on Iron Deficiency Anemia; Joint AMA-American Institute of Architects Committee on Environmental Health; a Committee to act as an advisory body to the US Bureau of Narcotics. Nov.–Dec. 1963:33.

Objectives of the Joint AMA-American Institute of Architects Committee on Environmental Health are as follows:

1. To study, develop, and recommend to the professions concerned, medical and health guides and criteria for incorporation into architectural and engineering design and urban planning practices;

2. To identify public and environmental health and medical problems which can be ameliorated through architectural and urban planning practices;

3. To correlate, interpret, and disseminate specific technical, medical, architectural, sociological, and related factors of mutual concern;

4. To develop proposals for the planning of environments and structures which promote health, safety, and mental and physical well-being;

5. To develop areas of mutual concern and enduring interprofessional cooperation;

6. To support, encourage, and endorse appropriate action taken by other organizations which meet these objectives, Nov.–Dec. 1965:37, 95.

AMA Advisory Committee on PL 89-97 and PL 89-239; Study Committee on Planning and Development; Committee on Health Manpower; AMA Interspecialty Committee; three review committees for the purpose of reviewing the programs of all councils and committees of the Association, Nov. 1966:24.

AMA Advisory Committee to meet with the President of the United States and other governmental officials; Committee on Physician-Hospital Relationships; Committee on Liaison with Government; expansion of the AMA Interspecialty Committee, Nov. 1967:37.

Advisory Committee on Health Care of the American People; Committee on Health Economics; change in title of Committee to Commission on Emergency Medical Services; expansion of membership of the Interspecialty Committee, Dec. 1968:38–39.

Quorum: The Houset of Delegates revised Chapter XVIII, Section 3 (C), of the Bylaws to provide that eight Trustees shall constitute a quorum rather than seven, Nov.–Dec. 1964:39.

Study of Size, Geographic Representation, Qualifications, Tenure and Method of Election of Members of the Board of Trustees: Because facets of resolution no. 43 were considered with the Report of The Committee to Review the Organization of the House of Delegates (Gundersen Committee; C–65:147–170), the House took no action on resolution no. 43 which proposed a study of the Board of Trustees, its size, geographic representation, qualification for membership, tenure, method of selection, and such other matters as may be considered pertinent to contribute to the better implementation of the policies of the AMA and its House of Delegates, in the best interests of the health of the nation, Nov.–Dec. 1965:170, 204.

General Officers—Attendance at Board Meetings: The House of Delegates adopted an amendment to Chapter XVI, Section 3 (E) of the Bylaws to provide that "if a general officer misses six consecutive regular meetings of the Board, this matter shall be reported to the House of Delegates by the Board of Trustees. His position shall be considered vacant. The vacancy shall be filled as provided elsewhere in the Bylaws," Nov. 1967:137.

Right of Vice-President to Vote at Meetings: Resolution no. 46 (C-67:210) urged that appropriate amendments be made to the Constitution and Bylaws so as to permit the Vice President to vote at meetings of the Board of Trustees. The Council on Constitution and Bylaws set forth the language changes necessary to accomplish the intent of the resolution (A-68:103–106) but the House voted not to adopt the amendments. Nov. 1967:210, June 1968:105–106, Dec. 1968:136.

Supervision of Councils, Committees and Headquarters Staff: The House of Delegates adopted substitute resolution no. 27 requesting the Board of Trustees, under its authority as established in the Constitution and Bylaws of the AMA, to continue to exercise supervision over the activities of all councils and committees of the Association and the AMA headquarters staff, June 1968:170.

Appointments to Councils and Committees: The House did not adopt resolution no. 63 regarding an exchange of information concerning appointments to councils and committees of the Association between the AMA and the constituent state association of which the members appointed to councils and committees are members. The House was informed that all names of physicians suggested for appointment to councils and committees of the Board of Trustees are submitted in advance to the executive secretary of the appropriate state medical association, and that careful consideration is given to any comments and suggestions from state associations. June 1968:187–188.

CANADIAN MEDICAL ASSOCIATION

100th Anniversary: The House of Delegates adopted resolution no. 64 extending congratulations and best wishes to the officers, members and staff of the Canadian Medical Association for 100 years of devoted service to the people of that great nation. Nov. 1966:227.

CANCER

Registry: The House of Delegates adopted a substitute resolution, in lieu of resolutions nos. 4 and 43, which urged medical staffs and state and county

undertake the formation of a national computer organization to serve physicians and their patients, Dec. 1968:177.

CONSTITUTION AND BYLAWS

References to amendments made in specific items in the Constitution and Bylaws *will be found under the subject.*

General Review: The House of Delegates approved a project of the Council on Constitution and Bylaws for "a general study of the *Constitution and Bylaws* for the purpose of directing attention to any inconsistencies or contradictions which might have been created during the years," June 1959:55, 57.

General Revision: The House approved a general editorial revision of the *Constitution and Bylaws*, with many of the detailed paragraphs in the *Constitution* being transferred to an appropriate chapter in the *Bylaws*, and rearrangement of many of the sections in the *Bylaws*. The changes of substance in the *Constitution* are as follows:

1. The Annual and Clinical "Sessions" are renamed "Conventions."

2. The word "constituent" is changed to "state."

The changes of substance in the *Bylaws*, proposed by the council and amended by the House, are:

1. "Sessions" are renamed "Conventions" and "constituent" changed to "state," as in the *Constitution*.

2. Two types of membership are created: "Active," composed of Regular or Service members; and "Special," composed of Associate, Affiliate and Honorary members.

3. Affiliated membership is available to American physicians engaged in medical missionary and similar educational and philanthropic labors located in possessions of the United States. On recommendation of the Board of Trustees (Dec. 1963:93-94, 126), the House approved extension of Affiliate Membership to scientists in sciences allied to medicine.

4. A procedure for nominating AMA representatives to serve on medical specialty certifying boards is provided.

5. The quorum is increased from 75 to 100 of the voting members.

6. A method is established to replace the President if he dies, resigns or is removed from office.

7. A method is established to replace a general officer who misses six consecutive meetings of the Board of Trustees.

Violence and Lawlessness: Resolution no. 53 requested that the AMA recognize the threat to our way of life posed by the increase in violence and lawlessness, and utilize its resources to help resolve this threat. The House of Delegate referred resolution no. 53 to the Board of Trustees with the objective that the Association urge all of its members, individually and through their local civic organizations, to search out and employ effective means of forestalling lawlessness and mass violence. June 1968:182–183.

DAVIS, NATHAN SMITH

Davis Memorial Room: The Board announced that the ninth floor meeting room would be known as the N. S. Davis Room. Nov.–Dec. 1960:14, 15.

DELEGATES—APPORTIONMENT, COMPOSITION, QUALIFICATIONS

Special Privileges: No action was taken on resolution no. 1, proposing nonvoting ex officio membership upon George F. Lull, former Secretary, and Josiah J. Moore, former Treasurer, the House recognizing the invaluable service rendered by them, but stating that adoption of the resolution "might set a dangerous precedent," Nov. 1962:213.

AMA Past Presidents: Because giving AMA Past Presidents full privileges of the House of Delegates might lead to upsetting the balance of voting power by the various state associations and might further lead to an extension of this prerogative to other general officers, present and past members of the Board of Trustees, etc., who have also served the Association long and well, the House of Delegates did not approve resolution no. 19 which proposed full privileges of House membership to all Past Presidents. Nov. 1966:206.

DELEGATES—ELECTION PROCEDURES, SEATING, TERM OF OFFICE

Registration: Registration for a limited period on the day before the opening session was tried with favorable results. Dec. 1959:1.

Term of Office: The House of Delegates approved the following amendment to Chapter IX, Section 3 (B), Subsection (1), of the Bylaws as recommended in resolution no. 13 (additions in italics):

(B) Term. – (1) Delegates and alternates from constituent associations, sections, the United States Army, the United States Navy, the United States Public Health Service and the Veterans Administration shall be selected for two-year terms, and shall assume office on January 1 of the year succeeding

their selection, except that *when vacancies are caused by resignation, death or inability to serve or* when the apportionment of delegates of a constituent association is increased, the delegates and alternates selected to fill the new vacancies shall assume office immediately after their selection and shall serve during that calendar year. Constituent associations entitled to more than one representative shall select them so that one-half the number, as near as may be, are selected each year. June 1964:129.

Seating of Delegates from a New Section: The House of Delegates approved an amendment to Chapter IX, Section 3 (B), of the Bylaws to provide that when a new section is created the delegate and alternate selected to fill the new vacancies shall assume office immediately following the Convention at which they are selected. Nov.-Dec. 1964:104–105.

Seating of Delegates: The House of Delegates adopted and referred to the Council on Constitution and Bylaws for implementation resolution no. 3 which proposed review and modification, where indicated, of the provisions of the Bylaws relating to the seating of delegates and alternate delegates. Nov.-Dec. 1964:144.

Voting Rights of Speaker: The House of Delegates amended Chapter XVI, Section 4, of the Bylaws to provide that the Speaker is entitled to vote when the vote is by ballot, and in all other cases he shall have the right to vote only in case of a tie. June 1965:43.

DELEGATES—REIMBURSEMENT

Travel Expenses: The House of Delegates did not adopt resolution no. 80 which called for the AMA to reimburse travel expenses for each member of the House of Delegates selected by the state associations for attendance at the annual, clinical and called meetings of the House. June 1967:128.

DIRECTORY, MEDICAL

Listing of Section Members: The House of Delegates, although in accord with the general objectives of resolution no. 33, proposing "an alphabetical listing of the members of each section in addition to the regular listing . . ." disapproved it because such separate listing would be impractical and add considerably to the size of the volume. The House suggested "that means of identifying section membership in the *Directory* be studied, in terms of possible implementation for the future." June 1963: 145–146.

Format: The House adopted substitute resolution no. 2 requesting the AMA to seek improvements in the format of its *Directory* to make it easier to use. Dec. 1963:172–173.

Limiting Authority of FDA: The House of Delegates referred to the Board of Trustees and its Council on Legislative Activities Resolution no. 78 which called for support by the AMA of S-3310 and HR-16562, identical bills which would transfer authority to approve new drug applications from the FDA to the National Academy of Sciences. June 1968:195.

New Uses of Old Drugs: The House of Delegates adopted resolution no. 14 which called attention to some of the questions relating to the legal implications of statements contained in labeling approved by the Food and Drug Administration, and requested the AMA to discuss the problem with the FDA Commissioner in an effort to enable the practicing physican to employ new, life-saving therapy legally when indicated. Dec. 1968:182.

DUES, MEMBERSHIP—COLLECTION METHODS

Payment on Installment Plan: The House of Delegates referred to the Board of Trustees for its consideration resolution no. 18 which requested that the AMA Board of Trustees authorize a study of the feasibility of installment plan payments of dues with the physicians involved considered in good standing as long as the specified requirements have been met. Nov. 1966:205.

Implementation: The House of Delegates concurred in the Board's opinion that there was no justification for a change in procedure to allow payment of dues on the installment plan, and took no further action on resolution no. 18. June 1967:52–53.

DUES, MEMBERSHIP—ESTABLISHMENT—INCREASE—DELINQUENCY

Specialty Journals and Today's Health: The Board of Trustees reported inclusion of *Today's Health* and a specialty journal as a benefit of dues paying membership, the House approving amendment to Chapter III, Section 3 of *Bylaws* to provide for this. June 1959:42, 44, 55, 56–57.

Dues Increase: The House approved the Board report calling for dues increase and adopted the reference committee report which advised "(1) that there be an increase in the annual dues of $20, to be implemented over a period of two years . . . ; (2) that these funds be used to inaugurate or expand the following programs: (a) financial assistance to medical students, (b) continuing education for practicing physicians, (c) health advice to the lay public, (d) medical research, (e) the expansion by the Communications Division of its program of faithfully portraying the image of the American Medical Association," the House concurring that the increase "is essential to

the continued welfare and progress" of the AMA, June 1960:57; Nov. 1960: 92–94; June 1961:32–33.

The House of Delegates disapproved resolution no. 1, recommending that a dues increase not be approved unless a public information campaign is initiated and carried out immediately and that the dues increase be reviewed in three years and cancelled if unnecessary; and resolution no. 35, recommending a one-step dues increase and that funds appropriated for financial assistance to medical students be limited to loans rather than to scholarships, June 1961:147.

Increase Proposed: The House of Delegates referred to the Board of Trustees a portion of the address of President Edward R. Annis which proposed the possibility of a dues increase, June 1964:5, 6, 7.

Implementation: The House of Delegates concurred in the Board of Trustees recommendation that the dues not be increased at that time, Nov.–Dec. 1964:97.

AMA's Financial Status: The House of Delegates approved the Board of Trustees' recommendation for an increase in dues from $45 to $70 a year, subject to final action by the House in June 1966, and requested the Council on Constitution and Bylaws to study possible changes in the *Bylaws* which will allow the finances of the Association to be planned more than one year in advance, Nov.–Dec. 1965:101–102.

Dues Increase: On reports of the Board of Trustees and resolutions nos. 15, 43, 74, 79, and 80, the House of Delegates adopted the Board's recommendation and resolution no. 43 proposing an increase in AMA dues from $45 to $70 a year, effective Jan. 1, 1967, and amended the *Bylaws*, Chapter III, Section 1(A) to read: "Annual dues for any year may be prescribed in an amount recommended by the Board of Trustees and approved by the House of Delegates. Dues so prescribed and approved shall remain in effect until changed." The House voted not to adopt the other four resolutions which either opposed the increase, or proposed a study of AMA finances or a one-time assessment of the membership, June 1966:27–28, 56–57, 77, 79–80, 116, 132, 147, 149–150.

Deletion of Reinstatement Fee: The House of Delegates did not adopt resolution no. 30 which asked that the *Bylaws* provisions relating to reinstatement of membership following termination of membership for nonpayment of dues (Chapter III, Section 1(E) be deleted, Dec. 1968:189–190.

ECONOMICS, MEDICAL

Costs of Medical Care: The House concurred with President-Elect Louis M. Orr, that the "attending physician should assist his patients in keeping costs

Implementation: The Board of Trustees reported that Equitable Life Assurance Society had been selected as the carrier of the employees' health insurance. The House recommended that the Executive Vice President make every effort to identify physicians' charges reimbursed under the program and insist that the carrier meticulously enforce this part of the contract, Nov.–Dec. 1965:93–94.

Accident Insurance: The Board approved additional benefits under the accident insurance for individuals on official business of the AMA, Nov.–Dec. 1965:22.

Health Insurance: The House of Delegates adopted resolution no. 44 commending the Board of Trustees and Officers of the AMA for their decision to select the Blue Shield and Blue Cross Plan as carriers for the health care program of AMA employees, Nov. 1967:209.

ETHICS, MEDICAL—PROCEDURE

Medical Discipline: The House of Delegates approved the first report of the Medical Disciplinary Committee, appointed by the Board in February 1959, to investigate the adequacy of disciplinary laws, rules and procedures relating to medical practice and licensure, medical society membership, and the degree to which efficient discipline is maintained among medical practitioners; and outlined the following program:

1. To examine the standards, procedures and rules of medical societies and boards which deal with professional discipline and to evaluate the adequacy of the existing systems of medical discipline within the perspective of practical, ethical and legal considerations.

2. To summarize and evaluate existing state laws and medical licensure board regulations governing medical discipline; the effectiveness of such laws and regulations; and the extent to which state licensure boards are equipped to or do maintain satisfactory medical discipline through revocation or suspension of medical licenses.

3. To study and report on the manner and extent to which discipline is maintained by medical staffs in hospitals throughout the United States with regard to: (a) rendering proper medical care to patients; and (b) interprofessional relations affecting the quality of patient care.

4. To determine whether the American Medical Association could or should become more active in guiding and participating in matters relating to medical discipline; and if an affirmative finding is made, to recommend the establishment of appropriate mechanisms and procedures to carry out such participation efficiently.

5. To conduct fact-finding surveys and field investigations as a basis for reporting on the problems relating to medical discipline and to recommend appropriate measures to improve the over-all mechanism of equitable medical discipline in the interests of the public and the profession.

6. To recommend and draft, if necessary, new legislation or amendments to existing legislation or additional procedures for medical societies in order that the quality of patient care may be improved by maintaining adequate standards of medical discipline. June 1959:40–41.

PROGRESS REPORTS: Dec. 1959:131–132; 136; Nov.–Dec. 1960:105.

Ownership of Pharmacies: On report of the Judicial Council relative to physician ownership of pharmacies, the House adopted the following report. Dec. 1959:135–136, 136:

The Judicial Council repeats that it is not in and of itself unethical for physicians to own pharmacies or hold stock in pharmaceutical companies, but that under certain conditions this can become unethical and contrary to the best interests of the public and the medical profession. The Judicial Council concludes with a paragraph that should be emphasized to the House:

> Because of the nature of these practices and because they can vary so greatly, the Council has insisted that it is the obligation of the local medical society to insure that no one of its members violates the high ethical traditions of the medical profession. It is the obligation of the county medical society to investigate complaints against its members and to take appropriate action, when indicated, to protect both the public and the profession.

Exploitation of Patient: The House concurred with the Judicial Council in its opinion that the *Principles of Medical Ethics* adequately cover resolution no. 35, December, 1959, which proposed amendment to Section II, prohibiting exploitation of the patient by a physician. Dec. 1959:219; Nov.–Dec. 1960: 112, 113.

Appeals to Judicial Council: The House adopted the following amended resolution to reduce the period of time for notice of appeal from 6 months to 30 days:

Resolved, That Chapter IV, Section 1 of the *Bylaws*, the second sentence thereof, be amended to read as follows: "Notice of appeal shall be filed with the Judicial Council within thirty (30) days of the date of the decision by the constituent association, and the appeal shall be perfected within sixty (60) days thereof; provided, however, that the Judicial Council, for what it considers good and sufficient cause, may grant an additional thirty (30) days for perfecting the appeal." June 1960:110.

Honor and Dignity of the Profession: The House adopted a report of Judicial Council which emphasized the role of local societies in censuring "the few

who take advantage of a situation for their personal and selfish interests," Nov.-Dec. 1960:112–113, 113.

Appeals to the Judicial Council: The House adopted a change in *Bylaws*, Chapter XI, Section 10 (A) (3), so that it would be consistent with changes in Chapter IV, Section 1, adopted June 1960 (110), the section reading as follows:

3) The Council shall have appellate jurisdiction in questions of law and procedure but not of fact in all cases which arise between a constituent association and one or more of its component societies, between component societies of the same constituent association, between a member or members and the component society to which said member or members belong or between members of different component societies of the same constituent association. Notice of appeal shall be filed with the Judicial Council within thirty (30) days of the date of the decision by the constituent association, and the appeal shall be perfected within sixty (60) days thereof; provided however, that the Judicial Council, for what it considers good and sufficient cause, may grant an additional thirty (30) days for perfecting the appeal, June 1961:106, 108.

Medical Discipline: The House of Delegates adopted a report of the Medical Disciplinary Committee, and discharged the Committee and assigned its functions to the Judicial Council. Recommendations contained in the report covered the following subjects:

1. Medical Schools and Ethics—That greater efforts be made to acquaint the medical student and the young medical practitioner with ethical and proper socioeconomic principles during the period of his schooling.

2. State Boards of Medical Examiners—That there is a need for closer and more effective liaison and cooperation between state boards of medical examiners, medical schools and medical associations.

3. Medical Associations—That state medical associations have not been as effective as they could be in the area of medical discipline because of the practice of limiting their concern to matters that are appealed to them from the local level. Some defects in basic mechanisms and considerable apathy at the county and state level in taking action against offenders have contributed to the situation which exists.

4. American Medical Association—That the American Medical Association should become more aggressive and active in supplying advice and assistance to state boards of medical examiners and state and county medical societies in all aspects of medical discipline. June 1961:8–10, 55–97.

Civil Immunity: The House adopted resolution no. 68 encouraging state legislation which would grant statutory immunity from damage suits to any member of the professional society or association acting in an official capacity

involving disciplinary proceedings against a fellow member for the protection and well-being of the public and the profession, June 1961:190.

Right of Free Speech: The Judicial Council reported a case of appeal from the action of a state medical association which affirmed a decision of one of its component societies finding a member guilty of unethical conduct by using intemperate language in discussing policy adopted by his county medical society. The House concurred in the Judicial Council opinion that: "A physician, as any other citizen, has the right to express himself freely and fully but always in accord with law and good taste. Membership in a medical society does not in any way curtail that right, but demands that it be exercised in accord with the dignity of the medical profession," Nov. 1961:131, 134.

Ownership of Pharmacies: The Judicial Council announced initiation of a questionnaire survey on abuse by physicians of the privilege of owning pharmacies or interest in pharmaceutical companies. The House reaffirmed AMA policy . . . that "Rentals by physicians for space leased by them to pharmacists based on a percentage of income are unethical; rental fees charged by physicians for space leased by them to pharmacists must be reasonable according to the commonly accepted standards of the community or they are unethical; and it is not considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of the patient," Nov. 1961:132, 133–134, 134.

Disposition of Samples: The Judicial Council reported study of practice of repackaging and sale of physicians' drug samples, many misbranded or contaminated, and made a statement of opinion regarding disposal of samples, the House concurring that the "physician himself is responsible for the control and custody of drugs once they come into his possession and in the high tradition of the medical profession he should not dispose of these drugs in any way that would cause harm to others." The Council opinion also stated that resale is unethical, and that county medical societies should encourage a system "so that these samples, under proper professional supervision, could be used for charitable purposes," Nov. 1961:132, 133, 134.

Judicial Council's Expanded Activities: The House concurred that the Judicial Council is most competent by reason of training and experience to implement the following new activities: "(1) providing services in the field of medical discipline to state and county medical societies and state boards of medical examiners; (2) the development, in cooperation with the Council on Medical Education and Hospitals and the Council on Medical Service of a medical school course in ethics and proper socioeconomic practices; (3) lending assistance to state boards of medical examiners in the field of medical discipline; (4) encouraging active disciplinary programs at state and county level by state and county medical societies; (5) drafting a model medical

practice act; (6) initiating a program of lectures annually on ethics and proper socioeconomic practices for medical staffs in hospitals; and (7) planning to hold institutes or conferences on ethics and discipline," Nov. 1961: 133, 135.

Discipline (Original Jurisdiction): In accordance with recommendation g under the heading of "AMA," of Medical Disciplinary Committee (June 1961: 9-10, 55-97), the House amended Section 1 of Chapter IV of the *Bylaws* to read as follows (additions in italics):

(A) In all controversies between a member and his component society or constituent association, an appeal may be made to the Judicial Council on questions of law and procedure only, but not of fact. Notice of appeal shall be filed with the Judicial Council within thirty (30) days of the date of the decision by the constituent association, and the appeal shall be perfected within sixty (60) days thereof; provided, however, that the Judicial Council, for what it considers good and sufficient cause, may grant an additional thirty (30) days for perfecting the appeal.

(B) In addition to such disciplinary action as may be taken under the constitution and bylaws of the component society and constituent association to which the member belongs, or *when a state medical association to which a member belongs requests the AMA to take disciplinary action, or when at the request of the American Medical Association the state association to which the member belongs consents to disciplinary proceedings by AMA,* the Judicial Council, after due notice and hearing, may censure *him* or *may* suspend or expel any member of the American Medical Association *from AMA membership only* for an infraction of the Constitution or these Bylaws or for a violation of the Principles of Medical Ethics, Nov. 1961:128, 129, 130; June 1962:34.

Physician Ownership of Pharmacies or Pharmaceutical Companies: On special report of Judicial Council, on its survey of practice of physician ownership of pharmacies and stock in a pharmaceutical company, the House adopted reference committee report which called attention to the following observations of the Council:

At the present time, the policy of the American Medical Association is as follows: "It is not in itself unethical for physicians to own pharmacies or to hold stock in pharmaceutical companies. However, the ownership of a pharmacy or the ownership of stock or a financial interest in a pharmaceutical company can, under certain circumstances, become unethical and contrary to the best interests of the public and the medical profession" (Dec. 1959:135–136).

When a complaint is made regarding the practices of a particular physician or group of physicians who own or have an interest in pharmacies, pharmaceutical companies or drug repackaging companies, the local medical society

has a positive obligation to investigate the facts. The society must ascertain whether the particular practice exploits the patient, whether it results in inferior medical care, whether the costs of drugs to the patient are increased, whether the situation is an act in derogation of the dignity and honor of the medical profession and its traditions; whether the practice is a subterfuge to permit the doctor to accept a rebate; or whether it tends to cause the doctor to over-prescribe or prescribe less effective drugs. Having conducted such an investigation, the local medical society must then take appropriate action, where indicated, to protect both the public and the profession.

The Judicial Council further suggests that the establishment of a code of cooperation between physicians and pharmacists might prove helpful in this area, as another measure to prevent abuse and to promote better understanding between these two professions. The Judicial Council and representatives of the American Pharmaceutical Association, American College of Apothecaries, and the National Association of Retail Druggists have agreed to draft a model code of cooperation. . . . . June 1962:36–45.

PROGRESS REPORT: Nov. 1962:200, 201.

Original Jurisdiction Rules: The House commended the Judicial Council on the "Original Jurisdiction" *Rules of Procedure* for institution of proceedings and conducting hearings before the Judicial Council in disciplinary action cases. Nov. 1962:201–203.

Physician Ownership of Drugstores, Repackaging Houses and Pharmaceutical Companies: The House approved the following opinion of the Judicial Council, June 1963:75:

Section 7 of the *Principles of Medical Ethics* provides: "Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient." Under this language it cannot be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patient.

It is unethical for a physician to have a financial interest in a drug repackaging company.

It is unethical for a physician to own stock in a pharmaceutical company which he can control or does control while actively engaged in the practice of medicine.

These practices are contrary to the best interest of the public and the medical profession.

In rendering the above opinion the Council called attention to the statement, adopted by the Council in June 1958, on the meaning of the language of Section 7 of the *Principles*:

> It is the opinion of the Judicial Council that this language was adopted to permit both the practicing physician and the local medical societies to evaluate the many

factual situations incident to prescribing and dispensing which are bound to arise in the practice of medicine. Under this language the doctor is permitted to exercise his own best judgment when caring for his patients. It is known that there will be situations when it is necessary or desirable for a physician to dispense or supply what he has prescribed. The *Principles* permit this to be done. On the other hand, this broad language provides a means by which a component medical society can inquire into the facts of a particular practice. The profession thus can act to prevent abuse of discretion and protect patients from exploitation. In essence this language means that a physician in the exercise of sound discretion may dispense "in the best interest of his patient", it does not authorize him to dispense solely for his convenience or for the purpose of supplementing his income.

Conduct of Charles E. Smith, MD: The House took no action on resolution no. 69 requesting that the report of the Judicial Council on the conduct of Dr. Charles E. Smith in the General Walker case be referred to an appropriate committee for consideration, on being informed that the final judicial authority in disciplinary matters under Chapter XI, Section 10(A) of the *Bylaws* is vested in the Judicial Council. June 1963:163; Dec. 1963:160.

Expanded Activities: The House of Delegates approved the recommendation that "an expanded program on medical ethics be undertaken by the AMA through the Judicial Council, and that the Council, working with the Board of Trustees, determine the means by which this program is to be implemented." June 1964:43.

Implementation: The Judicial Council announced that a National Congress on Medical Ethics and Professionalism had been scheduled as a means of implementing the above action. Nov.-Dec. 1965:143, 143–144.

Declaration of Helsinki: As recommended in Report M of the Board of Trustees and Report A of the Judicial Council, the House of Delegates endorsed the Declaration of Helsinki as a guide to those who are engaged in clinical medical investigation, and urged publication of the Declaration of Helsinki in state and local journals for the information of all physicians. June 1966:51, 73–74.

Implementation of Section 7 of the Principles of Medical Ethics: The House of Delegates did not approve the recommendation contained in Report II of the Board of Trustees that a physician may participate in the ownership of a pharmacy or regularly dispense drugs, remedies or appliances or provide eyeglasses to his patients only when approved by his component and constituent medical associations and when it is determined by them to be necessary in the best interest of the patient. The House referred the amended Report of the Reference Committe on Amendments to Constitution and Bylaws to the Board of Trustees with the directive that it take appropriate action for the widespread dissemination of the report as expeditiously as possible. The Reference Committee reaffirmed the 1963 House of Delegates interpretation of "in the best interest of the patient," which in part reads: "that a physician

in the exercise of sound discretion may dispense 'in the best interest of the patient'; it does not authorize him to dispense solely for his convenience or for the purpose of supplementing his income," June 1966:68–69.

Guidelines for Clinical Investigation: The House of Delegates adopted Report A of the Judicial Council which contained guidelines intended to aid physicians in fulfilling their ethical responsibilities when they engage in the clinical investigation of new drugs and procedures. Nov. 1966:189–190.

Use of Terms "Ethical" and "Unethical": The House of Delegates adopted Report C of the Judicial Council (as amended by the Judicial Council) interpreting the use of the terms "ethical" and "unethical" as used in opinions and reports of the Judicial Council and resolutions of the House of Delegates. Nov. 1966:191.

EXECUTIVE VICE PRESIDENT AND ASSISTANT EXECUTIVE VICE PRESIDENT

Special Address of Executive Vice President: The House of Delegates adopted resolution no. 2 which requested that the Executive Vice President prepare a report for the sessions of the House of Delegates as frequently as necessary but at least for each annual meeting, that the report be submitted in written form and referred to the appropriate reference committee, and that the Executive Vice President be prepared to present a brief oral summary of his report on request of the House of Delegates. Dec. 1968:175–176.

Office of Executive Vice President: The House of Delegates adopted resolution no. 40 recommending to the Board of Trustees that the office of the Executive Vice President be filled, if possible, by a Doctor of Medicine who is an active member of the American Medical Association at the time of his appointment and who possesses the necessary managerial qualifications, Dec. 1968:194.

EXPERT TESTIMONY

Non-Partisan Medical Testimony: The House of Delegates adopted Report J of the Board of Trustees containing a resolution which requested that the AMA endorse the principle of non-partisan medical testimony, and that the American Bar Association and other national bar and judicial organizations having a bonafide interest in the subject be invited to participate in a joint venture for the purpose of formulating a model plan for non-partisan medical testimony. June 1961:50.

FEES

Payment to Hospital Residents: The House of Delegates approved resolution no. 10, reaffirming its position "of opposition to payment of residents-in-

interpretations of policies be based on the official actions of this House of Delegates, Nov.–Dec. 1965:200–201.

Government Hospital Utilization Committees: The House adopted amended resolution no. 24 which requested that (1) the AMA bring to the attention of the appropriate federal agencies the responsibility of government hospitals for establishing active utilization review committees, and that participation by private physicians and local medical societies be encouraged wherever appropriate on such hospital utilization committees; and (2) that government hospitals at all levels in the United States and Puerto Rico (including Veterans Administration Hospitals but excepting military hospitals handling service personnel on active duty) be required to establish their utilization and review committees with participation of the staff member and representatives of local county medical societies, and that reports be made available to reviewing federal agencies concerned with utilization efforts under PL 89–97 for comparison with nonprofit hospital results, June 1966:119–120.

Utilization Review Committees and Claims Review Committees: The House took no action on resolution no. 66 on utilization review and claims review committees because of previous House action, June 1966:142.

Utilization Review Committee Immunity: The House of Delegates adopted amended resolution no. 10 requesting that state medical societies be urged to seek the passage of state legislation which would provide a physician who serves on a utilization review committee immunity from litigation arising from the actions of the committee, and that AMA staff provide state societies with requested technical assistance, Nov. 1966:201.

Utilization Standards in Hospitals: The House of Delegates adopted amended resolution no. 31 stating that tax-supported hospitals and private hospitals be governed by the same utilization standards, Nov. 1966:222–223.

Veterans Administration and Public Health Service Hospitals: The House of Delegates adopted resolution no. 10 commending the federal government for establishing utilization committees in Veterans Administration and Public Health Service Hospitals; and requesting that representatives of utilization committees in government hospitals be invited to participate in the deliberations of county medical society coordinating committees on utilization where these exist, Nov. 1967:188.

HOUSE OF DELEGATES—CONVENTIONS

Time of Meeting: The House of Delegates approved the suggestion of the Speaker that the first session of the interim meeting should begin on Monday

any council or committee of the AMA unless he is an active member of the Association" be rescinded, and that the policy read "that a physican shall be eligible for membership on AMA councils and committees provided he holds the type of AMA membership for which he is eligible," June 1967:94.

The House of Delegates adopted the recommendation of the Council on Constitution and Bylaws that no change be made in Chapter X, Section 2, of the Bylaws regarding eligibility for committee membership, Nov. 1967:133.

HULL AWARD

Establishment: The House adopted Supplementary Report Q of the Board of Trustees, proposing establishment of an award for the best scientific exhibit at the clinical meeting in honor of Dr. Thomas G. Hull, and acceptance of $2,500 from Smith, Kline & French toward sponsorship, Dec. 1959:133.

Administration: The House approved the administration procedures accepted by the Board, Nov.–Dec. 1960:15, 45, 48–49.

RECIPIENTS:

Nov.–Dec. 1960: Drs. H. A. Freckman, H. L. Fry, E. R. Maurer, and F. L. Mendes, Jr., of Cincinnati, Nov. 1961:44, 50.

Nov. 1961: Drs. William E. Loch, Edward H. Sharp, and Robert G. Chambers of Johns Hopkins University, Baltimore, Nov. 1962:51, 52.

Nov. 1962: Drs. Vernon M. Smith and Ruben P. Mallari, of Baltimore, Dec. 1963:39–40, 40.

Nov. 1963: Dr. Robley D. Evans of Massachusetts Institute of Technology, Cambridge.

Nov. 1964: Dr. Banning G. Lary of the University of Miami, Florida.

Nov. 1965: Dr. Leo J. Cass of Harvard University, Cambridge.

Nov. 1966: Dr. Gordon McHardy of New Orleans, Louisiana.

Nov. 1967: Dr. J. Alfred Rider of San Francisco, California.

Nov. 1968: Dr. Dan M. Gordon of New York City.

HYPNOSIS

Committee of Hypnosis: The Council on Mental Health reported that the Committee on Hypnosis, approved by the Board in Feb. 1959, had been appointed, and that its primary objective is to concern itself chiefly with the problem of implementing the suggestions and ideas expressed in the Council's report on medical use of hypnosis (Dec. 1957:26, 27; June 1958: 17–18), Dec. 1959:38, 40.

LEGISLATION

Activities at National Level: The House of Delegates adopted resolution no. 21 expressing appreciation for the outstanding and sustained efforts of the Board of Trustees, the Council on Legislative Activities, and the staff of the AMA, concurring that the effectiveness of the organization has been greatly increased through sound, constructive planning which has immeasurably enhanced our legislative relations. The House also expressed its appreciation of the activities of the various state and local legislative committees, further urging that all legislative activities of the AMA, states and counties be constantly coordinated so that the medical profession of the United States may present a united front in protecting the freedom of medicine and the rights of the public, June 1961:168.

AMA Activities: The House endorsed resolution no. 102 commending the AMA officers and executive office for their directness, honesty and dignified manner in their legislative activities, June 1961:201–202.

Council Rules: The Council on Legislative Activities listed its Standing Rules, Nov. 1961:53–54, 54.

Council on Legislative Activities: The Board adopted the following recommendations of the Council on Legislative Activities relative to the over-all legislative activities of the AMA:

(1) That all medical legislative issues should be cleared through the Council on Legislative Activities before action is taken by any other AMA council or committee, and that the Board take whatever action is appropriate to attempt to achieve this objective; (2) that the Council continue to refer issues to other committees and councils for advice and recommendation, when said issues properly fall within their sphere of knowledge and activities; (3) that the Board be advised of the Council's desire to maintain constant surveillance of legislative matters; (4) that the Council have authority to recommend to the Board the initiation of specific legislation or legislative policy to meet current problems confronting physicians or the American Medical Association; and (5) that the board be advised of the Council's willingness and ability to testify before congressional committees or to accompany the principal witnesses who may testify on behalf of the Association, Dec. 1963:27–28, 29.

Address of President James Z. Appel: The House of Delegates accepted for information the remarks of President Appel and recommended that the address be published in *The AMA News*. The address gave un-to-the-minute information in the rapidly developing programs of the federal government as it was seeking to implement legislation enacted by the 89th Congress, specifically Public Laws 89-97 (Medicare), 89–239 (Heart Disease, Cancer and

Stroke), and S9–290 (Health Professions Educational Assistance Act), Nov.–Dec. 1965:2–7.

Annual Education Conference for State Legislators: The House of Delegates referred to the Board of Trustees resolution no. 23 which pointed out the benefits that would accrue to medicine by convening national conferences aimed at informing state legislators of problems common to most states and relating to healing arts and public health, June 1967:102.

Implementation: The Board of Trustees recommended the development of regional conference for legislative leaders sponsored by several state associations with similar interest. In accepting Report H of the Board, the House recommended that (1) the Board of Trustees arrange a meeting of representatives of state medical associations for the purpose of planning regional conferences for physicians to discuss matters of special interest with state legislators, and (2) state medical association be encouraged to extend invitations to key lawmakers to attend AMA conferences, Nov. 1967:119–120.

The House accepted for information a report of the Board of Trustees which indicated that many states had individually undertaken joint legislator-physician conference and that there appeared to be little real interest in the further pursuit of activities mentioned in Report H of the Board (C-67), June 1968:64.

Legislative Liaison: The House of Delegates adopted resolution no. 55 urging each state medical association to establish and develop active legislative task forces at the congressional district level for the purpose of maintaining an effective working relationship with their congressmen, and that these activities be coordinated through the AMA Field Service Division, Nov. 1967:214–213.

Restricting Government Legislative Functions to Elected Bodies: The House of Delegates adopted in principle and referred to the Board of Trustees and its Council on Legislative Activities, for study and such action as deemed appropriate and report at the 1969 Annual Convention, resolution no. 70 which called upon the Association to urge Congress to establish a committee on rules and policies of federal administrative agencies and to remand to the agency for revision those rules that do not carry out congressional intent, June 1968:191–192.

LIBRARIANS—MEDICAL RECORD

Approval of Schools: The House approved the revision of the *Essentials of an Acceptable School for Medical Record Librarians* established by the Council

reorganization which reconstituted the Council's Committee on Federal Medical Services into three new committees on Health Care Financing, Governmental Medical Services and Community Health Care; the Committees on Aging and Maternal and Child Care were transferred to the Board of Trustees. Dec. 1968:60, 123, 134–136.

MEETINGS—MEDICAL

Meeting Dates: The House of Delegates referred to the Board of Trustees for its consideration a resolution proposing a more complete listing of all medical meetings so that organizations may plan sessions which will minimize conflicts, and that long-range planning be undertaken to establish a pattern of meeting dates for national, state, local and other medical groups to eliminate conflicting dates. It was reported that JAMA carries a complete listing of all meetings and that more detailed information is available on request; AMA help in arranging programs has been offered and accepted by some organizations; and that the Council on Scientific Assembly is considering the advisability of combining certain small society meetings with meetings of sections having similar interests, noting however, that the problem is two-sided, and it is not possible for the AMA itself, to undertake planning to eliminate conflicts in meeting dates. June 1959:81–82.

Hospital Staff Meetings: The House approved the Board of Trustees Supplementary Report I, and took no action on resolutions nos. 2 and 8 relative to Joint Commission of Accreditation of Hospitals actions regarding staff meetings, because they were covered by the Board report, which transmitted the revised standards of Joint Commission on Accreditation of Hospitals. Nov.–Dec. 1960:102, 195–196.

Decentralizing AMA-Sponsored Conferences: The House of Delegates adopted resolution no. 9 instructing the Board of Trustees to reevaluate its policy of sponsoring or co-sponsoring national conferences and consider instead the use of regional conferences to reach more physicians and to better assist and guide state and component societies in such implementation. June 1967:93–96.

AMA Sponsorship of National Conferences: The House of Delegates adopted resolution no. 70 continuing AMA sponsorship of nationwide conferences for the purpose of informing representatives of state and component medical societies of the findings of such reports and studies that are of interest and concern to physicians. June 1967:124.

AMA Winter Meetings: The House of Delegates did not adopt resolution no. 75 which called for the scheduling of AMA sponsored national meetings in

locations with a climate "more salubrious than that of Chicago" during the winter months. June 1967:126–127.

Joint Meetings of Medical Staffs and Medical Societies: The House of Delegates accepted a Council on Medical Service report stressing the need to foster more effective liaison between local medical societies and hospital medical staffs and better coordination of their activities, utilizing an approach approved by the JCAH. Nov. 1967:165–168.

Increasing Number: The House of Delegates adopted resolution no. 56 reaffirming for wide publicity Council on Medical Service Report C (C–67: 163–168); recognizing the excellent contribution made to the continuing education and improvement of physicians' knowledge by many methods of medical meetings, scientific conferences and critical review of clinical experiences which must, however, be contained within the physician's available time; and urging continued experimentation in methods that would serve to conserve the physician's time and thus improve the quality of patient care. June 1968:184.

MEMBERSHIP

Increasing: The House concurred with President-Elect E. Vincent Askey that efforts should be continued towards increasing membership. June 1960:9, 11.

Physicians Not-in-Private Practice: The House approved Board of Trustees Supplementary Report H on the study of relationships of physicians not-in-private practice to organized medicine, which contained the following conclusions and recommendations, and requested that the Board make every effort to reduce the numbers of physicians who are non-dues-paying members:

1. The substantial percentage decrease in the number of part-time specialists and general practitioners; the great percentage increase in full-time specialists; and even greater percentage increase in the number of physicians not-in-privat practice are of sufficient importance to the AMA to warrant special consideration concerning membership provisions, programming, and policy-making.

2. The causes of this alteration in physician distribution within the profession are many and complex, but one thing is clear, the resulting segmentation into a variety of national organizations might adversely affect the AMA as the organization representing *all* physicians.

3. The influence of physicians not-in-private practice is considerably more important than the number in this category would indicate; and to maintain a proper balance between private practice and the practice and activities of

research or administration at a special rate, and that the problem be referred to the Council on Constitution and Bylaws for study and report to the House. June 1961:190.

Eligibility Based on Race: The House endorsed Board of Trustees Supplementary Report K, taking official note of progress made in eliminating race restrictions in constituent medical society membership, and those societies which have moved forward in this area of human relations. Nov. 1961:115.

Ethical Obligation to Participate in Society Activities: The House endorsed a Judicial Council report which reads in part as follows:

The Judicial Council believes physicians have an obligation to be well informed in all matters of proper concern to medical organizations; that they have an obligation to express themselves and their opinions fully and freely with respect to activities of the medical organizations; and that they have an obligation to take from medical organizations such information as will enable them to inform their patients concerning the scientific and socioeconomic aspects of medicine and medical care. Nov. 1961:131, 134.

Affiliate Membership Candidates: The House of Delegates referred resolution no. 83 on Affiliate Membership for Teachers to the Committee to Study the Scientific Sections as a guideline for its study. The resolution stated that a candidate for Affiliate Membership in the AMA be sponsored by the appropriate departmental chairman in his or her teaching institution, and that the candidate also be recommended by the local county and/or state medical society or appropriate committee thereof. June 1962:123.

The House of Delegates approved the recommendation of the House-appointed Wheeler Committee that the resolution be adopted and that nominations be made by the Judicial Council, rather than by the Council on Scientific Assembly as recommended by the Committee to Study the Scientific Sections (Appel Committee). Nov. 1962:106, 110, 113; June 1963:115, 118, 119–120.

Affiliate Membership: The House of Delegates approved *Bylaws* changes extending Affiliate Membership to scientists in sciences allied to medicine who are citizens of the United States and are not eligible to Membership, to be approved and nominated by the Judicial Council. Dec. 1963:93, 94, 126.

Membership Eligibility: The House of Delegates did not adopt resolution no. 14 which urged that the Board of Trustees instructed to take such action as it deems necessary or appropriate to deny the rights and privileges of membership in the American Medical Association to members of any constituent association or component society thereof which denies membership to any qualified physician because of race, religion or place of national origin.

Instead, the House reaffirmed its position adopted in 1950, pointing out that since that time definite progress had been made in providing opportunities for membership in county and state medical societies, and directed that a copy again be sent to each constituent and component medical society of the 1950 resolution which stated that constituent and component societies having restrictive membership provisions based on race study this question in light of prevailing conditions with a view to taking such steps as they may elect to eliminate such restrictive provisions. Dec. 1963:178–179.

Discrimination in Medicine: The House of Delegates adopted a resolution which opposed the denial of membership, privileges and responsibilities in county medical societies and state medical associations to any duly licensed physician because of race, color, religion, ethnic affiliation or national origin, and called on all state medical associations, component societies and individual members of the AMA to exert every effort to end every instance in which such equal rights, privileges or responsibilities are denied. June 1964:121–123. Nov. 1966:208–209.

Prepaid Life: The House of Delegates approved the Board of Trustees recommendation that resolution no. 39 recommending prepaid AMA life membership not be implemented because membership in the AMA is dependent on state society membership. June 1964:141; Nov.–Dec. 1964:79.

Opinion Polls: The House of Delegates did not adopt resolution no. 51 which proposed an AMA membership poll in matters of importance that require no immediate decision because of problems involved in determining which matters would be of importance. June 1964:146–147.

Honorary Members: The House of Delegates approved an amendment to the Bylaws to provide that the election of Affiliate and Honorary Members shall take place at a time recommended by the Reference Committee on Rules and Order of Business. Nov.–Dec. 1964:103–104.

Service Members: The House of Delegates approved an amendment to the Bylaws which would require that a Service Member hold either a degree of Doctor of Medicine or Bachelor of Medicine. Nov.–Dec. 1964:104.

Discriminatory Practices by County Societies: In lieu of resolution no. 40, the House of Delegates reaffirmed its policy that, within the framework of its Constitution and Bylaws, the AMA continue to use all of its influence to end discriminatory racial exclusion policies or practices by any medical society which permits such policies or practices to exist. June 1965:107–108.

Affiliate and Honorary Members: The House of Delegates amended the Bylaws relating to Affiliate and Honorary Members to provide that physicians

who are members of the chartered national medical societies of foreign countries and scientists in sciences allied to medicine and others who have attained distinction in their fields of endeavor, who are not otherwise eligible to membership, be approved and nominated by the Judicial Council. Nov.–Dec. 1965:105–106.

Affiliate Members: The House of Delegates amended the Bylaws relative to Affiliate Membership to provide that dentists who hold the degree of DDS or DMD who are members of the American Dental Association and their state and local dental societies, and American physicians located in foreign countries or possessions of the United States and engaged in medical missionary, education or philanthropic labors be approved and nominated by the Judicial Council. Nov. 1966:127, 130, 131.

Discrimination in Medicine: The House of Delegates adopted a resolution directing the Council on Constitution and Bylaws to prepare changes in the Constitution and Bylaws to permit the Judicial Council to receive and act upon appeals filed by applicants who allege that they have been unfairly denied membership in a local and/or state society, and to report its recommendations at the 1966 Clinical Convention. June 1966:105–107.

The House of Delegates amended the Bylaws to provide that the Judicial Council shall have jurisdiction to receive appeals filed by applicants who allege that they, because of color, race, religion or ethnic origin have been unfairly denied membership in a component and/or constituent association, to determine the facts in the case, and to report the findings to the House of Delegates. Nov. 1966:130, 131–132.

Subclassification of Regular Members: The House of Delegates did not adopt resolution no. 60 proposing establishment of junior and senior membership classifications, the former to be assessed only one-half the regular annual dues, since the Bylaws already provided for waiver of payment of dues on the basis of financial hardship. Nov. 1966:226.

Local Consultation on Affiliate Members: The House of Delegates adopted an amendment to the Bylaws to provide that nominations for Affiliate Members must also be approved by the appropriate county and state medical society. Nov. 1967:135–136.

Discrimination in Medicine: Report LL of the Board of Trustees contained statements representing policies agreed upon by the Joint Liaison Committee of the AMA and the National Medical Association, and the recommendation that the current AMA policy on nondiscrimination in medicine and hospital staff privileges be reaffirmed by the House of the Delegates. In accordance with this recommendation, the House reaffirmed existing policy statements

against discrimination (A-64:122-123; A-65:107-108; C-65:86-87), June 1968:96, 99.

Discrimination: The House of Delegates amended Chapter I, Section 3, and Chapter XI, Section 11 (D)(7), of the Bylaws to provide (1) Membership in the AMA or in any of its constituent associations shall not be denied or abridged on account of color, creed, race, religion or ethnic origin, and (2) If the Judicial Council determines that the allegations of denial of membership because of color, creed, race, religion or ethnic origin are true, it shall admonish, censure or, in the event of repeated violations, recommend to the House of Delegates that the state association involved be declared to be no longer a constituent member of the American Medical Association, June 1968: 167, Dec. 1968:137.

Classification: The House of Delegates referred to the Board of Trustees for report at the 1968 Clinical Convention resolution no. 33 which proposed that the AMA undertake a study of membership classifications in cooperation with state and county medical societies and recommend establishment of uniform membership categories at all appropriate levels of organized medicine, June 1968:183.

Implementation: The House adopted a Board of Trustees report stating that several studies had been made by the AMA since the classifications were redefined and reestablished in 1930 when Active Membership dues were established, and that each such study had resulted in the same conclusion that the AMA classifications were sufficient to cover all needs and requirements at the state and county level, Dec. 1968:116-118.

Admission of Doctors of Osteopathy: The House of Delegates adopted resolution no. 3 requesting a change in the AMA Constitution and Bylaws so that qualified Doctors of Osteopathy may be admitted to full Active Membership in the American Medical Association, Dec. 1968:177-178.

MENTAL HEALTH

Joint Commission on Mental Illness and Mental Health, Inc.: The Council on Mental Health reported closing of the Joint Commission headquarters, and that a skeleton staff will complete editing and publication of nine monographs and final report of the Commission, Dec. 1959:39, 40; Nov.-Dec. 1960: 26, 31; Nov. 1961:32, 33.

Mental Health Conference: The House of Delegates concurred with the Board of Trustees and Council on Mental Health plans for AMA sponsorship of a conference on mental health and disease, the objective of which will be

The Council announced the appointment of the Committee on Scientific Matters and the Committee on Public and Professional Affairs, the other committees having been discharged, except the Committee on Pneumoconiosis, which was to be retained until completion of its statement, *The Pneumoconioses—Diagnosis, Evaluation and Management*, and the Joint Committee on Mental Health in Industry (Councils on Occupational Health and Mental Health). The Council had begun operating through its standing committees, consultants and monitors, the latter being the designation given members of the two new committees to denote the assignment given them in certain areas. The Council was preparing a *Guide to Relationships Between Council on Occupational Health and Its Consultants*. Nov. 1961:40, 42.

Publications: The Council on Occupational Health reported publication of (1) *The Pneumoconioses—Diagnosis, Evaluation and Management*, (2) *Guide on Small Plant Occupational Health Programs*, (3) A new *Guide for Medical Association Committees on Occupational Health*, and (4) *Guide for Evaluating Employability After Psychiatric Illness*, which were considered by the House of Delegates to be the most significant of their publications. Dec. 1963:37–39.

OFFICERS OF THE AMERICAN MEDICAL ASSOCIATION—NOMINATION, ELECTION, TENURE OF OFFICE

Successor to the President: On recommendation of the Council on Constitution and Bylaws, the House of Delegates approved the following amendments to the *Constitution and Bylaws*, relative to "Successor to the President," June 1959:53, 55; Dec. 1959:136, 138, 139, June 1960:38–39, Nov.–Dec. 1960:109, 110, 110–111; June 1961:107–108, 108; Nov. 1961:127–128, 128, 129–130:

Changes in the Constitution: (1) Amend Article VII, Section 3, by adding at the end of the first sentence the words "and as additionally provided for in Article VII, Section 5, hereof" and by changing the words "annual session" to "inaugural meeting," so that Article VII, Section 3, of the Constitution will read:

A President-Elect shall be elected annually as additionally provided for in Article VII, Section 5, hereof. He shall serve as President-Elect until the inaugural meeting next ensuing after his election and shall become President on his installation serving thereafter as President until the installation of his successor.

(2) Amend Article VII, Section 5, second paragraph to read as follows:

If the President-Elect dies, resigns, or is removed from office, the House of Delegates shall, at its first meeting thereafter, at a time recommended by the

Reference Committee on Rules and Order of Business, elect an eligible person to fill the vacancy.

(3) Amend Article VII, Section 5, third paragraph, to read as follows:

If there is a vacancy in the offices of both President and President-Elect, the Vice President shall act as President until the next annual session.

Changes in the Bylaws: (1) Amend Chapter XIV, Section 2 (A) by adding to the first sentence the word "except as provided in Article VII, Section 5, of the Constitution" so that Chapter XIV, Section 2 (A) will read:

Officers of the Association except the Secretary-Treasurer, shall be elected by the House on the fourth day of the annual session, except as provided in Article VII, Section 5, of the Constitution. The House may set the time or hour of such election by adopting an appropriate motion. The Reference Committee on Rules and Order of Business at each annual session shall consider this matter and shall make recommendations to the House.

Election of General Officers: The House of Delegates amended Chapter XIV of the Bylaws to provide that on recommendation of the Reference Committee on Rules and Order of Business the House shall set the day and hour of election of Officers by adopting an appropriate motion. June 1964:2–3, 44–45.

Inauguration of the President: The House of Delegates amended the Bylaws to provide that the inaugural meeting be held during the Annual Convention and that the President would deliver an address at his inauguration. Nov.–Dec. 1964:3, 4, 100.

Vacancies: The House of Delegates amended the Bylaws relating to appointment and election of general Officers to fill vacancies. Nov.–Dec. 1964:101–103.

Election Procedures: The House of Delegates did not adopt resolution no. 27 requesting that all elections whether they be on issues or on candidates for office be held while the House of Delegates is in session and that such elections be conducted either by a voice vote, a standing vote or a vote by delegation, and that any member of any delegation may request that the members of his delegation be polled. Nov.–Dec. 1964:156.

The House of Delegates did not adopt resolution no. 30 proposing the creation of a nominating committee for the general Officers and Trustees. Nov.–Dec. 1964:156.

Vacancy in the Office of President-Elect, Vice President, Speaker and Vice Speaker: The House of Delegates amended Chapter XIV of the Bylaws as follows:

Section 3. Terms: (A) A President-Elect shall be elected annually. He shall serve as President-Elect until the inaugural next ensuing after his election and shall become President on his installation, serving thereafter as President until the installation of his successor. The unexpired portion of the term of any vacancy in the office of President-Elect shall be filled by election of the House of Delegates at the earliest convenient time recommended by the Reference Committee on Rules and Order of Business approved by the House of Delegates.

Section 3. Terms: (B) The Vice President and the Speaker and Vice Speaker of the House of Delegates shall be elected annually each to serve for one year or until his successor is elected and installed. The unexpired portion of the term of any vacancy in the office of Vice President, Speaker or Vice Speaker shall be filled by election of the House of Delegates at the earliest convenient time recommended by the Reference Committee on Rules and Order of Business and approved by the House of Delegates.

Section 4. Successor to the President: If the President dies, resigns or is removed from office, the Vice President shall immediately become President, providing he was elected by the House of Delegates to the office of Vice President. If the Vice President was not elected, then the Speaker shall immediately become President. Nov.–Dec. 1964:158, June 1965:44–45.

Eligibility for Nomination to President-Elect: The House of Delegates did not adopt resolution no. 44 proposing that, as a condition of eligibility for the office of President-Elect, an interval of one year must intervene between the termination of his term as an elected Trustee and his nomination for President-Elect. Nov.–Dec. 1965:203.

Board of Trustees: The House of Delegates adopted the recommendation of the Reference Committee on Rules and Order of Business that Trustees be elected on the basis of a specific expired term as in the past rather than on the basis of running at large. June 1966:7–8.

The House of Delegates did not adopt resolutions nos. 48 and 53 (C–66) and resolution no. 36 (A–67) proposing that candidates for vacancies on the Board of Trustees should run at large. Nov. 1966:220–221; June 1967:109.

Elections: The House of Delegates did not adopt resolution no. 27 proposing that nominations for officers be made at the Monday morning session of the House and that elections be conducted on Wednesday morning. Nov. 1966: 210.

Campaigning by Nominees: The House of Delegates did not adopt resolution no. 54 which requested that candidates for office be permitted to address the House of Delegates outlining their positions on medical issues facing the Association. Nov. 1966:223.

Election of Trustees: The House of Delegates amended Chapter XIV, Section 3(D), of the Bylaws to read:

Four Trustees shall be elected annually, each to serve for a term of three years. A Trustee shall not serve for more than three terms. A Trustee elected to serve an unexpired term shall not be regarded as having served a term unless he has served two or more years. The unexpired portion of the term of any vacancy in the office of Trustee shall be filled by election by the House of Delegates at the earliest convenient time recommended by the Reference Committee on Rules and Order of Business and approved by the House of Delegates. Nov. 1967:131–132.

Term of Office of President-Elect: The House of Delegates adopted an amendment to Chapter XIV, Section 3(A) and Section 9 of the *Bylaws* to read as follows:

Section 3(A)—A President-Elect shall be elected annually. He shall serve as President-Elect until his installation as President at the next annual meeting, as provided in Chapter XIV, Section 9. He shall thereafter serve as President until the close of the next annual convention. The inauguration of the President may be held at any time during the convention. The unexpired portion of the term of any vacancy in the office of President-Elect shall be filled by election by the House of Delegates at the earliest convenient time recommended by the Reference Committee on Rules and Order of Business and approved by the House.

Section 9—The President-Elect shall be installed as President at the inaugural meeting of the annual convention following that at which he was elected and shall assume the duties of President at the close of the last meeting of that convention. Nov. 1967:132–133.

Terms of Office of President and Vice-President: The House of Delegates rescinded its action at the 1967 Clinical Convention (C–67:132–133) providing that the President-Elect assume the office of President at the close of the Annual Convention. The Council on Constitution and Bylaws recommended that the President assume office at his inaugural and that the term of office of the Vice President end with the term of office of the President with whom he served. The House amended Chapter XIV, Sections 3, 4, 5, 7 and 9 of the Bylaws to read as follows:

Section 3(A): A President-Elect shall be elected annually. He shall serve as President-Elect until the inaugural next ensuing after his election and shall become President on his installation at the inaugural ceremony, serving thereafter as President until the installation of his successor. The inauguration of the President may be held at any time during the convention.

(B) The Vice President shall be elected annually to serve one year. His term of office shall expire with that of the President with whom he served.

(C) The Speaker and Vice Speaker of the House of Delegates shall be elected annually, each to serve for one year or until his successor is elected and installed.

(D) The Secretary-Treasurer shall be appointed annually by the Board of Trustees from one of its members and shall serve for a period of one year.

(E) Four Trustees shall be elected annually, each to serve for a term of three years. A Trustee shall not serve for more than three terms. A Trustee elected to serve an unexpired term shall not be regarded as having served a term unless he has served two or more years.

(F) If a general officer misses six (6) consecutive regular meetings of the Board, this matter shall be reported to the House of Delegates by the Board of Trustees. His positon shall be considered vacant. The vacancy shall be filled as provided elsewhere in the Bylaws.

Section 4: If the President dies, resigns or is removed from office, the Vice President shall immediately become President. If the President dies, resigns or is removed from office during a period when the office of Vice President is vacant, then the Speaker shall immediately become President.

Section 5(A): The Board of Trustees may fill any vacancy in the office of Speaker, Vice Speaker or Trustee by appointment to serve until the next meeting of the House of Delegates.

(B) The unexpired portion of the term of any vacancy in the office of President-Elect, Trustee, Vice President, Speaker or Vice Speaker shall be filled by election by the House of Delegates at the earliest convenient time recommended by the Reference Committee on Rules and Order of Business and approved by the House of Delegates.

Section 7(A): Time – Officers of the Association, except the Secretary-Treasurer, shall be elected by the House at the annual convention, except as provided in Sections 4 and 5 of this Chapter of the Bylaws. On recommendation of the Reference Committee on Rules and Order of Business, the House shall set the day and hour of such election by adopting an appropriate motion.

Section 9: The President-Elect shall be installed as President and shall assume the duties of that office at the inaugural meeting.

The Council on Constitution and Bylaws also recommended that consideration be given to holding the inaugural on Wednesday instead of Tuesday, and in the evening instead of at 5:00 p.m., June 1968:109–111.

OFFICERS OF THE AMERICAN MEDICAL ASSOCIATION—REIMBURSEMENT

Travel Insurance: The House approved Board of Trustees Supplementary Report L announcing extension of individual coverage for accidental death for officers, trustees, delegates, alternate delegates, members of councils and committees, and staff when traveling on official AMA business. Nov. 1961: 175, Nov. 1962:26, 28.

Per Diem Allowances: The House of Delegates adopted substitute resolution no. 73 requesting that honorariums be provided for elected officers of the Association that will more than adequately compensate them for their services and that the amount of these honorariums be determined by the Board of Trustees. June 1962:120–121.

BOARD OF TRUSTEES REPORTED IMPLEMENTATION, Dec. 1963:23, 29.

OPHTHALMOLOGY

Relation of Medicine to Optometry: The House of Delegates approved in principle resolution no. 31 requesting establishment of a special temporary commission by the Board of Trustees to study the relation of medicine to optometry from the standpoint of the public interest. The House adopted the recommendation that a subcommittee of the Committee to Study Medical and Related Professions be created to carry out hte intent of resolution no. 31 to study specifically the relation of medicine to optometry and to provide consultative services on the problem, and that the staff of the subcommittee include a member of the AMA Law Division. June 1959:84–85.

PROGRESS REPORT: June 1959:44–49.

Glaucoma Identification Cards: The House of Delegates adopted resolution no. 40 directing the attention of members of the medical profession to the Glaucoma Identification Card introduced by the National Medical Foundation for Eye Care which will make immediately available to all attending physicians and information concerning the patient's use of and requirement for miotics and other medications. June 1959:88–89.

Contact Lenses: The House of Delegates adopted substitute resolution no. 51 which expressed concern with the indiscriminate use of contact lenses as a general substitute for spectacles. June 1960:113.

of the World Health Organization have led to the selection of the Sabin attenuated poliovirus strains for further development for licensing of oral, live attenuated, poliovirus vaccines, June 1961:99–103.

PROGRESS REPORT: Nov. 1961:28, 195.

Salk and Oral Vaccines: The House approved in principle amended resolution no. 2 which requested that medical societies at the local, county, district or state levels throughout the United States encourage, stimulate and participate in surveys to determine the percentage of individuals in each community who have undergone immunizing procedures; that on the basis of the results of the surveys, the local medical society should determine the type of vaccine and the most effective type of program which will be of greatest benefit to the public; and until such time as all three types of oral vaccine are available, the Salk vaccine should be the vaccine of choice for routine poliomyelitis immunization, with the choice of program for administering the vaccine to be determined on a local basis by each county medical society, Nov. 1961:194–195.

POLITICAL ACTION

Physicians in Public Affairs: The House adopted substitute resolution no. 3 encouraging AMA members to take a greater interest in public affairs and as private citizens, take a more active part in the local, state and national government endeavoring to select qualified candidates for office, regardless of party affiliation of such candidates, and that the individual members of the Association work toward the creation of policies which preserve representative government, free enterprise, fiscal solvency and the integrity of the dollar; and urging the component medical societies to further this program on the local level, June 1960:91.

Political Activity: On report of Council on Legislative Activities, the House adopted a report which reads in part as follows:

The institution of regional political conferences is noted and the effectiveness of such activity has been reflected in many recent congressional elections. Your reference committee believes that continuation and expansion of such activities are of prime importance if American medicine is to remain within the free enterprise system. The encouragement of non-partisan political activity by the AMA on the national, state and local level is desirable and proper, Nov.–Dec. 1960:19–24.

American Medical Political Action Committee: Dr. J. Lafe Ludwig, Chairman of Council on Legislative Activities and the Board of Trustees announced formation of AMPAC, a non-profit, voluntary non-partisan, unincorporated

political action committee, separate and distinct from AMA with membership available to physicians, their wives, immediate members of their family, and others. The purposes of AMPAC are (1) To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs; (2) to encourage physicians and others to understand the nature and actions of their government as to important political issues and as to the records, office holders and candidates for elective office. (3) to assist physicians and others in organizing themselves for more effective political action and in carrying out their civic responsibilities; (4) to do any and all things necessary or desirable for the attainment of the purposes stated above.

The House concurred that effective political action must be carried on at the local level and that effective implementation must be done by local groups of physicians. The formation of AMPAC recognizes the need for a national committee to coordinate the political activities of physician groups at all levels throughout the country. Nov. 1961: 13–14, 97–98, Nov. 1962:25–26, 28

Political Action Committee Contribution Statements on Society Dues Billing: The House of Delegates adopted resolutions commending those states that have established voluntary billing procedures, and urging all state and component medical associations to approve, where feasible, the inclusion of a voluntary nondeductible contribution to independent political action committees on the society's annual dues billing statement. Nov.–Dec. 1964:147–148, June 1965:111–112.

Address of President James Z. Appel: The House of Delegates received for information the inaugural address of President Appel on personal responsibility and freedom entitled "We the People of the United States—Are We Sheep?" Doctor Appel urged a continuation of AMA's effort to preserve the freedom of the medical profession. He presented a persuasive case for personal responsibility if an enlightened freedom is to be achieved, emphasizing that "We cannot have happiness, a fruitful life, we cannot have freedom unless we pay the price. The price for these desirable conditions of life is the acceptance of responsibility." He warned of "sweet voices" which wage a campaign to free people from responsibility at the price of loss of freedom, observing that physicians, because of their unique knowledge, must assume the sole responsibility of establishing and implementing utilization committees. June 1965:5–10.

Support of Community Action by Physicians: The House of Delegates received for information a Board of Trustees report advising the House that in 1966 the Board appropriated as a contribution to AMPAC, solely for education in civic affairs, the sum of $900,000, equal to about 3 percent of AMA's total appropriations of $27,000,000 for the year. The educational program of AMPAC is designed to acquaint physicians, their wives, and others with bi-

partisan community action of political and civic import. No part of the contribution made by AMA to AMPAC is used to support the candidacy of any person for public office. June 1966:70.

AMPAC: The House of Delegates adopted a Board of Trustees report praising the accomplishments of AMPAC and the various state PACs, noting the desirability of common billing service provided by the county and state medical associations whereby voluntary nondeductible contributions can be made to political action committees, and recommending that there be an annual informational report from each local political action committee to the state house of delegates in a manner similar to the informational reports which the AMA House of Delegates receives from the American Medical Political Action Committee. June 1967:60–61.

Political Action Committees: The House of Delegates adopted resolution no. 5 reaffirming its support of AMPAC and the individual state PACs and recommending that members of the House of Delegates urge the leaders and membership of their local organizations to continue their support of their own State PAC organization and AMPAC and to demonstrate their support by a membership contribution and participation in local PAC programs. June 1967:93–94.

AMPAC: The House of Delegates adopted resolution no. 17 reaffirming its support of AMPAC, commending the Board of Trustees for its development and support of AMPAC, and urging the Board to explore additional ways of increasing and strengthening its support of AMPAC. Nov. 1967:191–192.

Address of President Milford O. Rouse: The House of Delegates commended Doctor Rouse for his inspiring presidential address and recommended its dissemination to physicians and the public. In commenting on the address, the House felt that Doctor Rouse had perceptively identified and delineated the rightful and necessary role of government in the life of all American citizens, further identifying those areas where individual citizens and private organizations can best meet the needs of society, calling upon all American to assume their rightful civic responsibilities not only to preserve individual freedom but to help create a better and more just society for the future. Nov. 1967:5–11.

Public Affairs Programs at AMA Level: The House of Delegates referred to the Board of Trustees for further consideration resolution no. 62 which requested AMA endorsement and encouragement of the development of a public affairs program at the national level and similar state and local activity throughout the nation. A public affairs program was defined as one to educate physicians in the areas of politics, legislation and economics, to stimuate

active interest in the affairs of government, and to prepare physicians for more active participation in public affairs. June 1968:187.

Annual Conference Workshop on Public Affairs: The House of Delegates adopted resolution no. 24 recommending that the Board of Trustees consider sponsorship of periodic conference or workshops on public affairs for the continuing education and benefit of medical society leaders and physicians throughout the nation. Dec. 1968:186–187.

PRESIDENT AND PRESIDENT-ELECT OF THE AMERICAN MEDICAL ASSOCIATION

Address of President-Elect: The House approved the postponement of the address of the President-Elect until Wednesday, "in order that both the outgoing and incoming President can present his remarks without detracting from the comments of the other." June 1960:1, 2.

Time-Consuming Duties: The House adopted substitute resolution no. 66 recommending that the President and President-Elect accept only such engagements as they, and the official family of the Association, deem appropriate. June 1961:189.

Past Presidents Expenses: The House of Delegates approved a resolution recommending that provision be made to reimburse Association Past Presidents for expenses incurred in attending annual and clinical sessions. Dec. 1963:178.

PRESIDENT OF THE UNITED STATES

Protection: The House took no action on a resolution which requested that the AMA prepare for transmission to the Congress of the United States its recommendation for a joint resolution of the Congress expressing that it is the sense of the Congress, on behalf of the people of the United States, that the President be requested hereafter to travel at all times only by appropriate conveyance which is designed to provide adequate physical protection of the person of the President, even though travel by such conveyance will tend to limit to an extent the personal contact of the President with his people. The House shared the concern for the health, safety and welfare of the President but felt that the responsibility for the protection of the President and the manner in which it is discharged should be left in the hands of the government agencies which are charged with this responsibility. Dec. 1963:186.

mony before Congress on HR 6418 had adequately covered the recommendations contained in the resolution and it was suggested that the Board might wish to review this resolution for future presentations before Congress, June 1967:140–141.

Health Statistics: The House of Delegates approved for information a Board of Trustees report emphasizing the importance of health statistics programs and their role in helping to determine degrees of health of population groups, bringing health problems into view, implicating causal environmental factors, aiding in planning for relief, accommodating evaluation of remedies, and emphasizing the dependence of meaningful health statistics upon accurate reporting by members of the health care team and the need for education of and cooperation by physicians in this area, June 1968:91–92.

Health Data Banking Service: The House of Delegates adopted resolution no. 39 calling upon the AMA to evaluate the practicability and feasibility of establishing a national health data bank system and to evaluate other aspects of data processing related to the practice of medicine, June 1968:177.

Wilbur J. Cohen as HEW Secretary: The House of Delegates did not adopt resolution no. 54 which expressed concern on the appointment of Wilbur J. Cohen as Secretary of Health, Education, and Welfare, June 1968:183.

US Department of Health: The House of Delegates adopted substitute resolution no. 39 requesting that the Board of Trustees take appropriate action seeking the establishment of a separate Department of Health headed by a Doctor of Medicine, June 1968:186.

PUBLIC RELATIONS

Public Relations and Information: The House of Delegates took no action on resolution no. 12 requesting that AMA protest against public announcements portraying the medical profession in an unfavorable manner. The reference committee recapitulated the following past actions of the House relating to similar subjects, which obviated further action:

In 1953, eleven resolutions upon the subject were submitted and the House of Delegates took the following action: (a) Recommended no action on these resolutions but instead that the House give careful consideration to the ethical problem involved; (b) called on constituent associations to become increasingly vigilant and aggressive in the pursuit and correction of abuses; (c) recommended a positive public relations program pointing out the good things members of the AMA are doing to promote public health and welfare of this country; (d) approved the appointment of a Committee on Medical

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Practices to study "the problems of public relations created by adverse publicity" and "professional relationships." In 1958 the Connecticut delegation introduced a resolution which recommended that the American Medical Association express its firm disapproval of the publication of derogatory articles in lay journals. The reference committee recommended its passage and the House approved.

Your reference committee believes that the Communications Division of the Association should place even greater emphasis on its program of liaison with magazine editors, free lance writers and all other media of public information. June 1959:78.

Public Relations and Information: Regarding liaison programs with magazine editors, free lance writers, and other principal sources of public information, the Board reported that "in June and July, 14 national magazines requested material on medical or related subjects, or review of articles. Twenty-three articles appeared in June issues of mass circulation magazines, most of which presented a favorable image of the physician." Dec. 1959: 15-16, 24.

Public Statements by Physicians: The House of Delegates referred to the Board of Trustees for implementation resolution no. 15 which directed that the AMA strive for and maintain such rapport with all agencies and specialty groups in and of the profession as will lead to regular consultations with the AMA's Division of Communications so as to insure that the remarks and writings of all authoritative and quasi-authoritative spokesmen will at least be consonant with fact and truth, and therefore consonant with the genuine best interests of the profession and the public. Dec. 1959:210–211.

"MD" Designation: The House adopted the following amended resolution no. 48 requesting the Board of Trustees to have the appropriate division of the American Medical Association encourage physicians to use "MD" after their names instead of "Dr." before and to inform the public of the meaning of "doctor of medicine" as contrasted with other "doctor" designations. Dec. 1959:222–223.

Local Level Communication: Because the Board through the Communications Division is continuously studying and considering the best methods of communicating with the profession and informing the public, the House took no action on resolution no. 7 requesting that the AMA study and consider the best method of distributing information locally in keeping with the high standards of the profession in informing the public more about the noble and worthy services rendered to the public by the profession. June 1960:93.

Chambers of Commerce: The House approved substitute resolution no. 23 recommending that state medical societies support national and state chambers of commerce in promoting the free enterprise system. June 1961:168–169.

Communications: The House of Delegates adopted a substitute resolution directing that the Speaker of the House name seven elected members of the House of Delegates as a special committee to study and continually advise the Board of Trustees on the broad planning and coordination of all phases of communications of the AMA so that the public and AMA members are properly and adequately advised of the policies and concern of the medical profession with respect to all phases and aspects of medical care for all people and that this committee be given every assistance and cooperation by the Board, officers and staff, and that it report its progress and actions to the Board between sessions and to the House at its annual and interim sessions, June 1961:179–181.

PROGRESS REPORT OF COMMITTEE ON COMMUNICATIONS: Nov. 1961:10–12.

Free Enterprise Preservation: The House of Delegates endorsed in principle resolution no. 53, and requested the Board of Trustees to explore and implement such a program, which requested that the American Medical Association immediately solicit the support of all national organizations interested in preserving free enterprise and, collectively, conduct an aggressive and vigorous national campaign through all communication media to demonstrate the benefits of free enterprise, and to demonstrate the errors and weaknesses of socialism and the welfare state. June 1961:184.

The House endorsed the conclusion of the Board of Trustees, Supplementary Report D, that it was not feasible for the AMA to spearhead such a project proposed in resolution no. 53, for the reasons listed below:

1. The AMA speaks with authority and competence on legislative matters that affect medicine; it has no particular expert knowledge in agriculture, housing, transportation, foreign commerce, taxation and other target areas of the overall campaign to socialize the nation.

2. The AMA shares with many other national organizations a policy of dedication to the preservation of a free economy. Those other organizations have many cooperative undertakings and liaison arrangements, but in general it is not practical for them to merge their individual programs into a united campaign in which their identities are lost. Nov. 1961:102.

AMA Policy Support: The House of Delegates endorsed the intent and expressed opinion in resolution no. 84 which requested that the component county and state medical societies go on public record as stating emphatically that the American Medical Association does indeed represent their will and desire and that the leadership of the American Medical Association enjoys the full confidence and support of its membership. June 1961:196–197.

National Speakers Bureau: The Communications Division announced creation of a one-man department to organize and promote an AMA National

Speakers Bureau which will provide speakers throughout the United States for major conventions and meetings of all types of organizations, Nov. 1961: 64, 96.

National Public Information Campaign: The House referred to the Committee on Communications resolution no. 9 proposing a national public information campaign to supplement existing activities of AMA, Nov. 1961:199.

Communications: On report of the Committee on Communications, established June 1961 (179–151), the House of Delegates adopted the following reference committee report:

Your reference committee . . . recommends the acceptance of the report as information and submits the following recommendations for consideration by the House:

1. Recommendation no. 1 included in the report is concerned with the duties, responsibilities, objectives and methods of discharge of new committees established by the House. Your reference committee recommends that the Council on Constitution and Bylaws give consideration to the development of appropriate language to implement the following recommendations: (a) the duties, responsibilities and objectives of new committees be specified by the reference committee considering resolutions establishing new committees; (b) if, after it is established, a new committee finds that its assignment is not feasible, in an interim report to the House, it should make specific suggestions as to the modifications it believes necessary; (c) that all committees be appointed for a specific time and discharged following the submission of their final report unless extended by the House.

2. Recommendation no. 2 of the Communications Committee report urges that county and state medical associations redouble their communications efforts and that expressions of support be issued whenever and wherever unjust attacks are made on the American Medical Association. Your reference committee agrees, and recommends its adoption.

3. Recommendation no. 3 of the report is concerned with the informing of the House of Delegates by the Board of Trustees of the activities being carried on by the Association and with the integration of new delegates. During the hearings, it became evident that members of the Committee on Communications felt that there was insufficient communication between the Board of Trustees and the House of Delegates on the activities of the Association, especially between regularly scheduled sessions of the House. Your reference committee therefore recommends: (a) that a report of activities of the Association be presented to the House at each meeting by the Executive Vice President, and (b) that the Board of Trustees devise a system to inform the members of the House of Delegates of its activities between sessions of the House.

4. Recommendation no. 4 of the report urges state delegations and individual delegates to use more care in the wording of resolutions introduced in this

House, considering particularly the impact upon the public, and the medical profession. This has been suggested because in certain instances in the past situations have arisen which have resulted in unfavorable publicity to the medical profession.

It further recommends the formation of a committee on resolutions whose responsibility would be to review all resolutions in the light of established standards and to pass upon their acceptance, rejection or modification prior to introduction.

Your committee is in agreement with the first portion of the recommendation concerning the wording of resolutions. The second portion of the recommendation presents an area of potential danger to the democratic structure of the House as supported by testimony rendered before the committee. Therefore, your reference committee urges that it not be adopted.

5. Recommendation no. 5 of the report is concerned with the continued activity of the Communications Committee in studying other AMA divisions. Your reference committee believes that a study, limited to activities involving communications, should be completed and that a final report be presented by the Committee on Communications no later than June of 1963.

6. The recommendation listed as no. 6 in the report is simply an expression of appreciation of the committee to the officers and the Board of Trustees and staff for their cooperation. Your reference committee believes that the Committee on Communications deserves an expression of sincere appreciation from the House, June 1962:75–84.

Commendation: The House adopted a substitute resolution which extended its appreciation to the elected officers, executive personnel and staff of this Association; the Woman's Auxiliary of the American Medical Association, the National Speakers Bureau and the many other groups and organizations interested in the preservation of the free enterprise system for their exemplary efforts in preserving the American system of medical care and service, June 1962:98–99.

AMA News Releases: The House of Delegates referred to the Board of Trustees for submission to the Committee on Communications resolution no. 42 proposing that no reports or proposals to be submitted to the House be released and/or adjudged until the House has committed itself officially in connection therewith, Nov. 1962:232.

On recommendation of the Committee on Communications and the Board of Trustees, the House took no action on this resolution, and reaffirmed policy taken in 1958 on a related problem which reads as follows, June 1963:23–24, 88, 89:

> Supplementary Report H has to do with the release of advance stories on the report of the Commission on Medical Care Plans and the Committee to Study AMA

Objectives and Basic Programs and implies a request that the Board of Trustees be authorized to make available to the public and to the profession, factual, judiciously selected information on matters under consideration, as well as on those on which definitive action has already been taken.

After careful consideration your committee concluded that the advantages of the course of action suggested outweigh the disadvantages, and it therefore recommends that the House of Delegates concur in the course of action suggested by the Board of Trustees in this supplementary report.

Understanding of AMA: The House agreed with President Edward R. Annis that "an increased public understanding of the American Medical Association and an increased public understanding of our unique system of medical care can be accomplished by the continued use of press, radio, television, and magazines," and that "his suggestion of an AMA sponsored regular nationwide television program devoted to the science of medicine and the conquest of disease should be explored," June 1963:15, 17.

Communications: The House adopted an amended report of the Committee on Communications summarizing new and continuing public education programs, legislative communications and a recommendation relating to policy governing news releases, and approved continuation of the Committee for one additional year, June 1963:87–89.

Chambers of Commerce: The House of Delegates adopted resolution no. 21 which reaffirmed its previously adopted recommendation to all state medical societies that they become active in the US and state chambers of commerce; and requested that a similar recommendation be made to all county medical societies so that they too might be encouraged to become active in local, state and US chambers of commerce programs. Dec. 1963:183.

Committee on Communications: The House of Delegates adopted the following recommendations of the Committee on Communications (William A. Hyland, M.D., Chairman):

1. That county and state medical societies redouble their communications efforts and that expressions of support be issued whenever and wherever unjust attacks are made on the American Medical Association;

2. That physicians and staffs of state and county medical societies become acquainted with members of the communications media in their areas, provide them with factual information concerning the medical profession and its programs, and call to the attention of editors and station managers any misstatements of fact concerning the AMA or its activities, and that if facts are not available locally to reply to accusations or errors in articles or commentaries, the medical society contact the AMA for the information needed;

3. That the American Medical Association make every effort to inform state medical associations of such news releases or testimony before the Congress

as soon as possible, and that spokesmen for state and county medical associations refrain from commenting on statements and policies until they are aware of the content of such pronouncements. That the House of Delegates ask the Board of Trustees to investigate the feasibility of establishing a wire communications system between the AMA Headquarters in Chicago and offices of state medical associations, since frequently there is not enough time for the AMA to inform state associations of the content of releases and pronouncements before they are published or broadcast.

4. That the Committee on Communications be discharged. June 1964:115–121.

Teletypewriter System: The House of Delegates referred to the Board of Trustees resolution no. 15 requesting that the Board study the feasibility of, and be empowered to establish, a teletypewriter or comparable network between the AMA central office and those state medical society offices where justified. Such an arrangement was also recommended by the Committee on Communications (A-64:115–121). June 1964:130.

Implementation: The House adopted Report E of the Board of Trustees authorizing the establishment of a teletypewriter exchange service. Participation by an state society would be optional, the cost of installation and annual rental to be paid by the AMA and the cost of transmitting messages to be paid by the organization originating the message. Nov.–Dec. 1964:80–82.

The House of Delegates adopted the recommendation of the Board of Trustees that the AMA discontinue paying for the rental of the teletypewriter equipment in the state society offices and that each state have the option of keeping the equipment and paying rental itself because the low volume of messages in most states did not justify the expense. Nov. 1966:90–92.

Utilizing Talents of Edward R. Annis, M.D.: The House of Delegates referred resolutions nos. 55 and 74 to the Board of Trustees with the recommendation that the Board use the talents of Doctor Annis and other qualified spokesmen for medicine with appropriate remuneration. June 1964:149–150.

National Programs: The House of Delegates took no action on resolution no. 18 calling upon the AMA to afford state associations the opportunity of discussing and formally concurring in proposed national programs either by vote of their delegates at AMA conventions or by vote of authorized representatives at special conferences. Nov.–Dec. 1964:151–152.

Matching Dollars for Educational Purposes: The House of Delegates referred to the Board of Trustees for appropriate action resolution no. 31 calling for the immediate establishment of a program of "matching dollars" between the AMA and its state and component societies to improve and strengthen the

methods of communication in the public education field concerning medicine's activities, accomplishments and philosophies, Nov.–Dec. 1964:156–157.

Medical Journalism Awards: The House of Delegates received for information a Board of Trustees report which announced the winners of the 1964 medical journalism awards contest, recognizing journalism contributing to a better public understanding of medicine and health in the United States, in five categories: newspapers, magazines, editorial writing, radio and television, June 1965:13–15.

Public Response to Statements Discrediting Medicine: The House of Delegates adopted substitute resolution no. 25 directing the Board of Trustees to provide for immediate public response to statements which discredit American medicine and its organizations, and encouraging state and local medical societies to similarly react to statements appearing at the local level and concerning matters within the society's competence and knowledge, Nov.–Dec. 1965:193.

Relationships with Communications Media: The Board of Trustees reported its reaffirmation of its policy on AMA relationships with the communications media, Nov. 1966:23.

Study of Contemporary American Medical Practice: The House of Delegates referred to the Board of Trustees resolution no. 28 instructing the Board of Trustees to employ a reputable and respected professional but nonmedical organization or foundation to make an objective and independent study of contemporary American medical practice in its ethical, professional and economic aspects and that such a study, upon completion, be presented to the House of Delegates for its consideration, Nov. 1966:210–211.

Criticism of Medicine: The House of Delegates referred to the Board of Trustees resolution no. 13 which requested that the AMA take steps to answer articles criticizing the medical profession promptly and appropriately and that commentary on these articles and the AMA replies be published in *The AMA News* so that the membership may know what steps have been taken and supplied with information that they themselves might use in discussing these articles, Nov. 1967:190.

New Climate Involving Health Care: The House of Delegates adopted a Board of Trustees report which related to the importance of effective communications by the AMA in relation to the multitude of problems currently arising in relation to health care and medical practice. The report listed six areas for consideration in developing an equilibrium between the complex realities of health care and the burgeoning expectations of the public and government and six principle guides to be followed by the AMA, June 1968: 46–50.

AMA Posture on Public Comment: The House of Delegates adopted Report C of the Board of Trustees, with the recommendation that it be published in state medical journals, which noted the great increase in attention given in the press and broadcast media to medicine and health care and reported on the procedures being followed in dealing with the communications media. June 1968:50–51.

AMA Spokesman: The House of Delegates did not adopt resolution no. 32 which called for the designation of a spokesman with continuity in office empowered to speak out promptly on matters of concern to the Association. June 1968:172.

Defense of Private Practice: The House of Delegates adopted resolution no. 63 which called upon the Board of Trustees to continue to provide leadership in a counterattack against accusations made against the medical profession, including full activitation of the AMA Speakers Bureau using speakers of proven ability who will support the private practice of medicine. June 1968: 188.

AMA Speakers Program: Responding to an inquiry as to whether or not AMA speakers are made available upon request to the state and county medical societies and other public meetings, the Secretary of the Board of Trustees, Alvin J. Ingram, M.D., reviewed the program and how arrangements are made for acquiring speakers. Dec. 1968:25.

Present Climate of Public Attitudes: The House of Delegates adopted Report Q of the Board of Trustees which provided a succinct outline of how the AMA can appropriately furnish the leadership needed to effect a sound and orderly development of the health care complex in the months and years ahead. The five objectives for immediate and continuing action listed in the report were summarized by its closing statement: "Such activities can direct the current public climate toward the best health care system for the totality of the American people, through the creative leadship of the medical profession. This is the responsibility and the opportunity of the AMA." Dec. 1968:125–129.

Medical Ethics: The House of Delegates adopted substitute resolution no. 49 calling on the AMA to actively encourage all component and constituent medical societies and all specialty and subspecialty societies to observe the *Guidelines for Physicians in Their Relations with the Communications Media* already established by the Judicial Council. Dec. 1968:208.

QUACKERY AND HEALING CULTS

Legislation Against Cancer Quackery: The House of Delegates approved resolution no. 30, commending and congratulating the legislature and Gover-

WATER POLLUTION

Detergents: The House of Delegates adopted amended resolution no. 11 relative to the pollution of ground water and natural water caused by detergents. The resolution requested that the AMA undertake a full study of this question for the development of some controls of the use of such products throughout the nation and that an appropriate committee on the AMA work with the United States Public Health Service and the industry in providing a type of detergent that will assure safety to the health of the public. Dec. 1963: 176–177.

WAYNE STATE UNIVERSITY

100th Anniversary of the School of Medicine: The House of Delegates adopted resolution no. 23 extending congratulations to Wayne State University and its School of Medicine for 100 years of devoted service to the people of the State of Michigan. Nov. 1967:196.

WOMAN'S AUXILIARY

Commendation: The House of Delegates adopted a Board of Trustees resolution commending the Woman's Auxiliary to the AMA and urged each state and local medical society to support fully and to aid and encourage the Woman's Auxiliary in all its endeavors, particularly the joint husband-wife membership project. Nov.–Dec. 1964:97.

WORKMEN'S COMPENSATION

Ionizing Radiation: The Board of Trustees announced endorsement by the Council on Occupational Health of the Industrial Medical Association's statement on diagnosis of harmful effects of ionizing radiations; and that no definitive action was taken on the statement dealing with modification of state compensation laws. Constituent medical associations were urged to take steps to insure that all workmen's compensation laws include adequate provisions for coverage of all occupational diseases, including those arising from exposure to ionizing radiation. Nov. 1962:20, 28.

Review: The Board of Trustees reported that the Council on Occupational Health would continue the review of workmen's compensation, originally assigned to a Committee to Study Social Security and Workmen's Compensation. Dec. 1963:29.

Physicians' Employees: The House of Delegates referred to the Board of Trustees for study of its feasibility resolution no. 80 calling for an investigation by the AMA of the incidence of industrial injury and illness among physicians' office employees, the compensation of costs and awards involved and the loss ratio developed. June 1965:196–197.

HISTORICAL RECORD

TERM	PRESIDENT	EXECUTIVE AND ASSISTANT EXECUTIVE VICE-PRESIDENT	SECRETARY-TREASURER	SPEAKER	DATE OF MEETING	PLACE OF MEETING
1959–60	Louis M. Orr, Fla.	F. J. L. Blasingame, Ill. Ernest B. Howard, Ill.	Raymond M. McKeown, Ore.	E. Vincent Askey, Calif. Norman A. Welch, Mass.	1959 1959	Atlantic City Dallas (Clin.)
1960–61	E. Vincent Askey, Calif.	F. J. L. Blasingame, Ill. Ernest B. Howard, Ill.	Raymond M. McKeown, Ore.	Norman A. Welch, Mass.	1960 1960	Miami Beach Washington, D.C. (Clin.)
1961–62	Leonard W. Larson, N.D.	F. J. L. Blasingame, Ill. Ernest B. Howard, Ill.	Raymond M. McKeown, Ore.	Norman A. Welch, Mass.	1961 1961	New York City Denver (Clin.)
1962–63	George M. Fister, Utah	F. J. L. Blasingame, Ill. Ernest B. Howard, Ill.	Raymond M. McKeown, Ore.	Norman A. Welch, Mass.	1962 1962	Chicago Los Angeles (Clin.)
1963–64	Edward R. Annis, Fla.	F. J. L. Blasingame, Ill. Ernest B. Howard, Ill.	Raymond M. McKeown, Ore.	Milford O. Rouse, Texas	1963 1963	Atlantic City Portland (Clin.)
1964–65	Norman A. Welch,* Mass. Donovan F. Ward, Iowa	F. J. L. Blasingame, Ill. Ernest B. Howard, Ill.	Raymond M. McKeown, Ore.	Milford O. Rouse, Texas	1964 1964 1965	San Francisco Miami Beach (Clin.) Chicago (S)
1965–66	James Z. Appel, Pa.	F. J. L. Blasingame, Ill.† Ernest B. Howard, Ill.	Raymond M. McKeown, Ore.	Milford O. Rouse, Texas	1965 1965 1965	New York City Chicago (S) Philadelphia (Clin.)
1966–67	Charles L. Hudson, Ohio	F. J. L. Blasingame, Ill. Ernest B. Howard, Ill.	Gerald D. Dorman, N.Y.	Walter C. Bornemeier, Ill.	1966 1966	Chicago Las Vegas (Clin.)
1967–68	Milford O. Rouse, Texas	F. J. L. Blasingame, Ill. Ernest B. Howard, Ill.	Joseph B. Copeland, Texas	Walter C. Bornemeier, Ill.	1967 1967	Atlantic City Houston (Clin.)
1968–69	Dwight L. Wilbur, Calif.	Ernest B. Howard,** Ill.	Alvin J. Ingram, Tenn.	Walter C. Bornemeier, Ill.	1968 1968	San Francisco Miami Beach (Clin.)

*Dr. Norman Welch died September 3, 1964 and was succeeded by Dr. Donovan F. Ward, President-Elect for 1964-65.

**Dr. F. J. L. Blasingame resigned as Executive Vice President in September 1968. Dr. E. B. Howard was appointed Executive Vice President in March 1969.

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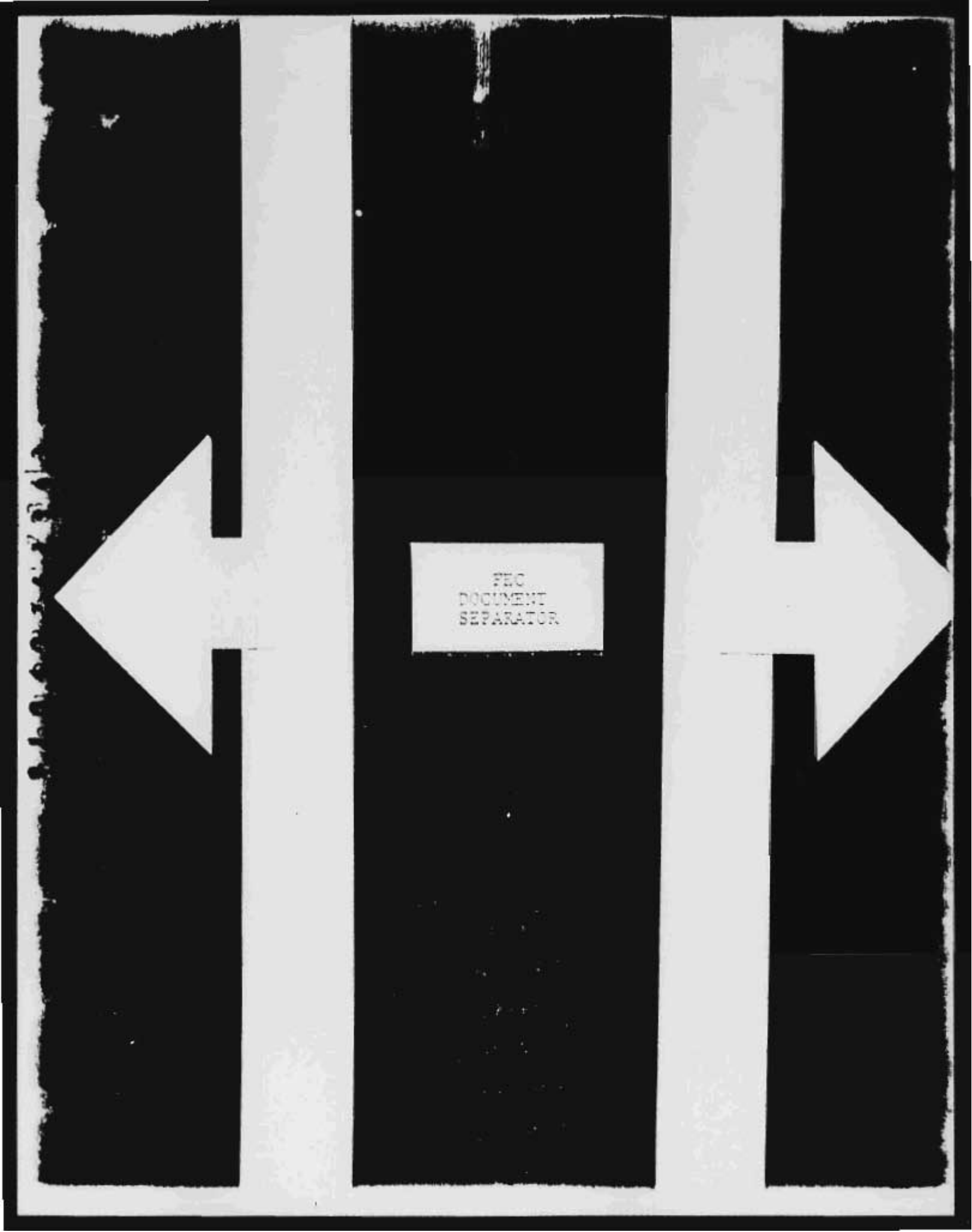
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FILED: November 13, 1978

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

DOCKET NO. 9064

In the Matter of

THE AMERICAN MEDICAL ASSOCIATION,
a corporation,

THE CONNECTICUT STATE MEDICAL SOCIETY,
a corporation,

THE NEW HAVEN COUNTY MEDICAL
ASSOCIATION, INC.

INITIAL DECISION

Ernest G. Barnes
Administrative Law Judge

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APPENDIX A . . . .

APPENDIX B . . . .

9102531173

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

In the Matter of THE AMERICAN MEDICAL ASSOCIATION, a corporation, THE CONNECTICUT STATE MEDICAL SOCIETY, a corporation, THE NEW HAVEN COUNTY MEDICAL ASSOCIATION, INC.	DOCKET NO. 9064

3102534174

INITIAL DECISION

By Ernest G. Barnes, Administrative Law Judge

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Medical Society and
The New Haven County
Medical Association, Inc.

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:

(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.

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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 16, 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. */ 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.

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

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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 */ 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 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).

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

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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. */

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*/ 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.

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.

(cont'd)

FINDINGS OF FACT

I. DESCRIPTION OF RESPONDENTS AND THEIR STRUCTUAAL 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 Street, 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).

(footnote cont'd)

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.

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 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).

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 9902S-27; 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

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 Street, 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

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 68, 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)).

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

D. Commerce

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

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

The United States mail has been used by CSMS and NHCMA in corresponding with AMA and others, including specific applications of AMA's restrictions on advertising and solicitation (CX 78B, 673, 781, 783, 785; CSMS and NHCMA Adm. 20(b), (d), filed June 20, 1977), and in obtaining from AMA and distributing to their members copies of, or excerpts from, AMA's Principles of Medical Ethics and

interpretations thereof (CX 202-19, 221, 1748, 1787; CSMS and NHCMA Adm. 19(c), (d), filed June 20, 1977). Also, delegates, executives, members and employees of CSMS and NHCMA attend AMA conventions and conferences outside Connecticut, including conventions of AMA's House of Delegates at which AMA's Principles of Medical Ethics, and interpretations thereof, are adopted, amended, 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 threshhold 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.

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 concerned 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).

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 Accredited Residencies" (RX 9), a document compiled and published annually by the AMA (Tr. 4097). The Directory also contains statistical data on and analyses of trends in graduate medical education, lists of residencies broken down by geographic location and specialty, information on the availability of graduate medical education in the U.S. and information on the standards against which residency programs are measured. It is distributed to all third year medical students, all deans of medical schools, all hospitals with accredited residency programs, state licensing boards and various other private and governmental entities (Tr. 4097-99). The AMA publishes about 40,000 copies of the Directory each year and distributes 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).

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

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

(d) Summary. It is AMA's position that AMA's accreditation of educational programs assures students that a school is properly prepared to train them and assures the public that a physician or other health professional has completed a satisfactory course of study (Tr. 4076). AMA asserts that it has undertaken accreditation activities because of its responsibility for the improvement and furtherance of education and knowledge in medicine and related health fields (Tr. 4075, 4090, 4104, 4128). In participating in the field of medical education, it is AMA's position that it has sought to promote the science of medicine and the betterment of public health (Tr. 5174). In doing so, AMA seeks to continually improve the qualifications and skill of American physicians (Tr. 5174-75), thereby improving the quality of care delivered to the patient (Tr. 5176). No fees are charged to medical schools for the accreditation process, and the income from other accreditation activities does not cover AMA's costs (Tr. 4101-03). AMA incurs a net operating deficit for

accreditation activities of approximately $2 million per year (Tr. 4102). The AMA contends that no pecuniary advantage accrues to members as a result of its involvement in the accreditation of undergraduate, graduate, continuing and allied medical education (Tr. 4091, 4119, 4129-30).

(e) Education Counseling and Health Manpower. The second division of the Group for Medical Education is the Division of Educational Policy and Development, which is, in turn, comprised of two departments: the Department of Health Manpower and the Department of Physician's Credentials and Qualifications (Tr. 4135). The Department of Health Manpower provides information and advice to people seeking information about health careers, including students, guidance counselors and health career program directors (Tr. 4137). The AMA responds to about 60,000 such inquiries each year (Tr. 4137). The Department also publishes a number of books on different health careers, which are available to the public upon request (Tr. 4147). The AMA does not charge for any of these services other than bulk requests for pamphlets, which are then sold at cost (Tr. 4138). The Department of Health Manpower is responsible for evaluating federal and state legislation which affects medical education and training programs, and for staffing the committee which recommends whether or not a new health occupation should be recognized for the purpose of establishing essentials for the educational program (Tr. 4138-39). The Department is also involved in the accumulation and distribution of data (RX 10, 28, 562), the AMA being the primary repository for physician manpower information needed by private agencies and local and regional planning bodies (Tr. 4139, 4144-45). Other data, developed by the AMA in conjunction with the Census Bureau and the National Center for Health Statistics, is used by the U.S. Department of HEW, state licensing bodies and other groups for such things as targeting continuing education courses (Tr. 4141, 4148-49). Data collected by the Department of Health Manpower is also used in the preparation of directories published by other AMA departments (Tr. 4139). AMA contends no pecuniary benefit flows to its members from these activities (Tr. 4150).

(f) Vietnamese Medical Education. In 1966, the Agency for International Development ("AID") requested the AMA to join in its efforts to improve the quality of Vietnamese medical education (Tr. 4756; RX 512). In response to this request, the AMA conducted a feasibility study and thereafter entered into a contract with AID whereby AMA agreed to assist in the development of medical education in South Vietnam. AMA's first attempts were to recruit American medical school faculty members to instruct Vietnamese students at the medical

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 functions 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).

(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).

(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 the problems associated with mental illness and alcoholism (Tr. 4646). This information is distributed to all physicians without regard to AMA membership (Tr. 4647). Included among the activities of the Department of Mental Health are the publication of booklets and pamphlets, sponsorship of conferences, and abstracting of the scientific literature (Tr. 4648. See, e.g., RX 35, 65, 142, 188). Reprints of articles from AMA scientific journals are distributed free of charge; charges for other publications are equal for AMA and non-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).

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 determining how best to identify such physicians and remove them from practice until they are rehabilitated (Tr. 4672-76). The AMA has published an article in JAMA, entitled "The Sick Physician" (RX 523), has made recommendations on dealing with the impaired physician to state and local medical societies (Tr. 4675-78) and has drafted model legislation authorizing state licensing boards to examine and deal with impaired physicians and provide legal immunities for the person making an allegation of impairment (Tr. 4678-79). Other activities of the AMA in this area include involvements in workshops and symposia (RX 524-25; Tr. 4679). The out-of-pocket expenditure incurred to date by the AMA in connection with the impaired physician program is approximately $200,000 (Tr. 4681). These efforts are directed at AMA and non-AMA members alike (Tr. 4682-83).

(f) The Department of Food and Nutrition is another part of the AMA Group on Scientific Affairs. The AMA's formal involvement in the areas of food and nutrition dates back to 1929 (Tr. 4514). From 1955 to the present, the AMA has sponsored more than 40 symposia, published 15 books and caused about 125 articles to be published in JAMA, all

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 House Conference on Food and Nutrition and various other groups (Tr. 4539-40). Several books have resulted from these conferences, including works in topics such as food processing technology (RX 47) 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).

(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 seeking to identify a relationship between school environment and learning, and screening school children for visual defects and hearing impairment (Tr. 4585-86).

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

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 157, 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). These conferences bring together professionals with expertise in the area of 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).

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 need to chart the growth progress of a child, and has helped prepare "Growing Pains" (RX 74), a publication directed to parents (Tr. 4487). Other AMA publications are concerned with issues relating to drinking and smoking; "Breath Alcohol Tests" (RX 97) is an exposition of the various tests that can be used for measuring blood alcohol levels (Tr. 4488). The AMA also distributes plaques containing the words "For the Sake of Your Health and the Comfort of Others, 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).

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)

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

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).

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 (PSRD'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

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).

(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

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

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

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).

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,

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 non-member 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).

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).

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 $[illegible]00,382 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

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).

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

the remarkable range of tangible benefits it provides for its members (CX 259C, 263&4) 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:

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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 relicensure
- Unrealistic restrictions on physician discretion in prescribing drugs
- Mandatory government service for all medical school graduates
- Premature HEW establishment of conversion program review teams for Medicare and Medicaid

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

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

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

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

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

Drafted and Sponsored

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

Supported

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

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

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

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

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

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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).

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).

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).

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).

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).

H. Professional Liability Insurance

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

L. Allied Health Professionals

34. Through 1977, the AMA's legislative position has been that allied health professionals should practice only under the supervision 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. 9914-16). 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).

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).

AMA took this position in large part because of the increase in supply of American physicians (Tr. 5120-21). A report approved by AMA, and published in the December 1972 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).

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 P. 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

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).

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. 1500-03). 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)

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

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.

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

(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).

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).

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

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 non-clinical 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.

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).

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

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:

(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).

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).

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;

(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 FTC 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;

(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.

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:

> [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).

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

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

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.

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 non-members 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).

The Committee on peer review systems has been concerned with matters of peer review and regulation by third parties. The committee undertook a study of ways to help elderly patients by increasing the number of physicians willing to be reimbursed by Medicare solely on the basis of the assignment of patients' Medicare benefits rather than requiring extra payments by the patients. The Committee's report was sent to the Connecticut Congressional delegation and the Department of HEW (Tr. 8301-07; RCX 68, p. 30, 102A-D, 103A-M).

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

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

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

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

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

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

The cancer coordinating committee has coordinated activities in the fields of cancer treatment, research and education throughout Connecticut, has worked with the committee on legislation to support legislation to maintain a cancer tumor registry, developed a booklet on follow-up cancer treatment and has emphasized physician education regarding cancer treatment (Tr. 8332-35; RCX 68, p. 35, RCX 97).

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

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

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

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

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

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

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

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

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

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

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

B. Publications

56. CSMS publishes Connecticut Medicine, the journal of the Connecticut State Medical Society, on a monthly basis. The journal has been in publication since 1936. It has a physician editor as well as a CSMS committee which functions as an editorial board (Tr. 8321-23; CX 1352Q; RCX 129. See also F. 71, p. 91). Connecticut Medicine is available to CSMS members and nonmembers who wish to subscribe, as well as through public libraries. The subscription rate is $7.50/year for CSMS members and $15.00/year for nonmembers. Approximately 150 to 200 nonmembers subscribe to Connecticut Medicine. The members' subscription costs are allocated out of the $100 membership dues of CSMS (Tr. 8240, 8254-55). Connecticut Medicine generally contains articles of educational value in clinical medicine; philosophical issues in medicine; comments of the Dean of the University of Connecticut; articles of general intellectual interest (for example, by the Connecticut Society for the Humanities); comments of CSMS officers, employees, or representatives; the proceedings of the CSMS House of Delegates; notices of scientific symposia; letters to the editor; and a physician placement service. Many of the authors of these articles are not members of CSMS (Tr. 8322-23; CX 1352A-Z85; RCX 129). The physician placement service includes listings of physicians wishing to locate in Connecticut and entities wishing to list opportunities for practice. The service is available without charge to all physicians, regardless of membership in CSMS, and to Connecticut municipalities and governmental agencies seeking physicians (Tr. 8238-40; RCX 129). Connecticut Medicine's costs of publication exceed the revenues obtained from advertising, subscriptions and reprints. In 1975, CSMS lost about $44,000 in publishing and maintaining Connecticut Medicine as the Society's journal (Tr. 8369; RCX 68, pp. 14, 16-17).

CSMS publishes Connecticut SportsMed, which is distributed by CSMS free of charge several times annually to team physicians, coaches, trainers and others interested in contact sports in Connecticut. SportsMed is primarily intended for consideration and use by people dealing with sports in the middle and secondary schools. The April 1976

issue of Connecticut SportsMed (Vol. 3, No. 1) included articles on lateral flexion injury to the neck; cauliflower ear; athletic training; physical examinations; and, injury reporting (Tr. 8330; RCX 94).

C. Public and Governmental Interface

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

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

CSMS has developed informational pamphlets and materials for use by physicians and others. Examples include "The Team Physician: A Brochure for Team Physicians, Coaches & Trainers" and "Follow-up of Cancer". These booklets have been distributed by CSMS free of charge to physicians (CSMS members and nonmembers) and other interested persons (Tr. 8333-34, 8338-39; RCX 93, 97).

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

CSMS sends designated representatives and advisors to governmental and quasi-governmental bodies concerned with health care. CSMS sends representatives and delegates to the following groups: committee on allied medical services (considering the interrelationship of care rendered by physicians and nurses); committee on hospitals; committee on cooperation with the medical schools of Connecticut (resulting in educational programs cosponsored by CSMS); liaison committee with the Connecticut Pharmaceutical Association; liaison committee with the State Department of Social Services; Connecticut Health Association; Connecticut Nutrition Council; Connecticut Advisory Council on School Health; Connecticut Advisory Committee on Food

and Drugs; Council of New England State Medical Societies; State hospital, pharmaceutical, dental, and nurses' associations; and several state medical associations. CSMS has two designated representatives on the Connecticut PSRO Council, which is the state-wide board responsible for the federally mandated PSRO function in Connecticut (Tr. 8347, 8349-51, 8353-54; CX 1352T, U; RCX 68, pp. 40-44).

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

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

CSMS annually provides an $8,000 grant to the medical schools in Connecticut, to be used as a revolving loan fund for needy students. The funds are disbursed at the discretion of the deans of Connecticut's medical schools (Yale and University of Connecticut) (Tr. 8350, 8361; RCX 68, p.15).

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

CSMS has communicated with governmental officials and legislators concerning issues of health care and health care regulation in order to express its opinions regarding the delivery of health care in the State of Connecticut, including: establishing a State poison information center; State Health Department authority to regulate fishing in contaminated areas; protecting members of peer review panels; strengthening the powers of public health inspectors regarding unsanitary restaurants; fees for State Health laboratory work; licensing of clinical laboratories; reexamination of motor vehicle operators; health education in public schools; disclosure of information regarding

patients in mental health facilities; radiation level limits for health treatment; the practice of chiropractors; professional liability (malpractice) and the establishment of a commission to study that issue; the establishment of a separate commission on physician disability; maintenance of a State license registration fee; the practice of nursing; insurance coverage for mental or nervous conditions; disclosure of information received from the State Department of Health by the Commission on Hospitals and Health Care; defining the types of surgical practices performed by podiatrists; ear piercing; generic drug prescription; drug interchange and equivalency; procedures for the State Welfare Department payment for provider services; child abuse; motor vehicle operation; prenatal testing of pregnant women; school sports; sale of BB guns; fluoridation of water; abortion; human experimentation; optometrists' recommendation of physicians; health insurance for ambulatory care; restructuring of Medical Examining Board; and other matters referred to above in the discussion of committees (Tr. 8323-29; CX 192, 368A-F, 429, 1236A-D, 1252A-B, 1253, 1256A-B, 1257, 1263A-D, 1264, 1749; RCX 5, 10A-B, 142, 143, 144, 145. See also F. 64, p. 86; 66-67, pp. 88-89).

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

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

D. Connecticut Medical Political Action Committee

58. The Connecticut Medical Political Action Committee ("COMPAC") is a political action committee which is registered with the Federal Election Commission. COMPAC was formed

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

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

CSMS provides COMPAC with office space and use of a telephone line to make local telephone calls at the CSMS office free of charge. CSMS staff employees, from time to time, provide administrative or clerical services to COMPAC in connection with the processing of dues statements or the sending out of occasional pieces of mail. CSMS charges COMPAC for all postage, long distance and toll telephone charges, office supplies, printing charges and other expenses which might be incurred by, or billed to, CSMS and which are attributable to COMPAC. CSMS maintains a ledger sheet for recording expenditures chargeable to COMPAC, and on the basis of the ledger sheet bills COMPAC for such expenditures (Tr. 8240-41, 8243; CX 2599D; RCX 123A-C).

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

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

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

E. Insurance Programs

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

Since 1971, CSMS has endorsed a professional liability insurance program which is administered and underwritten by the Aetna Life and Casualty Company. A brochure on the Aetna program is presently included in the CSMS membership information file which is provided to new members (Tr. 8294; RCX 2B, 148N). A physician must be a CSMS member in order to participate in the CSMS endorsed program. Participation is voluntary and subject to Aetna's determination of insurability. Policies written in connection with the professional liability program are issued by Aetna to individuals, not to CSMS on their behalf. Approximately 85 percent of the CSMS membership obtain professional liability insurance through the Aetna program (Tr. 8295, 8297, 8300; RCX 3A-E. See also F. 70, p. 90). infra).

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

Nonmembers of CSMS, and members of CSMS who choose not to participate in the above described Aetna program, can purchase individual professional liability insurance policies from Aetna, but at a higher rate. Other insurance

companies sell group professional liability insurance policies in Connecticut, but only to members of certain medical specialty societies (Tr. 8377-79, 8778).

F. Relative Value Guides

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

G. Income and Expenditures

61. In 1975, CSMS received gross income of $353,196 (less journal income). This amount included $305,442 annual dues payments from members, less $539 in administrative charges paid to a county association for processing CSMS dues payments in that county; $35,155 special assessment of the CSMS membership to cover the funds granted by CSMS to the establishment of the Connecticut Medical Institute to implement federally mandated PSRO legislation; $18,095 interest and dividends on CSMS reserves; $5,800 rental income to CSMS from renting a portion of the CSMS building; $1,763 received from the AMA as compensation for administrative costs of processing AMA dues payments; less $13,487 loss on sale of securities; and $967 miscellaneous (Tr. 8356-57; RCX 68, p. 14).

In 1975, CSMS made expenditures of $242,229 (RCX 68, p. 14). Expenditures of $4,488 were used in the publication of CSMS Newsletters from the Executive Director's Office to CSMS members (RCX 68, p. 15); $10,386 represents the cost of sending CSMS delegates and officers to the AMA

conventions twice a year; $8,731 represents legal fees and the cost of retaining a legislative lobbyist; an $8,000 contribution to a financial aid fund for medical students was made; and, $2,886 was paid to a consultant to study the CSMS endorsed professional liability program (Tr. 8358-62; RCX 68, p. 15).

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

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

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

As of December 31, 1975, CSMS had general fund reserves of $359,697, building fund reserves of $152,442, depreciation fund reserves of $61,942 and other special fund reserves of $5,365 (RCX 68, p. 14).

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

A. Background

62. CSMS acts on behalf of the medical profession of Connecticut, representing its professional interests and its professional responsibilities to the public, in a way

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

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

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

B. Relative Value Guide

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

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

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

C. Third-Party Payers

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

CSMS actively opposed the "Century Contract" adopted by Connecticut Medical Service, the Connecticut Blue Shield Plan, under which the maximum payments the Blue Shield Plan made to physicians were lower than the levels of usual and customary charges then being received by CSMS member physicians and, therefore, deemed unacceptably low by CSMS (CX 420A, 417, 418, 2430). Acting in behalf of and representing its members, CSMS joined in a lawsuit in 1972 challenging the Blue Shield contract--after the contract had been approved by the state insurance comissioner--in an effort to protect CSMS members from suffering "substantial competitive disadvantage," undergoing loss or damage to their businesses and being deprived of their ability to determine the level of compensation for their services (CX 2430B, D, E). In the year the suit was filed, CSMS

allotted $4,249 to "Legal Fee--special litigation" and $1,009 to "Third Party Payments" committee activities, a total of $5,258; it allotted only $5,289 to all the rest of its committees (RCX 155C).

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

D. Foundations for Medical Care

65. The CSMS Council voted that foundations for medical care are more acceptable to it than HMOs, partly because of CSMS's concern for protecting the physician in private practice (CX 892A). The Council has urged the CSMS component medical societies to consider forming foundations for medical care on a county-by-county basis, each foundation to serve as the negotiating agent for contracting physicians in all matters having to do with third-party payments to physicians (CX 892A-B, 2414C). CSMS has issued a $4,999 interest-free loan to the New Haven County Foundation for Medical Care to be repaid "when feasible" (RCX 68, p. 17).

Foundations "owned, controlled and administered by organized medicine" and incorporating fee-for-service medicine as a basic principle are one means available to

medical societies to protect the interests of practicing physicians (CX 388A, B, E, F). They provide physicians with a "common front in meeting the socioeconomic pressures facing the practice of medicine," such as presented by HMOs, where fees are not necessarily controlled by doctors (CX 2412E, F).

E. Efforts to Influence Governmental Action

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

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

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

CSMS has also lobbied for adoption of malpractice insurance legislation (RCX 68, pp. 29-30; CX 1749A, E) to forestall continued premium increases in physicians' liability insurance costs (CX 1252A, 1749A). A number of CSMS's legislative proposals, in 1974 and 1976, were specifically designed to make it more difficult for plaintiffs to prevail in malpractice litigation and to reduce the size of malpractice liability awards against physicians (CX 1262, 1263; Tr. 8324).

In 1974 and 1975, CSMS lobbied for increases in and faster payment of physicians' claims under the Medicaid program in Connecticut (CX 431A, 432, 1236C; RCX 68, p. 42, 103I; Tr. 8396-97). CSMS has also opposed the charging of

fees by the State Health Laboratory, questioning whether the state government should compete with the private sector (CX 1264), and has opposed legislation expanding the scope of practice of podiatrists (CX 1236C) and chiropractors (CX 192A).

F. Connecticut Medical Political Action Committee

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

CSMS made financial grants to COMPAC in its early years (Tr. 8258-60; CX 1211), and COMPAC officials have attended CSMS Committee on Legislation meetings (CX 458A). Various physicians have served simultaneously as officers of COMPAC and as officials of CSMS (Tr. 8387-89). For example, in 1971, the physician who chaired both the CSMS Public Affairs Division and National Legislation Committee was also the chairman of the COMPAC board (CX 1214C, 2109B). CSMS's president, president-elect, vice president, treasurer, the chairmen of the CSMS judicial, public relations and third-party payments committees and three other CSMS officials all were on the COMPAC board that year (CX 1214C, 2109B). Promoting membership in COMPAC has been one of the two main goals of the CSMS public affairs committee (CX 1258B). CSMS endorses COMPAC and acts as its collection agency, soliciting contributions to COMPAC and AMPAC in the annual dues statements sent to CSMS members (CX 1214C, 1714, 1715, 312). CSMS provides office space and local telephone service to COMPAC at no charge and receives reimbursement from COMPAC for other administrative services CSMS provides for COMPAC (CX 2599C, D). The two organizations are in close liaison (CX 1206A), and work together (CX 1214C). COMPAC reports to the CSMS Council twice a year (Tr. 8383-84) and files reports with the CSMS House of Delegates (RCX 129, p. 68; CX 458B).

G. Membership Services

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

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

H. Public Relations

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

I. Insurance Programs

70. CSMS sponsors a variety of group insurance programs available exclusively to its members, the most significant being the Professional Liability Insurance Program (RCX 2D, 68, p. 29; CX 192B, 206F. See also F. 59, pp. 82-83). This program, underwritten by the Aetna Life and Casualty Company, is designed to assist CSMS members caught in the "expensive bind" of rising malpractice costs (CX 367U, 1235, 1328). The program is available only to CSMS members (Tr. 8299; CX 1328, 309, 317), and is the only group malpractice insurance available in Connecticut with the exception of policies available to members of certain medical specialty societies (Tr. 8378-79, 1722-23; CX 1328). A Connecticut physician who is ineligible for a group policy can obtain malpractice insurance only by purchasing a nongroup, individual policy from Aetna at a higher rate than that charged to CSMS members under the sponsored program (Tr. 8778). Approximately 85 percent of CSMS's members subscribed to the program, and CSMS intervenes with Aetna on behalf of CSMS members who protest initial determinations by Aetna refusing coverage of them (Tr. 8295, 8297, 8300; CX 428; RCX 2D, 148N, 3A-E).

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

J. Publications

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

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

K. Source of Funds

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

L. Federal Income Tax Status of CSMS

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

VII. ACTIVITIES OF NEW HAVEN COUNTY MEDICAL ASSOCIATION

A. Committees and Programs

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

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

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

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

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

The committee on public relations has two functions: to improve internal relations within NHCMA and between NHCMA and others; and to educate the public with regard to health care matters. This committee is also responsible for the publication of Issues and Insight (Tr. 8443, 8524).

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

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

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

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

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

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

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

B. Income and Expenses

75. In 1975, NHCMA received gross income of $107,239. This amount included $95,845 annual dues payments from members; $1,268 from tickets to the NHCMA annual and semi-annual meeting; $2,816 interest on NHCMA reserves; $975 received from insurance companies for reviewing third-party payments questions ($25 per case reviewed); $1,598 revenue from advertising placed in the NHCMA publication, Issues and Insight; $4,011 reimbursement

from the New Haven County Foundation for Medical Care, Inc. for consultant's administrative services; $726 reimbursement from the Professional Standards Review Organization for administrative services and office equipment.

In 1975, NHCMA had expenditures of $95,027 (Tr. 8513-17; RNHX 138C). NHCMA expended $54,186 as Executive Office expenses, including salaries, pensions, health insurance and payroll taxes (Tr. 8517-18; RNHX 138C). NHCMA expended $12,952 to hold meetings of NHCMA (annual and semi-annual) and its committees. This amount included $9,077 to hold its annual and semi-annual meetings; $2,261 to hold Board of Governors meetings, Executive Committee meetings and special meetings; $524 to hold meetings of the NHCMA standing committees; $353 to hold meetings of the Board of Censors; and $737 in secretarial, postage and printing costs of the credentials and orientation committee to consider membership applications and prepare certificates of membership (Tr. 8518-20, 8525; RNHX 138C). NHCMA expended $9,900 to retain an outside public relations consultant, and an additional $766 for expenses incurred by the consultant (Tr. 8520-24; RNHX 138C). NHCMA expended $3,454 in direct costs of publishing and distributing Issues and Insight, and expended $200 as an honorarium to its physician editor. The duties of the public relations consultant included aiding in the production and publication of Issues and Insight. NHCMA expended $788 in direct costs of publishing and distributing the NHCMA President's Newsletter to members. The duties of the public relations consultant also included aiding in the production and publication of the newsletter (Tr. 8524-25; RNHX 138C). NHCMA expended $997 to cover the Clerk's office equipment, cost of travel to meetings elsewhere in Connecticut, etc. and a $400 honorarium to the NHCMA President. NHCMA expended $340 as a miscellaneous reserve or "emergency" fund and $319 as a donation to the NHCMA Woman's Auxiliary to help defray the costs of holding the Auxiliary's annual scholarship dance (Tr. 8525-26, 8529; RNHX 138C). NHCMA expended $9,627 in maintaining its office, including the cost of rent, utilities, janitorial services, telephone and answering service, insurance, office equipment and supplies, printing and postage. NHCMA expended $600 for auditor's services and $120 for legal services (Tr. 8526-30; RNHX 138C). NHCMA expended $372 for the Executive Secretary's attendance at an AMA leadership conference in Chicago on current topical issues such as medical care for jail populations and the control of "the sick doctor" (Tr. 8527-28; RNHX 138C). NHCMA had a net excess for the year of $12,212 (RNHX 138C).

C. Public and Governmental Interface

76. NHCMA has sent representatives and advisors to several community-oriented health organizations such as the New Haven Alcohol Council, the Cancer Society and the American Heart Association. NHCMA sends a representative to the Health Systems Agency which is a federally mandated health-planning organization designed to determine and make recommendations concerning the adequacy of presently available medical care. NHCMA sent a representative to the South Central Connecticut Comprehensive Health Planning, Inc., which was the predecessor of the Health Systems Agency (Tr. 8452-57; CX 995I). In 1971, the NHCMA Executive Committee met with chiefs of staff of hospitals in New Haven County to discuss topics of mutual interest (CX 447A-E). In 1972-73, NHCMA had an ad hoc committee on staff appointments at Yale-New Haven Hospital. This committee met with a committee of the New Haven city medical association to discuss three physicians' efforts to obtain staff privileges at Yale-New Haven Hospital (CX 442, 443, 445, 446A-C). In 1975, representatives of NHCMA met on two occasions with representatives of the New Haven County Bar Association in exploratory meetings aimed toward improving relationships between the two organizations (CX 995M). NHCMA does not have a physician placement service, but has endorsed plans covering major medical, hospitalization and disability insurance (CX 339, 1280, 1281, 323A-F, 324A-F, 327A-F, 328A-B, 329A-B; Tr. 8446-47).

D. Publications

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

E. COMPAC

78. COMPAC is a voluntary political action committee registered with the Federal Election Commission (see F. 58, pp. 80-82; 607, p. 89). COMPAC is not a committee of NHCMA

and NHCMA granted no money, funds or property to COMPAC in 1975 and 1976, and provided no administrative services to COMPAC (Tr. 8574; CX 500A, 2599A, D). NHCMA members are not required to join COMPAC. As of the end of 1974, 94 members of NHCMA chose to belong to COMPAC. As of April 1975, 74 members of NHCMA had chosen to do so. (CX 312, 996B, 1214B, 1712, 2599A). On occasion, a COMPAC member may make a brief oral statement to NHCMA or its Board of Governors regarding the purpose of COMPAC and the importance of participating in the electoral process. The phrase, "Join COMPAC," was printed on the back side of one NHCMA meeting notice in 1973, one notice in 1975 and one meeting agenda in 1976 (Tr. 8570, 8573-74; CX 1[illegible]C, 988C, 996B, 998D, 1221A, 1391A, 2599D).

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

A. Background

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

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

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

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

B. The New Haven County Foundation for Medical Care

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

In April 1971, the NHCMA third-party payments committee discussed medical care foundations and, in November 1971, the NHCMA long range planning and development committee meeting included a discussion of medical care foundations (CX 2415A-B, 2422A-B). At its 1973 annual meeting, NHCMA voted to establish the New Haven County Foundation for Medical Care. The Foundation was incorporated as a separate entity in May 1973 (CX 998C, 2424C; Tr. 8549). Following their incorporation of the Foundation, NHCMA's officers elected the original Board of Trustees (CX 2604D, 2428C, 2416, 443). Thereafter, NHCMA selected two members of the Foundation's trustee nominating committee (CX 992E, 994D, 2428E). In 1975, every NHCMA officer and executive committee member also served on the Foundation's Board of Trustees (CX 994D; RNHX 2). NHCMA officials were the Foundation's chairman of the board, secretary and treasurer in 1975 (CX 994D; RNHX 2). Currently, the Foundation president is the NHCMA vice-president (Tr. 8550).

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

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

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

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

The Foundation is also designed to put its participating physicians "in a secure position to continue their current private fee for service practices" in the event Congress passes national health insurance legislation incorporating independent practice association HMOs (CX 2424K). Through the Foundation, physicians participate in the development of standards for quality control and peer review, rather than having them "imposed from outside sources" (CX 2424D), thereby retaining "control of medicine's destiny in the hands of the practicing physician" (CX 2413A).

C. Peer Review Activities

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

Pursuant to an official vote by the NHCMA membership that physicians should be reimbursed on the basis of their usual and customary fees (CX 1177C), the Committee handles the complaints of patients and of insurance companies that challenge physicians' charges (CX 1365, 995F). To resolve complaints that a physician's fees are too high, the

Committee has relied largely, at least through 1976, on the CSMS Relative Value Guide (CX 1354A, 2425, 2433, 1178; Tr. 8472) and a conversion factor geared to what NHCMA considers to be the usual and customary fees among its members (CX 1176A, B, 453; Tr. 8472-73). The Committee resolves the vast majority of its cases in favor of the physician where fees are concerned (CX 2425, 2433; Tr. 8535-36, 8546). As a rule, the Committee's suggested fee is usually at or near the maximum, according to the 1971 CSMS Relative Value Guide (CX 2425). According to the chairman of the NHCMA Peer Review Committee, the CSMS Relative Value Guide plays an important role in maintaining and solidifying loyalty among members of the medical profession (CX 1178B). The NHCMA membership adopted a resolution in October 1975, reaffirming its support of the CSMS Relative Value Guide and urged CSMS to print new copies and distribute them to all new CSMS members (CX 988D).

NHCMA members have been kept informed of the conversion factor used by the Committee (CX 455). When the Committee feels it is appropriate, the conversion factor has been adjusted upwards to accommodate for increases in the consumer price index (CX 995F, G, 1358). Patients who have submitted grievances about physicians' fees are not invited to Peer Review Committee meetings (RNHX 112A).

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

D. Efforts to Influence Government Action

82. NHCMA and its officials actively promote the economic interests of NHCMA's members through lobbying and legislative activities. In 1974, NHCMA wrote to Congress opposing extension of Economic Stabilization Act controls on physicians' fees, protesting that optometrists, opticians and psychologists were exempt from controls while opthalmologists, psychiatrists and other physicians were not exempt (CX 1277). NHCMA also protested that health maintenance organizations were being given special treatment

not available to private practitioners (CX 1277). The NHCMA Board of Governors wrote an official letter to nine state senators and 37 state representatives in 1974 urging repeal of the $150 annual physicians' license registration fee in Connecticut (CX 1276A, B, 1278, 441). NHCMA issued a newsletter, "Call to Action," urging its members to join the NHCMA leadership in a grassroots effort against continued price controls on physicians' fees and against the licensing fee of $150 (CX 1278).

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

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

NHCMA's executive secretary urged the CSMS Councilor representing NHCMA to press the Connecticut Welfare Department to bring the Medicaid program up to "usual, customary and reasonable" levels and to make fee payments "acceptable to the average physician" (CX 448B). NHCMA's president urged its members to contact their state legislators in opposition to extension of a seven percent sales tax on professional services (Tr. 8567-68).

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

E. Other Activities

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

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

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

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

F. Federal Income Tax Status

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

IX. RESPONDENTS' ETHICAL CODE AND ITS ENFORCEMENT

A. The Ethical Code

85. According to AMA publications, the earliest written code of ethical principles for medical practice was conceived by the Babylonians around 2500 B.C. That document, the Code of Hammurabi, set forth in considerable detail from that era of history the nature of conduct demanded of the physician. The Oath of Hippocrates,

conceived some time during the period of Grecian greatness, probably in the fifth century B.C., has come down through history and remained in Western Civilization as an expression of ideal conduct for the physician. The most significant contribution to ethical history subsequent to Hippocrates was made by Thomas Percival, a physician of Manchester, England, who published his Code of Medical Ethics in 1803 (CX 462E).

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

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

The Judicial Council, a standing committee of AMA's House of Delegates (CX 990U), exercises the judicial power of AMA (CX 990X). Its five members are physicians nominated by AMA's president and elected by its House of Delegates (CX 990V, 1769A). The AMA Bylaws state that "[t]he [Judicial] Council shall have jurisdiction on all questions of medical ethics" (CX 990X). The Judicial Council's role is to interpret the Principles and to review and hear actions based on infractions of the Principles (CX 1769B, 486A, 462Z48-Z49). AMA publishes the Judicial Council's ethics interpretations periodically under the title, Judicial Council Opinions and Reports ("Opinions and Reports") (CX 462-67). Many of the ethics interpretations published in Opinions and Reports, including many of those governing advertising and contract practice,

have been adopted or approved by AMA's House of Delegates (Compare CX 462I, J, Z-5 through Z-15 with CX 463F, G, P-W). In December 1975, when the complaint in the instant proceeding was issued, the 1971 edition of Opinions and Reports was in effect (CX 462; Motion of Respondent American Medical Association for Reconsideration of Issuance of the Complaint in this Docket, filed January 14, 1977, at p. 9). A revised edition was issued in March 1977 (RX 1, Tr. 4335). AMA has distributed thousands of copies of both the Principles and Opinions and Reports to medical societies, individual physicians and medical students (Complaint and AMA, CSMS and NHCMA Ans. ¶ 7; Response of American Medical Association to Motion of Complaint Counsel to Determine the Sufficiency of its Responses to Request for Admissions, dated July 26, 1977, at p. 106, Request #19(a); CX 482, 667, 1774-76, 1779, 1788-89).

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

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

AMA's 1974 Report on Physician-Hospital Relations (CX 959) contains most of AMA's ethical restrictions on physicians' contractual arrangements with third persons, some of which also are printed in the 1971 Opinions and Reports (CX 959Z63-Z64, 462Z12-Z13). The Report on Physician-Hospital Relations, approved by the AMA House of Delegates in 1974 and copyrighted in 1975 (CX 959B, C), was included in the Proceedings of the House of Delegates, summarized in American Medical News (distributed to every member of AMA), published separately in booklet form (over 5,000 copies distributed) and sent to each state and large

county medical society (Motion of Respondent American Medical Association for Reconsideration of Issuance of the Complaint in This Docket, filed January 14, 1977, at p. 7).

B. The Ethical Code Enforcement Process

86. AMA, CSMS, NHCMA and most of AMA's other constituent and component medical societies have made adherence to the AMA Principles of Medical Ethics a condition of membership (CX 990I, 991D, 1404I). AMA's constituent and component societies have adopted bylaws which provide that the AMA's Principles of Medical Ethics shall govern the conduct of their members and that unethical conduct shall be grounds for expulsion (see Appendix A attached hereto). The AMA's House of Delegates has adopted a resolution making state medical societies' own ethical principles binding upon the respective association's members provided that the principles are not inconsistent or in conflict with the Constitution and Bylaws of AMA (CX 1435Z20). NHCMA's bylaws specifically provide that its members are governed by the AMA's Principles of Medical Ethics "as reflected in the [AMA] Judicial Council" (CX 1404I). AMA has declared it the duty and obligation of its local medical societies to initiate enforcement of AMA's ethical standards and to insure full compliance with the spirit and intent of the Principles of Medical Ethics (CX 462Z9 [Sec. 5, Op. 20]). AMA has frequently urged its constituent and component societies to fulfill this obligation (CX 462Z1 [Sec. 4, Op. 9], Z2 [Sec. 4, Op. 14], Z5-6 [Sec. 5, Op. 9], Z6 [Sec. 5, Op. 11], Z6-7 [Sec. 5, Op. 12], Z7 [Sec. 5, Op. 13], Z9[Sec. 5, Op. 20], Z10 [Sec. 5, Op. 23], Z40 [Sec. 10, Op. 4], Z45 [Sec. 10, Op. 13], 26B, 54, 488B-C, 489, 662B-C, 673A,E, 845, 1392C, 1810). AMA has declared that when a physician disregards "local custom," as determined by the local medical society, he has acted unethically (CX 1439, 462Z9-Z10, 27). AMA advised one local society that compliance with AMA's ethical principles should be achieved through "education prospectively and disciplinary action retrospectively" (CX 662B). NHCMA and other component societies of AMA frequently investigate alleged breaches of AMA's ethical standards and convey their concern to the physicians involved by letter, telephone or personal meeting (see e.g., F. 95, p. 119; 98-100, pp. 124-32; 103-07, pp. 135-43; 110-11, pp. 145-46; 112, pp. 147-48; 113-14, pp. 148-52; 117, pp. 154-56; 119, p. 160, 120-22, pp. 160-71; 123, pp. 172-73; 136-37, pp. 194-98).

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

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

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

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

association meeting (Tr. 4270-21; RX 275A-C). The appellate jurisdiction of the Judicial Council has been invoked in approximately one case per year over the past 35 years (Tr. 4325). Appellate review, which is initiated by the filing of an appeal from a decision of a state medical society, is limited to questions of law and procedure (Tr. 4326-27).

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

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

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

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

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

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

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

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

The threat of disciplinary action by medical societies is extremely effective, for membership in the medical society is an important and valuable asset to the physician (CX 503M. See also F. 23-49, pp. 38-59; 62-72, pp. 84-91; 79-83, pp. 96-101). Actions to enforce AMA's ethical standards may deprive the diciplined physician of valuable rights and affect his or her reputation, professional status or livelihood (CX 462Z2, Z3 [Sec. 4, Op. 15]), including:

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

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

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

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

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

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

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

Actions to enforce AMA's ethical restrictions on solicitation, advertising and contract practice have deterred reputable physicians from repeating the conduct which allegedly violated the restrictions (F. 98-100, pp. 124-32; 103-07, pp. 135-43; 110-11, pp. 145-46; 112, p. 147; 113-14, pp. 148-52; 117, pp. 154-56; 121, pp. 167-68 123, p. 172; 132, p. 187; 135-37, pp. 192-98; 148, pp. 213-15).

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Most physicians abide by medical society ethics (CX 516D, 1392B, 1407; Tr. 9535, 554, 5787).

C. State Medical Licensing Boards

88. Robert C. Derbyshire, M.D., Secretary-Treasurer of the New Mexico Board of Medical Examiners testified in this proceeding (Tr. 6723 et seq.). He has been president of the Santa Fe County Medical Society, the Bernalillo County Medical Society and the New Mexico Medical Society (Tr. 6725). He has also served as president of the Federation of State Medical Boards of the United States,

the association of state medical licensing and disciplinary boards (Tr. 6727-28). He has written extensively on the subjects of medical discipline, education and licensing, including a book entitled Medical Licensure and Discipline in the United States (Tr. 6730-31). In 1977, the Federal Trade Commission commissioned Dr. Derbyshire to prepare an analysis of the relationship between state medical licensing boards and state medical societies, and the effectiveness of state regulation of medical disciplinary cases.

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

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

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

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

A. Present Sources of Information about Physicians

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

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

(1) Physician specialty;

(2) Solo or group practice;

(3) Physician age and number of years in practice;

(4) Medical school, internship, residency, and fellowships;

(5) Specialty board certification or eligibility;

(6) Teaching positions;

(7) Hospitals to which physician admits patients;

(8) Office hours and after-hours coverage;

(9) Appointment required;

(10) Acceptance of new patients (any minimum or maximum age);

(11) Willingness to make house calls;

(12) Proximity of public transportation;

(13) Availability of free parking or other parking facilities;

(14) Availability of ramp, elevator, wheelchair; whether office access requires climbing stairs;

(15) Precription of birth control devices;

(16) Performance in office of x-rays, electrocardiograms, blood tests, urine tests, pregnancy tests, throat cultures and pap smears;

(17) Prescription of drugs by generic names;

(18) Fees for particular services and tests;

(19) Acceptance of Medicare and Medicaid patients;

(20) Acceptance of Medicare reimbursements as payment in full;

(21) Acceptance of credit cards;

(22) Languages spoken; and

(23) Willingness to make patient's records available to the patient.

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

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

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

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

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

There is record evidence about several local directories of physicians which have been prepared and distributed in recent years. In each instance, there was a perceived need, usually by physicians and medical societies, for such a directory to provide consumers with information about physicians and medical care (Tr. 5759 [Pima County, Tucson, Arizona], 5415-16 [Lane County, Eugene, Oregon], 2367-70 [Catawba County, Hickory, North Carolina], Tr. 7566 [Northwestern Denver, Colorado], Tr. 5958 [Allegheny County, Pittsburgh, Pennsylvania], Tr. 9596 [New Haven, Connecticut]; RX 267, p. 1 [Hennepin County, Minneapolis, Minnesota], 489, p. 1a [Lane County, Eugene, Oregon], 666, p. 1 [Allegheny County, Pittsburgh, Pennsylvania]). Except in isolated instances (Tr. 5845-46, 5770-72, 5950; RX 666), physicians' directories sponsored by local medical societies frequently omit information relating to individual physicians' fees, acceptance of Medicare reimbursements as payment in full, special facilities, and other aspects of physician availability and services (RX 267, 489, 526, 656, 677). The directories may contain information which, because of publishing lag time, is out of date and possibly inaccurate (RX 407, p. 1, 489, p. 1a, 656, p. 5); publication of updated editions is not assured (Tr. 7556-57, 5470). In any event, these directories have received little attention from consumers in the service areas that they purport to cover. In the Denver metropolitan area, with a population of approximately two million people, only about 700 copies of a medical society-sponsored physician directory were sold to consumers in the first nine months after publication (Tr. 7551-53, 7573). Dissemination of other physician directories also has been minimal (Tr. 5774, 5779, 2398, 5468, 5888-89, 5987-90). Advertising that directories are available is needed (Tr. 9355).

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

Information on physicians obtained by word-of-mouth does not in itself provide an adequate basis for selecting a physician (Tr. 2525, 2552-53, 2292, 2297, 9319-20).

The small number of physicians a consumer can learn about from his friends and relatives may not provide the type of services that the consumer is seeking or be in a location convenient to the consumer (Tr. 2525, 2552-53). For a newcomer in a community of newcomers, word-of-mouth information may be largely unavailable (Tr. 2292, 2297). Moreover, word-of-mouth information spread from one consumer to another is anecdotal (Tr. 9537), reflects the speaker's personal preferences (RX 297, p. 1) and may prove faulty (Tr. 9320).

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

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

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

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

91. The AMA Principles of Medical Ethics ("Principles"), the 1971 AMA Opinions and Reports and other AMA medical society interpretations of the Principles prohibit solicitation of patients and severely restrict advertising and solicitation of patients by physicians. Section 5 of the AMA Principles of Medical Ethics states that a physician "should not solicit patients" (CX 462Z4; RX 1, p. 5). */ Opinions 6, 11, 12, 13, 18, 23, and 29 of Section 5 in AMA's 1971 Opinions and Reports also contain absolute prohibitions on solicitation of patients or patronage, whether directly or indirectly, by a physician or by groups of physicians (CX 462Z5-Z11). For example, Opinion 6 states, inter alia, "Solicitation of patients, directly or indirectly, by a physician or by groups of physicians, is unethical" (CX 462Z5). Opinion 12 states, inter alia: "The ethical principle remains: No physician may solicit patients. A physician may not do indirectly that which he may not do directly. He may not permit others to solicit patients for him" (CX 462Z7). In its 1971 Opinions and Reports (CX 462Z13) and 1974 Report On Physician-Hospital Relations (CX 959Z64), AMA defined "solicitation" as "to seek professional patronage by oral, written or printed communications either directly or by an agent." This definition has been adopted by the AMA House of Delegates (Compare CX 463V with CX 462Z13).

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

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*/ Section 5 of the Principles of Medical Ethics reads as follows:

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

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

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

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

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

Statements of a number of AMA's member societies further show the sweeping nature of the ethical prohibition of physician advertising. In 1972, respondent CSMS's executive director declared that,"'Advertising' is prohibited by medical ethics" (CX 30, 31).

In October 1973, the Judicial Commission of the Michigan State Medical Society stated in an ethics advisory letter that "individual physicians or groups of physicians are not

permitted to advertise their services under the provisions of the American Medical Association Code of Ethics . . ." (CX 1602G). In May 1974, the Judicial Commission's members reiterated "[t]he ethical principle that physicians are not allowed to advertise under any circumstances . . ." (CX 1607B).

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

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

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

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

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

> The component medical society must, in the final analysis, determine what practice is in accord with local custom, but in so doing, it should exercise great caution to insure full compliance with the spirit and intent of the Principles. The practice of medicine

should not be commercialized nor treated as a commodity in trade. Respecting the dignity of their calling, physicians should resort only to the most limited use of advertising .... (CX 462Z9).

In 1967, the Secretary of the AMA Judicial Council advised a component society inquiring about a large sign on a physician's lawn advertising certain medical treatments that it "suggest to the physician that this sign was, in the opinion of the Society, contrary to the honor and dignity of the profession and should be removed . . ." (CX 91).

In June 1975, AMA advised a component society that:

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

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

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

1. Restrictions on Dissemination of Price Information

95. In 1974, an organization in Bergen County, New Jersey, specializying in preventive medicine, submitted to the local medical society a proposal to send a form letter to the Mayors and Councils of the 72 communities in the county (CX 112B). The proposed form letter offered physical examinations for the communities' firemen, police

and volunteer ambulance corpsmen at $50 each (CX 112B). A local medical society official forwarded the proposal to AMA, commenting: "I question the ethics involved and feel that it borders on solicitation. However, in all fairness to the group, they do have a tremendous investment and do need to get their message out" (CX 112A). Edwin Holman, Director of AMA's Department of Medical Ethics, responded: "I agree with you that this letter is out and out solicitation of patients or patronage as proscribed by Section 5 of the Principles of Medical Ethics and Opinion 11 thereunder, a copy of which is enclosed" (CX 111).

In 1969, a Minnesota physician wrote to AMA stating that he was contemplating running a pap smear clinic for one week during which he would reduce his fee for a pap smear and pelvic examination by one-fourth. Stating that he wished to alert the community to the program through newspaper and radio announcements, the physician asked AMA for its opinion (CX 170A). The Assistant Secretary of the AMA Judicial Council (CX 524A) cautioned the physician against sponsoring the newspaper and radio announcements:

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

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

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

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

At a meeting of an ad hoc committee of the Chicago Medical Society charged with preparing guidelines on physician advertising, it was mentioned that fees should not be listed in physician announcements (CX 2117A, B). The guidelines subsequently issued by the Chicago Medical Society in 1975 omitted fees from the list of items of information which a physician or health plan could include in newspaper announcements (CX 2122B, C; 2121). Edwin Holman, Director of the AMA Department of Medical Ethics, attended meetings of the ad hoc committee as an AMA consultant and approved the committee's final report (CX 2121; Tr. 4919, 4939).

The Illinois State Medical Society drafted "Guidelines for Consumer Information Materials (Physician Directories)" in 1975 for its component medical societies to apply in their communities (CX 718). Quoting the AMA Judicial Council's 1974 opinion on physician directories, which

forbids inclusion of "self-aggrandizing" statements in directory listings (CX 718B, 507B, D; F.134, pp. 191-92), the Guidelines stated that a physician directory "should not be a comparison of fees" (CX 718B). The Guidelines also declared that "ISMS does not recommend publishing individual physician's fees" (CX 718G). Other AMA member societies have opposed the inclusion of fee data on individual physicians in community directories (CX 2178C, 2179A, 680, 2035, 2186A, D, 2303B, 2304; RX 887; Tr. 2383-84, 2410, 5460-63).

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

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

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

In numerous instances, physicians have been admonished by their local medical societies for sending out brochures and letters which included fee or billing information among other things (F. 99, pp. 130-31; 110, p. 145; 112, pp. 147-48; 136, pp. 194-97).

Physicians establish "usual" fees for the services, procedures and tests they perform (F. 40, p. 51; Tr. 7726-30; RX 267, pp. 7-8; CX 2186D, 705H; RX 407, p. 5; RX 526, p. 7; RNHX 149C; CX 738, 979C, 4A, 1866C-E; RX 251B).

These services, procedures, and tests are identified and coded in standardized terminology and relative value guides used by physicians, respondent medical associations, insurance companies and governmental agencies (F. 40, p. 52; 63, pp. 85-86; 81, pp. 98-99; RX 18, pp. 155-71; Tr. 7729-30). During the period of federal price controls in the 1970's, federal regulations required all medical practitioners to post a sign in their facilities announcing the availability for public inspection of a schedule showing their customary prices for those services which accounted for 90 percent of their aggregate annual revenues (CX 2602). From this evidence, it is concluded that physicians' fees are readily capable of being publicized in a nondeceptive manner.

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

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

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

In June 1972, a physician in San Francisco wrote to an insurance company offering to perform medical examinations for it. The letter briefly described the physician's

services and facilities and invited a representative of the insurance company to inspect his office (CX 25B). A claim analyst at the insurance company sent the letter to the AMA's Department of Medical Ethics for its opinion (CX 24, 25A). AMA responded that the physician's letter constituted solicitation in violation of Section 5 of the Principles of Medical Ethics (CX 23). AMA also urged the claim analyst to send a copy of the physician's letter to the San Francisco County Medical Society for whatever action would be considered appropriate (CX 23).

In 1973, the president of the Erie County (Ohio) Medical Society wrote to AMA regarding the ethics of a small advertisement that a board certified thoracic surgeon had placed in newspapers and distributed by mail (CX 51C). The announcement contained only the doctor's name, address, telephone number and the statement that he was opening "a laboratory for Cardio-Pulmonary and Heart Catheterization diagnosis and office for the practice of Thorasic-Cardiovascular [sic] Surgery and Internal Medicine and Cardiology on July 1, 1973" (CX 53). The Secretary of the AMA Judicial Council responded by enclosing a copy of the 1971 Opinions and Reports and calling the local society official's attention to Opinions 16 and 17 of Section 5 (CX 52, 46228). He stated in his letter that:

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

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

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

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

97. AMA's 1971 Opinions and Reports provides that AMA's ethical principles, including those restricting advertising and solicitation, apply to medical clinics and groups as well as individual physicians (CX 462I, J, K, Z5, [Preamble, Ops. 2, 6, 8; Sec. 5, Op. 8]), and that contractual arrangements between a physician and any health care organization that seeks professional patronage by oral, written, or printed communications are unethical (CX 462Z12, Z13 [Sec. 6, Ops. 2, 3]). In December 1974, the AMA's House of Delegates adopted a resolution declaring unethical any advertising by a prepaid medical care plan or a health maintenance organization which identifies any physician providing services to the plan's members or subscribers (CX 951). These ethical restrictions have been applied, inter alia, to prepaid group health plans, including health maintenance organizations, medical clinics offering specialized services and preventive medicine programs.

a. Innovative Clinics and Preventive Medicine Programs

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

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

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

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

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

the other clinics which compete with PIMC are the Sunnyvale Medical Clinic and the Palo Alto Medical Clinic (Tr. 2055, 2057-59, 2063).

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

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

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

In October 1974, Dr. LaDou complained to the SCCMS that a clinic which competed with PIMC was soliciting lay executives of Santa Clara area firms in a manner which the Medical Society had told PIMC was impermissible in 1973 (CX 760). Dr. LaDou stated that if the Medical Society allowed the competing clinic to continue this solicitation, it would only be fair to permit PIMC to do the same (CX 760). The Medical Society responded by calling Dr. LaDou and the medical director of the competing clinic to a meeting of its Professional Standards

Committee (Tr. 2072-73). The Committee reviewed specific passages from the AMA's 1971 Opinions and Reports and gave the two physicians copies of the Opinions and Reports, with several provisions referring to restrictions on solicitation and advertising underlined (Tr. 2973-74).

In an April 1975, letter to Dr. LaDou, the SCCMS's Professional Standards Committee announced guidelines prohibiting outside industrial physicians from making any direct contacts with companies through personnel officers or other executives (CX 759). In a July 1975, letter to Dr. LaDou, the Medical Society's Professional Standards Committee stated that the guidelines also applied to nonphysician sales agents of industrial physicians (CX 1751). The letter quoted in full Opinion 6 of Section 5 of AMA's 1971 Opinions and Reports entitled "Solicitation of Patients, Direct or Indirect" (CX 46225), and stated that the Committee "trusts that you will conform to the ethical standards of our medical community" (CX 1751).

Dr. LaDou interpreted the 1975 Medical Society guidelines to prohibit PIMC from talking to lay people about occupational health and safety programs and to deny PIMC totally the opportunity to expand occupational safety and health coverage in smaller industry in its area (Tr. 2076). Dr. LaDou and PIMC have abided fully by the guidelines with respect to nonclient companies (Tr. 2077). The only lay representatives PIMC has dealt with directly were the approximately 50 existing client companies of PIMC; Dr. LaDou testified that he deals frequently enough with them such that he knows there will be little likelihood of his being reported to the local medical society (Tr. 2077). Due to fear of disciplinary action against him, Dr. LaDou has never made the general promotional mailing to Santa Clara area companies which he proposed in his August 1973, letter to the Medical Society (Tr. 2077-78).

In July 1976, the Santa Clara County Health Department asked PIMC to participate in the national Swine Flu Immunization Program by contacting both client and non-client companies in the county about PIMC providing immunizations to their employees (CX 762). PIMC accepted the invitation and mailed an announcement of immunization services to a number of area companies (Tr. 2083; CX 763). Physician members of the Palo Alto Medical Clinic and the

Sunnyvale Medical Clinic complained to SCCMS about PIMC's Swine Flu Program announcement (Tr. 2057-58, 2084-85). In October 1976, Dr. LaDou was called to a meeting at which three SCCMS officials informed him of the complaints against PIMC and again showed him a copy of AMA's Opinions and Reports (Tr. 2085-86).

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

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

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

> I find the client companies relying heavily on the local medical society. They call it the AMA. They say when they are looking for a new source of medical care, they will call the AMA and find out who is legitimate and who they would recommend. What they are in fact calling is the Santa Clara County Medical Society,

> which is what the telephone operator would give you if you asked for the AMA. Under the circumstance like that, to show a letter, a stern warning to me for unethical behavior to a potential industrial client would be very damaging in a competitive situation. (Tr. 2094).

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

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

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

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

Dr. James Warren

99. James Warren, M.D., head of the Department of Obstetrics and Gynecology at Washington University Medical School, St. Louis, Missouri, testified in this proceeding. In his capacity as Department head, Dr. Warren is also medical director of the Washington University Center for Outpatient Gynecological Surgery ("Center"), which is staffed by members of the Department who perform various surgical procedures such as tubal ligations and pregnancy terminations on an outpatient basis (Tr. 721-23). In January 1975, to publicize the Center, assist its patients and clarify the guidelines under which pregnancies were being terminated, Dr. Warren prepared a brochure describing its facilities, services, specific fees and office and billing procedures (CX 979A-E; Tr. 723, 725). At that time, the Center was unique among facilities performing abortions in St. Louis in that it was immediately adjacent to a complete hospital (Tr. 726-27). This enabled the Center to transfer quickly to a hospital operating room any patient developing complications in the course of outpatient surgery (Tr. 726). The brochure was distributed to physicians in the St. Louis area using the St. Louis Medical Society's facilities and mailing list; it was not distributed to the lay public (Tr. 724).

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

In early February 1975, the Council of the Missouri State Medical Association passed a resolution providing, with respect to the Center's brochure, that "Washington University was to be reminded by the . . . Council that advertising and solicitation of patients was unethical" (CX 976). A week later, on February 14, 1975, the Council wrote to the dean of the Washington University School of Medicine declaring that the brochure "constitutes a breech [sic] of medical ethics regarding solicitation" (CX 971A). The letter referred to, and enclosed copies of, Opinions 6, 7, 8, 11 and 12 of Section 5 of AMA's

1971 Opinions and Reports (CX 971A-B, 46225-27). At a meeting on February 14, the Ethics Committee of the St. Louis Medical Society considered the brochure and Dr. Warren's apology, and decided that the brochure was "patently unethical" advertising and solicitation (CX 969A). The Committee recommended that the Medical Society censure Dr. Warren (CX 969A).

In April 1975, the chairman of the Medical Society's Censors Committee wrote to Dr. Warren to inform him of the ethical charges of solicitation (Tr. 730-33). He enclosed a copy of AMA's Principles of Medical Ethics (Tr. 732-33; CX 982). At a meeting with Dr. Warren later that month, the Medical Society official told him that the controversy over the Center brochure could be put to rest if Dr. Warren wrote a second apology letter (Tr. 737-42). In May, Dr. Warren sent a letter to the Censors Committee chairman apologizing for his actions and assuring the members of the Medical Society that he would not repeat them (CX 975C). Characterizing Dr. Warren's letter as one "in which the physician recants, repents and promises in the future not to repeat this action," the Censors Committee reported to the Medical Society's Council that the matter had been resolved (CX 975B). In early June 1975, the president of the Medical Society sent a form letter to all Medical Society members enclosing copies of Dr. Warren's letter of apology and the Censors Committee Report (CX 975A).

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

Dr. Richard Hansen

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

The program, called "Operation Heartbeat," charged each patient $25 for the package of tests, approximately half of what a hospital or private doctor in the area would have charged to administer the same tests (Tr. 1813, 1815). It received free publicity on radio, television and in the newspapers, and local stores placed posters announcing the program in their windows (Tr. 1812, 1815-16). Some of the printed publicity carried the name and picture of the program's cardiologist (CX 2005; Tr. 1816, 1821). The program was held three or four times in the fall and winter of 1973-74 (Tr. 1818). In 1974, the Medical Society summoned Dr. Hansen to a meeting of the Society's Board of Governors to inform him that the inclusion of the cardiologists' name and picture in Operation Heartbeat's publicity violated an AMA Opinions and Reports section on advertising (Tr. 1822-23). Dr. Hansen was told by a Medical Society official that it was cardiologists in the area who had raised the objections about the program's publicity (Tr. 1820-21). After the meeting, the Medical Society sent Dr. Hansen a letter recommending that, if the program were held in the future, a physician licensed in Tennessee should conduct the program and that any future announcements of Operation Heartbeat should be worded so as "to avoid the appearance of advertising, which, as you know, is unethical according to the AMA Code of Ethics" (CX 108). Dr. Hansen dropped the program shortly after receiving the letter (Tr. 1829).

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

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

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

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

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

> As you know, Section 5 says that the physician should not solicit patients. It is axiomatic that a physician may not do indirectly that which he cannot do directly. The mere fact that the College solicits patients on behalf of the specialists does not change the nature of the act.
>
> This is a situation that has occurred infrequently in several widely scattered college communities. Experience has very definitely indicated that beyond question that the best way to resolve situations like this is to convince the College that its practice is in derogation of medicine's long established ethical principle, and demeaning to the profession as a profession and is unacceptable to physicians as individuals (CX 768).

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

b. HMOs and Other Prepaid Group Practice Plans

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

AMA has promulgated several restrictions on prepaid group practice plans' advertising and solicitation activities, in addition to extending the ban on solicitation to physician groups and clinics and prohibiting contract medical practice involving solicitation (See F. 97, p. 120. AMA's 1971 Opinions and Reports declared that "[t]he medical profession must oppose any prepayment or postponement program that might result in advertising or solicitation of patients by physicians . . ." (CX 462Z22 [Sec. 7, Op. 13]). In 1973, and again in 1974, the AMA Judicial Council ruled that although a health maintenance organization could advertise its payment or insurance aspects, it could not ethically solicit patients (CX 512C-D, 510B-C). The Council noted that where one practice ends and the other begins may require astute investigation of the facts of the particular case (CX 510C).

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

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

Constituent and component medical societies of AMA which require their members to abide by the AMA Principles of Medical Ethics have issued further ethics interpretations restricting advertising

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

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

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

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

Florida Health Care Plan

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

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

that ... had difficulty hiring any new physicians. Trying to balance the number of staff physicians with the number of enrollees has caused financial problems for FHCP (Tr. 9182-83).

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

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

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

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

FHCP placed an advertisement in a newspaper at the time it received federal certification in 1975 (Tr. 9193-94). Since then, FHCP has not advertised or placed a listing in the Yellow Pages of the telephone directory because it could not get any clarification on the ethics of advertising in Volusia County and did not want to incur the displeasure of the state or local medical societies (Tr. 9194). As

required by federal law, FHCP has printed a list of its staff physicians and a brochure, but it never mails them out to the general public (Tr. 9192-93).

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

Arizona Health Plan

104. The Maricopa County Medical Society, the AMA component organization in Phoenix, Arizona (CX 1568E), has hindered the marketing efforts of two local HMOs through the application of ethical restrictions based on AMA's 1971 Opinions and Reports. The Arizona Health Plan ("AHP"), a state-certified HMO in Phoenix, supplies physician, hospital and other health services to approximately 40,000 subscribers on a flat-prepayment, non-fee-for-service basis (Tr. 78-79, 84). The Maricopa County Medical Society opposed AHP's early development, in 1970 and 1971, because it felt that the Plan was no different than a Kaiser-type closed panel system and was "unacceptable" to organized medicine (CX 1569, 1570A-B; Tr. 91-92). The Medical Society wanted the efforts to promote AHP terminated, in part to prevent it from competing with the Medical Society's own Maricopa Foundation (CX 902; Tr. 96-98). The Maricopa Foundation offers subscribers a plan for financing medical services obtained from privately practicing physicians on a fee-for-service basis (Tr. 97-99). The Foundation stated, in a December 1976 letter to its over 1200 participating physicians, that it is a "competitive alternative" to HMOs in Maricopa County and that it seeks to keep patients in the private practice sphere (CX 933).

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

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

The Medical Society's 1974 HMO Guidelines have handicapped AHP in its marketing efforts (Tr. 129, 142, 272). AHP has refrained from distributing lists of its staff physicians to potential subscribers (Tr. 114-15). The restriction on the holding of open houses has made the recruitment of federal employee subscribers difficult for AHP (Tr. 130-31). Compliance with the advertising preclearance requirement has been time consuming and has hindered the scheduling of AHP's advertising program (Tr. 131-32).

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

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

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

ABC-HMO

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

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

of the addresses of HMO facilities in advertisements (CX 927). Dr. Foster responded that ABC-HMO would see to it that its advertising did not include the addresses of its medical center locations (CX 928).

Harvard Community Health Plan

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

In 1970, Blue Cross, with which HCHP was then affiliated (Tr. 451), placed several advertisements in the news media to promote the new health plan (Tr. 454-55). MMS received a number of letters from physicians complaining that the HCHP advertising was attracting patients away from private practitioners (CX 2148, 2151B, 2153) and was unethical (CX 2147-51). The Society's Ethics and Discipline Committee discussed the complaints with HCHP and expressed concern over the ethics of pursuing advertising and widespread solicitation through the newspapers, television and radio (CX 2133). In 1971, HCHP agreed to refrain from advertising in the future (CX 2139-40) and instructed Blue Cross not to advertise on its behalf (Tr. 460).

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

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

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

In late 1976, the HCHP physicians, taking into consideration the instant FTC proceeding among other things, reversed their position and authorized the health plan to advertise in the media (Tr. 474-75). The medical director of HCHP proposed guidelines for the advertising which incorporate the AMA and MMS restrictions on HMO advertising (CX 883C, 877, 880A; F. 102, p. 134). The guidelines declare that HCHP advertisements should avoid qualitative statements about the professional staff and/or services offered and should not mention the names of staff physicians or the medical schools or hospitals at which they trained (CX 883B). Prospective subscribers sometimes telephone HCHP to ask whether a particular physician is on HCHP's staff (Tr. 547). HCHP does not give out such information because giving out the names of staff physicians to non-subscribers is "an unethical form of advertising" (Tr. 547-48). Mr. Biblo, HCHP's president, would like to see a "less bland" advertising approach, one which discusses the differences between HCHP's services and costs and those of fee-for-service physicians (Tr. 478-79, 481). HCHP does not do this sort of advertising today because it would prompt ethical objections among HCHP's physicians based partly on their feelings about how the Ethics and Disciplinary Committee of the MMS would react (Tr. 479, 481).

Metro Health Plan

107. Two private physicians complained to the Michigan State Medical Society, in April 1973, that Blue Cross-Blue Shield advertisements on behalf of its HMO in Detroit, the

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

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

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

The latter motion was published in the Michigan State Medical Society's November news bulletin (CX 1731A). Blue Shield asked the Medical Society to identify those references in the HMO's advertising--newspaper or radio--which it found disturbing (CX 1602K). The Society responded that it was not the specific wording of the advertisements that was in question, but rather the entire concept that physicians were advertising (CX 1602L).

In March 1974, the Medical Society's Judicial Commission wrote to MHP, noting that MHP had not stopped advertising (CX 1602E). The Judicial Commission expressed its hope that MHP would stop advertising so that the Judicial Commission would not be forced to consider ethical charges against the

specific doctors participating in the Plan (CX 1602E). Following a Judicial Commission meeting attended by MHP representatives, the Judicial Commission, in June 1974, reaffirmed its earlier opinion that advertising by both physicians and HMOs was unethical and could lead to disciplinary action against the physicians involved (CX 1602B). The Judicial Commission relied for authority on AMA's Principles of Medical Ethics and Opinions 6 and 8 of Section 5 of AMA's 1971 Opinions and Reports (CX 1602B, 4622S). In October 1974, the Medical Society's Judicial Commission reported that, as far as it was able to determine, MHP's unethical advertising had ceased (CX 1605).

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

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

1. Announcements, Form Letters, and Brochures

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

Opinion 16 of Section 5 of AMA's 1971 Opinions and Reports declares: "Announcements of the opening of an office should not be mailed indiscriminately to all persons in the community, nor should commercial mailing lists be utilized" (CX 4622S).

Opinion 11 of Section 5 of AMA's 1971 Opinions and Reports permits "dignified" announcements, provided they do not amount to solicitation, which is a question of fact to be determined locally by the local medical societies. Opinion 11 limits the content of such announcements to name, type of practice, location of office, office hours and the like (CX 4622S).

Opinion 14 of Section 5 permits a doctor to send announcements regarding the need for follow-up care only to his own bona fide patients (CX 4622S). The interpretation further provides:

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

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

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

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

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

In numerous instances, the AMA and local societies have invoked the ethical restrictions on advertising resulting in the restraint of member physicians' distribution of announcements, form letters and brochures (F. 110-12, pp. 145-48), even to other physicians (F. 110, p. 145; 112, pp. 146-47).

Dr. Charles Arnold

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

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

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

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

In January 1974, in response to a telephone call from Dr. Arnold, WSMA stated that, if PCMS revoked his membership, he would also lose his membership in WSMA and in AMA (CX 132B). WSMA also noted that Dr. Arnold would not be eligible to renew the WSMA Professional Liability Insurance Program sponsored by the Aetna Insurance Company if he lost his membership in the county and state societies (CX 132B). In June 1974, Dr. Arnold withdrew his membership in PCMS (CX 133).

Anthropometrics

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

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

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

Other Incidents

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

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

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

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

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

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

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

The letter then quoted Opinion 8 of Section 5 in AMA's 1971 Opinions and Reports (CX 4622S), and ended by stating that the brochure should be recalled and not distributed (CX 2071).

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

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

2. Newspaper Advertising

Dr. Cyril Lundvick

113. In 1975, two medical societies in Washington State (CX 474B, 475H, K) relied on AMA's 1971 Opinions and Reports in an ethics action to stop a physician, new to the area,

from advertising in the newspaper. In late 1974, an ophthalmologist from Tacoma, Washington, Dr. Cyril Lundvick, moved his office to Kitsap County, Washington, and applied for a transfer of his medical society membership to the Kitsap County Medical Society ("KCMS") (CX 58-60). In January 1975, the ophthalmologist's name, specialty and address appeared in a one-inch space at the bottom of an optical dispensary's advertisement in the local newspaper (CX 61B). Early the next month, the physician, who chaired the local hospital's Department of Ophthalmology, wrote to the Executive Director of the Washington State Medical Association ("WSMA") stating that the advertisement might be a breach of professional ethics (CX 61A). In February 1975, the Executive Director of WSMA wrote to the Executive Secretary of KCMS regarding the physician complaints about the ophthalmologist's advertisement (CX 62). The WSMA official called KCMS's attention to Opinion 6 of Section 5 of AMA's 1971 Opinions and Reports and stated that Dr. Lundvick's ad appeared to be contrary to it (CX 62).

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

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

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

Dr. Ralph Robinson

114. In 1976, a local medical society in Knoxville, Tennessee, prohibited physicians from affiliating with clinics which advertised in the public media. The ruling, based on the advertising restrictions in AMA's 1971 Opinions and Reports, led a reputable abortion clinic in Knoxville to curtail its advertising efforts.

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

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

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

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

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

> [W]e understand your practice in this community will be largely related to one of the abortion clinics. Our Executive Committee questions the propriety and ethical considerations of the daily newspaper ads. Our concern is based upon the Judicial Council Opinions and Reports of the American

> Medical Association; namely, on pages 24-25 [CX 46226, Z7] and I quote: 'The ethical principle remains: no physician may solicit patients. A physician may not do indirectly that which he may not do directly. He may not permit others to solicit patients for him.' Our By-Laws clearly state that any member of our staff must abide by the Code of Ethics of the American Medical Association (CX 48).

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

In the absence of the ethical prohibition against advertising, the Volunteer Medical Clinic would like to advertise its services and fees in newspapers and on radic and television (Tr. 644-45, 674). An abortion performed at a Knoxville hospital costs between $450 and $600; an abortion performed at the Clinic costs $175 (Tr. 634-36).

Additional Newspaper Advertising Incidents

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

James Martin

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

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

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

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

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

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

> [T]he legal opinions of Vern Miller [the Attorney General of Kansas, CX 737K] . . . [have] nothing to do with our Canons of Ethics, [and] the threat of professional boycott to your client [Medi-Call] I think is significant and most assuredly will occur . . . .
>
> Now listen here you are legal but we are still declaring you unethical . . . . [I]f you continue advertising, I will continue to believe that you are unethical. The fact that you are legal doesn't influence me at all . . . . Now if you want to criticize the system that brought me up to believe this, criticize it . . . . Your client didn't know the Canons of Ethics and that's that. He needs the book read to him and that's what we're doing. You understand that? (CX 2156 A, B, E, L).

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

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

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

4. Publicity in the News Media

a. General Restrictions on Media Publicity

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

Opinion [illegible] of Section 5 states: "Among unethical practices [illegible] are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned" (CX 4623S).

Opinion 13 of Section 10 prohibits "self-exploitation" by means of physician publicity and requires physicians to clear certain publicity with their local medical society in advance (CX 462Z44). The Opinion states, in part: "Photographs of physicians in connection with civic or social affairs, not related to medical news or the care of patients, may be published unless the frequency of such photographs bespeaks self-exploitation. This applies also to magazine articles. Physicians should clear such publicity, whenever possible, with their county society" (CX 462Z44).

The 1977 Opinions and Reports contains a similar provision (RX 1, p. 35).

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

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

In 1975, the Chicago Medical Society adopted guidelines specifying the limited types of information which a physician may include in a news item in a neighborhood newspaper to announce the opening of his practice (CX 2122B; F. 95, p. 120).

The guidelines state that telephone numbers are not considered appropriate (CX 2122B). Edwin Holman, Director of the AMA Department of Medical Ethics, participated in the writing and approval of the guidelines (F. 95, p. 120).

In February 1976, the Santa Clara County (California) Medical Society published guidelines prohibiting promotional statements which are considered self-aggrandizement or solicitation (CX 751C).

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

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

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

The Code contains provisions which discourage the use of physicians' names in media publicity (CX 898D) and label as unprofessional conduct the printing of physicians' addresses or telephone numbers in programs or articles of general public medical information (CX 898F). The Code condemns as unprofessional conduct any regularly appearing radio broadcast, television appearance, or signed column by a physician in active practice, which is not specifically authorized by the Medical Society (CX 898G). In drafting the "Radio-Press and TV Code," the Medical Society was influenced by AMA's 1960 Opinions and Reports provisions relating to advertising and solicitation (CX 1919S-U).

b. Incidents Involving Physician Publicity

119. In 1967, an AMA component medical society (CX 1979C, E, 475H, K) asked AMA to comment on a physician's article on heart care published in Seattle magazine (CX 145A). In reply, AMA sent copies of Opinion 4 of Section 10 of the 1964 Opinions and Reports (CX 465Z11, 462Z39, Z40) and the media guidelines which AMA included as Opinion 13 of Section 10 of its 1971 Opinions and Reports (CX 462Z42-Z45, 145A). AMA also offered a standard for the local society to apply in determining whether the physician had acted improperly:

> If it finds that the article was instigated by a particular physician for his own self aggrandizement or finds in its preparation an attempt of a particular physician to aggrandize himself, then perhaps the Media Relations Committee might want to present this matter to the Ethics Committee for further consideration (CX 145A).

A 1971 article published in the New York Times Magazine concerning the physician for the Jets football team included a footnote stating that permission to do the article had to be obtained at considerable delay from the Medical Society of the County of New York. The Society's executive director sent a copy of the article to the Secretary of the AMA Judicial Council (CX 177). The AMA official wrote back to commend the county medical society "for the manner in which this feature story was handled"(CX 175, 516E).

The Knoxville Academy of Medicine, an AMA component society (F. 114, p. 150),asked AMA in 1972 whether it would be ethical for a dermatologist to write a column for a local newspaper (CX 184). The Director of the AMA Department of Medical Ethics responded with a copy of the 1971 Opinions and Reports and the advice that Opinion 6 of Section 10 (CX 462Z40) suggests that it is inadvisable for physicians in active practice to write health columns for lay readers (CX 183).

In 1973, the Bergen County (New Jersey) Medical Society sent AMA a local chamber of commerce publication containing an article by a former president of the Medical Society, entitled "Preventive Medicine-Its Importance to Business and Industry" (CX 36, 1747). The Medical Society asked whether the article was a "questionable case as far as

advertising is concerned" (CX 36). In its reply, AMA referred the Medical Society to Section 10 of the 1971 Opinions and Reports (CX 462Z38 - Z45) and commented, "[I]f one physician extols his own services, facilities, competence, etc. what is to prevent another physician from doing likewise and then what is the need of a medical society at all?" (CX 1747).

In June 1974, a member of the CSMS Council, the executive body of CSMS (F. 11, p.9), filed a formal complaint with NHCMA concerning alleged advertising by an NHCMA member physician who practiced acupuncture (CX 701A). The NHCMA Board of Censors considered the charges at a June 24,1974 meeting attended by the accused physician (CX 701A, B). The Board indicated that a newspaper article based on an interview with the physician on "the medical approach to acupuncture . . . left a feeling like it was advertising" (CX 172A). The Board consulted Opinion 4 of Section 10 in AMA's 1971 Opinions and Reports (CX 701B, 462Z39-Z40); it warned the physician never again to discuss this subject with the daily papers (CX 172A) and to disseminate information through recognized medical journals in the future (CX 701A). The Board decided not to take further action largely because the physician had granted the newspaper and television interviews in question as chairman of the official CSMS Ad Hoc Committee on Acupuncture (CX 172A, 701A, B). After hearing a report from the Peer Review Committee, the NHCMA Board of Governors decided to furnish transcripts of the NHCMA proceedings on the matter to the CSMS Council (CX 173A, B).

Dr. Edward Diethrich

120. In the early 1970's, the Maricopa County (Arizona) Medical Society ("MCMS") denied membership in the society to Dr. Edward Diethrich, a cardiovascular surgeon and director of the Arizona Heart Institute, on grounds of unethical advertising and publicity based on the Society's "Radio-Press and TV Code" and the AMA Principles of Medical ethics. The MCMS, the AMA Judicial Council and other professional medical societies participated in the actions against Dr. Diethrich because of the alleged unethical advertising and publicity. Dr. Diethrich testified in this proceeding that these actions by the MCMS and the AMA had adversely affected the Arizona Heart Institute.

Dr. Edward Diethrich is a board certified cardiovascular surgeon practicing in Phoenix, Arizona (Tr. 1262). He has won a number of awards for his achievements in medical education, research and practice, including two major scientific awards from AMA (Tr. 1264, 1265, 1270-71, 1280-81). He trained under, and later worked closely with, the noted cardiovascular surgeons in Houston, Drs. Michael DeBakey and Denton Cooley (Tr. 1265-67). In addition to performing

over 1,000 heart operations a year in Houston, he was an assistant professor of surgery at the Baylor College of Medicine and conducted research (Tr. 1266-70). During this period in which Dr. Diethrich was an active member of AMA, he frequently attended conventions and presented papers and scientific exhibits (Tr. 1274). He testified that he valued his AMA membership for the opportunity it gave him and his associates to present their scientific work to the medical world, for the assistance it provided him in applying for research grants and obtaining patient referrals and for the prestige it accorded him (Tr. 1274-76).

In 1971, Dr. Diethrich and a team of physicians moved to Phoenix and established the Arizona Heart Institute for the study and treatment of cardiovascular problems (Tr. 1281-83). The Institute, which occupies a specially constructed wing of a hospital, brought the latest diagnostic and treatment procedures to Phoenix (Tr. 1283-91). The Institute also charged fees which were often less than those of competing cardiovascular surgery practices (Tr. 1357-58).

In the spring of 1971, the Arizona Heart Institute held a press conference to publicize its establishment and the programs it would be introducing (Tr. 1294). In May 1971, the President of MCMS wrote Dr. Diethrich that:

> The physicians in this area have traditionally adhered to the code of ethics regarding all publicity and have cleared news releases, public speeches, T.V. appearances and other public contacts through the Society.
>
> I would request that public relations efforts regarding the institute be kept strictly within acceptable ethical bounds so that all physicians in this city will be fairly regarded (CX 1407).

On March 6, 1972, the chairman of the Medical Society's Professional Committee wrote to the director of public relations at the hospital with which the Arizona Heart Institute was associated. He thanked the hospital's public relations staff for attending a meeting with the Professional Committee, and expressed his feelings that the Institute was a superb facility with an unusually qualified director and his hope that the public relations department of the hospital and the Professional Committee would work with one another. He also

expressed concern that unusual publicity for any one group of physicians usually creates antagonism in other physicians (CX 1408 A). In April 1972, the chairman of the Professional Committee complained about Dr. Diethrich's "self aggrandizing" publicity in a letter to the chief of staff of the hospital with which the Arizona Heart Institute was affiliated (CX 1409). The letter stated that Dr. Diethrich was not a member of the Medical Society so that the Society did not have jurisdiction over his activities, but the letter noted that the chief of staff of the hospital could remind the hospital staff and the hospital board of trustees that Dr. Diethrich's constant publicity has become self-aggrandizing. The letter also referred to possible loss of referrals as a result of continued publicity: "[The publicity] has antagonized many physicians in Phoenix against the Institute. It would be a shame that a facility like the Arizona Heart Institute would find no support among referring physicians and other physicians" (CX 1409).

In June 1972, the Medical Society's Professional Committee invited Dr. Diethrich to a meeting to question him about his recent network television appearances on the Johnny Carson and Dick Cavett Shows (CX 1410; Tr. 1299-1300). Dr. Diethrich did not attend the June meeting. At a meeting of the Society's Board of Censors in September, Dr. Diethrich was told he would have to abide by the Society's Radio, Press and TV Code. Dr. Diethrich stated that he could not abide by the Society's Code (CX 1413A-B) and still raise enough funding for the continued development of the Institute (Tr. 1303-06). As a result, the Board of Censors voted to table his application for membership in the Medical Society (CX 1413A; Tr. 1306).

Prior to the meeting, the Board chairman told Dr. Diethrich that the Society's opposition to the Institute's publicity was due to some members' feeling that the publicity was "unfair economic competition" (Tr. 1308).

Shortly thereafter, Life Magazine published a highly complimentary article on Dr. Diethrich and his Arizona Heart Institute (CX 2010). On October 12, 1972, the MCMS wrote to AMA enclosing a copy of the article and seeking AMA's advice: "The members of our Board of Censors feel that this is an example of blatant self-advertising and is not in accordance with the AMA code of ethics. We would like to have your opinion as to what might be done to curb Dr. Diethrich's endeavors to publicize himself" (CX 1415). The Secretary of the AMA Judicial Council responded by referring the Medical Society to the Opinions and Reports relating to solicitation, advertising and publicity, and commenting that "[i]t seems to me you are following the dictates of fair practice . . ." (CX 1416).

On October 18, the Medical Society asked Dr. Daniel Cloud, a Phoenix physician who was then a member of the AMA House of Delegates (CX 2014H) and who, since 1974, has been a member of the AMA Board of Trustees (CX 1535A, D), to chair a committee to study the Arizona Heart Institute's publicity and make recommendations "concerning replies" to it (CX 2013). Dr. Cloud met with Edwin Holman, secretary of the AMA Judicial Council, in late October to discuss the issue of Dr. Diethrich's publicity (CX 1417A).

In an October 31, letter to the MCMS referring to the meeting, Mr. Holman stated: "Two ethical concepts, of course, are applicable: solicitation of patients and upholding the dignity and honor of the profession" (CX 1417A). Noting that it might be difficult for the Medical Society to prove sufficient intent to solicit on the part of Dr. Diethrich "to support a charge of unethical conduct," Mr. Holman stated, "as there are several ways to skin a cat there are different ways to handle this problem" (CX 1417A). One suggestion by Mr. Holman was counter publicity and an editorial to be published in the medical society's bulletin, with copies left in hospital waiting rooms for public access (CX 1417B).

In his report to MCMS in November, AMA delegate Cloud noted his meetings with the AMA staff, including two AMA staff attorneys, and concluded that the Arizona Heart Institute's publicity "appears to have violated medical ethical concepts with respect to advertising, solicitation of patients, and the boasting of cures and extraordinary success and ability" (CX 1418A). Dr. Cloud recommended that the Medical Society take final action on Dr. Diethrich's application for membership and consider other actions, including the publishing of a general statement "on the malethics of physician advertising" based on "excerpts from the reports of the Judicial Council of the AMA" (CX 1418B-C).

In December 1972, Dr. Diethrich informed MCMS that he would abide by its code of ethics, and the Society's Board of Censors voted to accept him for probationary membership (CX 1421). A month later, a group of Medical Society members, including Dr. Arthur Nelson, a cardiovascular surgeon whose group performed large numbers of the same type of surgical procedures as the Arizona Heart Institute (Tr. 7336, 1293), petitioned the Society's Board of Directors to reverse the Board of Censors' decision to admit Dr. Diethrich to membership (CX 1422). One of the items which Dr. Nelson objected to was a February 1973, newspaper photograph of a Motorola Corporation representative presenting Dr. Diethrich

with a check for $5,000 for the Arizona Heart Institute in recognition of its contributions to the advancement of heart surgery (CX 1424B, 1423C; Tr. 7331-32). In March 1973, the Board of Directors reversed the earlier decision admitting Dr. Diethrich and denied his application for membership due to his advertising (CX 1426). Dr. Diethrich has attempted three times since late 1971 to join AMA directly, but his applications were returned to him because he was not a member of the AMA component society in Phoenix (Tr. 1277, 1346-47).

The President of the Allegheny County Medical Society in Pittsburgh wrote to the Secretary of the AMA Judicial Council, in January 1973, to complain about the article in Life Magazine as "yet another example of a gross breach of basic medical ethics on a grand scale" (CX 167A). The AMA official responded that he had been told that the medical community in Phoenix, including the local medical society, "is active in its efforts to persuade the individual to cease these practices" (CX 168B). He further commented:

> Your letter seems to me to point out that there will always be someone out of step, either innocently or deliberately. Lawyers are disbarred. Clergymen are unfrocked. Human nature remains. The LIFE article is notorious but it is not being overlooked. What voluntary, permissible actions within organized medicine can be taken, are being taken (CX 168B).

In June 1973, MCMS wrote to the American College of Surgeons ("ACS") for advice as to the ethics of the publicity surrounding Dr. Diethrich (CX 1429). ACS, of which Dr. Diethrich had been an active fellow (Tr. 1365-67), endorses the AMA Principles of Medical Ethics as standards to govern the conduct of their physician-fellows (CX 1911B). In response to the Medical Society's inquiry, ACS referred the Medical Society to Opinion 6 of Section 5 of AMA's 1971 Opinions and Reports, stating that, "solicitation of patients directly or indirectly, by a physician, or by groups of physicians is unethical" (CX 1430A, 462Z5). ACS subsequently brought its own disciplinary proceeding against Dr. Diethrich and put him on three years' probation for solicitation of patients, which included a ban prohibiting Dr. Diethrich from presenting scientific papers or exhibits to the College (Tr. 1371-72). Dr. Diethrich received the same penalty from

another specialty society to which he belonged, the Society of Thoracic Surgeons (Tr. 1387-89). That Society's bylaws require its members to adhere to the AMA Principles of Medical Ethics (CX 1981, p. 96).

Since 1973, the Arizona Health Institute has become less visible and more restrictive in bringing its programs before the public (Tr. 1343). It has experienced difficulty in raising funds because of an inability to bring its program to the public (Tr. 1346). The Institute has also been stigmatized in the eyes of potential patients (Tr. 1349), and has suffered a dramatic decrease in the number of patients referred to it (Tr. 1346). These problems are attributable, at least in substantial part, to the actions of AMA, MCMS, ACS and the Society of Thoracic Surgeons against Dr. Diethrich (Tr. 1342-49, 1375-78, 1394).

AMA also correctly points out that the Life Magazine article (CX 2010) was in some respects flamboyant (Tr. 7280), and that Dr. Diethrich himself found it distasteful and was disturbed by the overall impression that it left (Tr. 1312, 1433; RX 382). The Life article may imply to some that the Institute's facilities and Dr. Diethrich's skills were unique and of extraordinary quality (Tr. 7280-81). More specifically, the article contains the statement that Dr. Diethrich is one of the world's best heart surgeons (CX 2010), a statement which would be difficult to justify (Tr. 7281-82). A group of eminent cardiac surgeons concluded that Dr. Diethrich's competency in certain areas, particularly mitral valve surgery, was below the national standard (Tr. 7282, 7289-90).

The Life article (CX 2010) quotes Dr. Diethrich as claiming that his team can identify in advance 90% of all likely heart attack victims. The Life article indicates that Dr. Diethrich can prevent most heart attacks in those who have been discovered to be potential victims by doing a coronary bypass and that he performs bypass operations on patients who are in the midst of a heart attack (CX 2010). The article claims that Dr. Diethrich will perform bypasses on those with hearts already too far gone for most surgeons to touch (Tr. 7298). The article indicates that it took Dr. Diethrich only 90 minutes to do a coronary bypass on one identified patient and 70 minutes to do another such procedure (CX 2010). The Life article notes that Dr. Diethrich may do 10 operations per day. These statements, and others in the article, may imply to some that Dr. Diethrich possesses unique, special skills, and that the Arizona Heart Institute has equipment and performs tests and procedures not utilized by others, when such is not the case (Tr. 7291-7310).

The Life article indicates that, when Dr. Diethrich was 16, an obliging general surgeon let him do one side of a vasectomy. The article states that Dr. Diethrich's technology threatened to make obsolete the methods of practitioners in Phoenix with 40 years' expertise in reading resting EKGs. The article concludes with Dr. Diethrich disparaging a surgeon who would walk into a patient's room the night before an operation and say, "I'm not sure we'll be able to do the job tomorrow. You've got a bad heart, bad arteries, you might have a stroke and the blood pump might break down." These statements might, in fact, constitute a reasonable assessment of the probability of success and the degree of risk involved (Tr. 7315). In short, the article in question (CX 2010) is flamboyant, and could be deceptive and possibly disparaging of other physicians.

In 1974, under the provisions of the Arizona Medical Practice Act (RX 378, 389), the MCMS filed information with the Arizona State Board of Medical Examiners which had led the Society to conclude that the publicity efforts of Dr. Diethrich might constitute advertising in violation of state law (Tr. 1400; RX 387). The State Board admonished Dr. Diethrich for his participation in the publicity practices of the Arizona Heart Institute, which were "looked upon with disfavor" (Tr. 1403; RX 387, 388).

Dr. Diethrich is now a member in good standing of the American College of Surgeons and the Society of Thoracic Surgeons (Tr. 1385-89). Further, some of the decline in patient referrals at the Arizona Heart Institute can be attributed to the admonition of the Board of Medical Examiners (RX 387, 388) and to the stories appearing in the press at that time about malpractice actions pending against Dr. Diethrich (Tr. 1478-79). Dr. Diethrich's nonmembership in MCMS has not affected his ability to obtain malpractice insurance or to hold hospital staff privileges (Tr. 1408). Dr. Diethrich continues to receive referrals from throughout the United States (Tr. 1418-19), and from members of the AMA and the Medical Society (Tr. 1408-09). Dr. Diethrich has also delivered several medical papers to scientific assemblages and has published a number of articles in respected peer-reviewed medical journals (Tr. 1412-13). He has participated in scientific exhibitions and has had his exhibits reviewed by his peers (Tr. 1413-14); and, he has produced and distributed several movies both to medical and lay audiences (Tr. 1414-16).

Dr. Leon Zucker

121. Dr. Leon Zucker, an ophthalmologist in Waterbury, Connecticut, is an NHCMA and CSMS member who testified on behalf of complaint counsel (Tr. 1709-11).

In April 1976, a newspaper article discussing an operation performed by Dr. Zucker appeared in both the Waterbury Republican and the Waterbury American, entitled, respectively, "John Leahy sights his future with hope after eye operation" and "He Eyes Chance to See Again After Rare Triple Operation" (Tr. 1716, 1759; CX 692; RNHX 91). The article described the operation, which involved cataract removal, corneal transplant and lens implantation, as "rare" and "unusual" (CX 692). The article was based on the reporter's interviews with the patient and Dr. Zucker (CX 692; Tr. 1718). The reporter had expressed an interest in the eye operation when, as a patient of Dr. Zucker, she had been in his office and Dr. Zucker had mentioned that the operation was a "fairly rare" one (Tr. 1718). Dr. Zucker is a board-certified ophthalmologist in Waterbury, Connecticut, who taught ophthalmology as a clinical instructor at Yale Medical School from 1964 to 1969 (Tr. 1709-12).

Dr. Zucker testified that he participated in the interview that resulted in the article because he thought the public had a right to know that such procedures are possible and that they are being done and can be done (Tr. 1720). At the time Dr. Zucker performed the operation, it was a rare triple operation in the sense that it was not performed very often by physicians in the area (Tr. 1719, 1755-57).

In early May 1976, Dr. Jerome K. Freedman, in his capacity as Vice President of CSMS, wrote to NHCMA to request an investigation of the newspaper article on Dr. Zucker (CX 2006A). Dr. Freedman, a New Haven ophthalmologist, stated that Dr. Zucker's "ophthalmic colleagues are not pleased with the articles which they regard as publicity" (CX 2006A; Tr. 1731). Shortly thereafter, the ophthalmologist-president of the Connecticut Society of Eye Physicians also wrote to NHCMA to complain about the newspaper article and to urge NHCMA "to take whatever action is necessary to discourage continued use of the local press for personal aggrandizement" (CX 2006B-C; Tr. 1732).

The Chairman of the NHCMA Board of Censors, Dr. Samuel Climo, wrote to Dr. Zucker in early June 1976, informing him of the two complaints and requesting his appearance before the Board of Censors at its next meeting (RNHX 92; Tr. 1720). Dr. Zucker believed that a disciplinary proceeding was being instituted against him that could result in expulsion from the society, and that expulsion would be the "death knell" of his professional life in Connecticut because malpractice insurance was obtainable only through NHCMA and CSMS (Tr. 1721-23; CX 1328).

Dr. Zucker met with the NHCMA Board of Censors in July 1976, accompanied by his attorney (Tr. 1723-24; CX 695C). At the meeting, the Board presented the two ophthalmologists' complaint letters and noted that they raised a question of ethical behavior and self-aggrandizement (CX 695C; Tr. 1724). A major concern expressed at the meeting related to a statement in the newspaper articles, in which Dr. Zucker is quoted as saying, "He [the patient] was told he'd never see again, but we made them out to be liars." Some members of the committee stated that they understood the quotation to mean that Dr. Zucker was stating that other physicians who had previously seen or treated the patient were liars. Dr. Zucker testified that he thought the above-noted quotation was susceptible to misunderstanding, and that the phraseology of the statement as reported in the article was inaccurate (Tr. 1719, 1766-67; CX 692; RNHX 91). Another concern expressed at the meeting was that the article's headline was misleading to the public because it stated that the operation performed by Dr. Zucker is "rare" when, in fact, it is more accurately described as fairly rare or uncommon (Tr. 1718, 8483). Dr. Zucker said that he was sorry about the newspaper article (CX 695C). The chairman of the Board of Censors asked Dr. Zucker whether it wouldn't have been less embarrassing if the article had come through hospital sources (Tr. 1724-25). Dr. Zucker agreed to allow the publicity department of his hospital to write and handle future releases (CX 695C, 696, 697E).

Dr. Zucker was notified a few days after the meeting by receipt of a letter, written by the Chairman of the Board of Censors/Peer Review Committee to the NHCMA Executive Director, stating that no action need be taken. Upon receipt of the letter, Dr. Zucker believed that the matter had been concluded (Tr. 1767-68; CX 296). NHCMA's action made Dr. Zucker very circumspect about communicating any information to anyone (Tr. 1725). He was disturbed by the stigma associated with even being charged with unethical behavior and by the resulting impression of at least one of his fellow ophthalmologists in New Haven that he had been censured (CX 136C; Tr. 1745-46). The NHCMA action also was expensive to Dr. Zucker, causing him to incur attorneys' fees and to spend time away from his practice (Tr. 1746-47).

Dr. Lee Hirsch

122. In March 1975, an article was published in a Springfield, Massachusetts, newspaper describing a local ophthalmologist's performance of eye surgery through an

accepted cataract removal technique called "phacoemulsification" (CX 161Z69, Z70; RX 281; Tr. 4206, 4252, 830-36, 7813, 7883, 1714-15). At the time the article was published, the ophthalmologist Dr. Lee Hirsch, and his associate, Dr. Krawiec, were the only physicians in western Massachusetts performing eye operations by use of the phacoemulsification procedure (Tr. 892; CX 161H). In response to complaints from other Springfield ophthalmologists who did not perform this surgical procedure (CX 152-53; Tr. 874-75, 892) and action of the local AMA component medical society in Springfield (Tr. 868-74; CX 1838, 1990B, E, 885S, Y, 153), the Massachusetts Medical Society ("MMS") formally censured Dr. Hirsch in early 1977 for the newspaper article and subsequent newspaper publicity (CX 159, 150, 161; RX 277, 278, 280, 281). The MMS ruled that Dr. Hirsch had violated the prohibition on solicitation in the AMA's Principles of Medical Ethics (CX 150A, D, 159). As a result of the medical societies' proceedings against him, Dr. Hirsch incurred substantial legal expenses, lost practice time and patients, was temporarily removed from a hospital's emergency room roster, experienced difficulty in obtaining membership in the American College of Surgeons and suffered much aggravation (Tr. 892-93, 862; CX 161Z80, Z81, 1862). In general, the newspaper articles which appeared described phacoemulsification and very favorably compared phacoemulsification to the more traditional intracapsular technique of cataract removal (RX 277, 278, 280, 281).

Phacoemulsification was developed by Dr. Charles Kelman in 1967 (Tr. 835). In this procedure, the surgeon breaks up the nucleus of the cataract with an ultra-sound needle vibrating 40,000 times per second, and then sucks out the emulsified material (Tr. 835-36). Nevertheless, the intracapsular method is the most widely accepted method of cataract removal (Tr. 833, 7840). In this procedure, the surgeon removes the entire cataract through an incision (Tr. 836-37). Dr. Hirsch took the Kelman course in phacoemulsification in 1974 (Tr. 830-31), and his practice since that time has been limited almost exclusively to the removal of cataracts by phacoemulsification. Since 1974, Dr. Hirsch has performed about 1,450 phacoemulsification operations and about 50 intracapsular extractions (Tr.838-39). Dr. Hirsch owns two Cavitron machines, the device which he uses to perform a phacoemulsification procedure (Tr. 839), each of which costs approximately $25,500 (Tr. 939). In late 1974 and early 1975, Dr. Hirsch apparently was seeking publicity of some kind (CX 150E, G, 161 O, 271, 273).

Dr. Hirsch testified in this proceeding as a witness for complaint counsel (Tr. 825 et seq.).

Shortly after publication of the first article, entitled "Eye Surgery Goes Ultrasonic" (Springfield Republican, March 3, 1975) (RX 281), Dr. Hirsch was censured by and expelled from the Greater Springfield Ophthalmological Association for engaging in advertising and personal publicity without Association clearance, conduct which the Association found to be "reprehensible" (Tr. 855, 860; CX 161Z78-79). This Ophthalmological Association is not affiliated with the AMA (Tr. 903).

Two days after publication of the article (RX 281), Dr. Hirsch was asked by the Hampden District Medical Society to appear for a meeting (Tr. 871; CX 1838). At the meeting, which took place on March 13, 1975 (Tr. 873), it was decided to refer the matter to the MMS. The bylaws of the MMS provide that members shall be guided by the AMA's Principles of Medical Ethics (CX 1990E). At MMS, the Committee on Ethics and Discipline advised Dr. Hirsch that it believed the article in question was not in the best interests of the community in that it did not give a fair evaluation of the technique such as would enable a consumer to make an intelligent choice (Tr. 878, 5586, 5589). The Committee took the position that one who publicizes a new technique such as phacoemulsification should make sure that the public understands all aspects of the general situation (Tr. 5590). On the basis of its proceedings, the Committee concluded that the article was misleading (Tr. 5591).

The Committee suggested to Dr. Hirsch that he write to the Springfield Republican to try to have an explanation published to give the general public a more accurate description of phacoemulsification, and that he explain to physicians in the District Society what had happened and straighten the problem out at the local level (Tr. 5587; CX 1852). Dr. Hirsch did neither (Tr. 5587-88; CX 1852). The Committee recommended that Dr. Hirsch be censured and be suspended for one year. It advised him of his right to appeal to the Judicial Committee of MMS (Tr. 881, 5588, CX 161Z67). Dr. Hirsch did appeal to the Judicial Committee (Tr. 5588; CX 161Z68) and, after notice and a hearing (RX 375A-G; CX 161A-Z66), the Judicial Committee, on February 22, 1977, censured Dr. Hirsch for unethical conduct but did not suspend him from membership (Tr. 865, 5588; CX 159). The Judicial Committee stated that it censured Dr. Hirsch because the particular publicity at issue was "misleading to the average person" (CX 150D-E), and that Dr. Hirsch had done nothing "to attempt to correct the one-sided slant of the article" (CX 150G-H). The Judicial Committee of MMS, in censuring Dr. Hirsch, cited with approval the Opinions and Reports of the Judicial Council of the AMA concerning advertising and solicitation, including the 1976 revision of the Opinions and Reports (CX 150A-D, I).

The March 2, 1975, article in question (RX 281) sets forth the purported advantages of the phacoemulsification tecnhique without any discussion of the possible complications of the procedure (Tr. 4212, 4213, 4270) or the contraindications to the procedure (RX 288C). It leaves the distinct impression that phacoemulsification is superior to intracapsular surgery as a procedure for cataract removal (RX 281) when, in fact, such often is not the case (Tr. 7812-17, 7830, 7837; RX 288C, 293). The article emphasizes what the patient can do immediately after surgery (RX 281); however, the real measure of success of an operation is long term results (Tr. 4224, 4229, 7856-57).

In recent years, phacoemulsification procedures for cataract removal have been used less often than they once were (Tr. 7812-13, 7838). It is to be considered an adjunct to, and not a replacement for, older procedures (RX 288C). Dr. Robert C. Troutman, an extremely expert and talented ophthalmologist who testified in this proceeding, stated that only one-half of one percent of the cataract operations currently being performed at Manhattan Eye and Throat Hospital, where Dr. Troutman is surgeon director, are phacoemulsification procedures (Tr. 7812-13). It has been determined recently that complications of phacoemulsification obviated some of the earlier results claimed for the procedure (Tr. 7814). Dr. Troutman prefers the intracapsular procedure for cataract removal, which he described as "a good technique that is applicable on a worldwide basis and has a minimum of complications and particularly late complications" (Tr. 7840). Dr. Troutman is of the opinion that phacoemulsification should not be used on patients who are over 40 years of age (Tr. 7837), and that the procedure is seldom a procedure of choice in cataract removal operations (Tr. 7838).

5. Yellow Pages Listings

123. AMA and its constituent and component medical societies have restricted the form and content of physicians' listings in the telephone directory Yellow Pages. The American Telephone and Telegraph Company asked AMA, in 1965, to establish a national policy governing the listing of physicians in the Yellow Pages (CX 535D). In June 1966, the AMA Judicial Council adopted and distributed to all state and county medical societies a set of "Guidelines for Telephone Directory Listings" by physicians (CX 534C-D, 533K, 673B-I). The AMA House of Delegates approved the Guidelines (CX 663). The AMA Guidelines proscribe the use of display or box advertisements by physicians and physician groups or clinics (CX 673D). They require uniformity of size and face of type (CX 673D). They declare that the name of a physician should not be listed in a telephone directory of a locality where he or she does not have an office, residence or hospital affiliation (CX 673E). They limit a physician to separate listings under no more than two specialties or subspecialties, which must be on the list

approved by AMA (CX 637D). The examples of acceptable Yellow Pages listings published in the Guidelines contain only the physician's name, address, phone number, specialty, if-no-answer phone number, residence address and phone number and office hours (CX 673G).

The AMA Judicial Council intended the Guidelines, among other things, to maintain the dignity of the medical profession and assure uniformity of practice from community to community (CX 637C). The Guidelines declare that it is incumbent on the county medical society to implement them for the local medical community (CX 673E), and the local medical societies' standards implementing the Guidelines may vary only to the extent that they do not allow a significant inroad on the general prohibition against solicitation (CX 669A).

In March 1975, AMA advised a professional corporation of psychiatrists who practice in Virginia and North Carolina that, under the Guidelines, the physician is expected to confine his listings to the area in which he maintains his principal practice (CX 663-64).

AMA has distributed the Guidelines and interpretations of them to physicians and member medical societies (CX 663-70, 672-73, 1646-47, 501E), and constituent and component medical societies of AMA have applied the AMA restrictions on telephone directory listings.

In 1969, the Hartford County Medical Association, a component society of respondents CSMS and AMA (CX 991D, 1657A, G, Q), wrote to respondent NHCMA, stating that certain New Haven area physicians were violating the Hartford Society's policy that physicians should not be listed in a telephone book (in this case the Bristol directory) unless they reside, have an office or have a hospital appointment in the area served by the phone book (CX 1822) [this is the ethical policy set forth in the AMA Guidelines for Telephone Directory Listings (CX 673E)]. The Hartford County Society advised NHCMA that it had asked its members to comply with the requirement with respect to Yellow Pages outside Hartford County, and that it hoped NHCMA would do the same with respect to its member physicians (CX 1822). NHCMA informed the physician in violation of the policy that he should delete his listing from the Bristol phone book (CX 1821). The physician then asked the telephone company to remove his name from the Bristol directory and NHCMA passed this news on to the Hartford County Medical Association (CX 1820).

In April 1975, a telephone company representative asked NHCMA whether NHCMA had any policy regarding telephone directory listings, and specifically inquired about the listings placed by a Dr. Henri Schapira of New Haven. The NHCMA Executive Secretary wrote to Dr. Schapira about the inquiry, and stated that NHCMA policy was that it is ethical for a physician to list himself in telephone directories in areas where he resides, has an office or has hospital privileges, and noted that NHCMA was going to seek advice from the Connecticut Psychiatric Association regarding aspects of Dr. Schapira's listings. The letter states that it is to inform Dr. Schapira of the matter and is a notice of NHCMA's existing policy (CX 677).

In June 1975, NHCMA wrote to AMA's Judicial Council for specific guidelines on these ethical issues, stating that NHCMA had been having problems in the telephone directory listings area (CX 672). In its reply, AMA enclosed a copy of its Guidelines for Telephone Directory Listings and advised NHCMA that "the county medical society . . . must assume a strong leadership role and insist that the guidelines be followed" and that "[i]t is incumbent on the county society to implement these guidelines . . ." (CX 673A). Before this response was received from the AMA, NHCMA's Executive Secretary again wrote to Dr. Schapira, stating that the NHCMA Executive Committee reaffirmed its previously stated policy; the letter set forth an opinion of the Connecticut Psychiatric Society about the contents of psychiatrists' telephone directory listings which concurred with NHCMA's policy. AMA's guidelines and NHCMA's policy are the same (CX 672, 673A-I, 678).

At the time of trial, Dr. Schapira was listed in the Yellow Pages of six telephone directories in areas in and around New Haven. In each of these directories, Dr. Schapira is listed under "Adolescent and Adult Psychiatry Center" as well as under "Schapira Henri J." The listings under Adolescent and Adult Psychiatry Center state "Emotional Sexual & Alcohol Disorders" and "Marital and Family Therapy." All directories list the two addresses and telephone numbers where Dr. Schapira has offices, New Haven and Wallingford. It can be determined at a glance in all the telephone directories that the doctor's offices are located in New Haven and Wallingford. Dr. Schapira's listings in the 1977 New Haven, Connecticut, telephone directory Yellow Pages, printed after the above-noted correspondence from NHCMA, are identical to his listings in the 1974 New Haven directory that was printed before the above-noted correspondence (RNHX 125A-D, 126A-D, 127A-E, 128A-C, 129A-D, 130A-D, 131A-D).

In February 1977, the Executive Director of the Multnomah County Medical Society in Portland, Oregon, stated in a "Third Warning on Bold Face Listings," that the Society had decided in 1975 that:

> [I]t is 'inappropriate and unethical for a physician, clinic, group or professional corporation to use a bold face listing in the Yellow Pages or White Pages of the Portland Telephone Directory.' To do so goes beyond acceptable informative advertising, which is permissible, and becomes 'solicitation of patients,' and presents an advantage to some physicians. (CX 1815A).

This warning appeared in the Portland Physician magazine. At about this same time, the Multnomah County Medical Society also sent a form letter to the 30 medical clinics and others who had inserted bold face listings in the 1977 Portland Yellow Pages, specifically calling their attention to the Society's position and requesting compliance with that policy in the future (CX 1815A, B, 1733). The letter states that use of bold face listings borders on solicitation of patients and quotes from the statement of the AMA Judicial Council in its 1971 Opinions and Reports that, "No physician member of a clinic may permit the clinic to do that which he may not do. Each physician must observe all the Principles of Medical Ethics" (CX 1733A, 462K).

In May 1975, the Committee on Ethics and Discipline of the Massachusetts Medical Society urged that:

> the names of physicians in telephone directories be uniform as to size and style of type without the use of bold face letters. The display box advertisements for individual physicians, groups of physicians or clinics is not in keeping with the dignity of the profession and should not be used (CX 877B).

These restrictions parallel the AMA Guidelines (CX 673D).

The August 1976 compendium of ethics determinations of the state medical society in Maryland contains detailed limitations on the form and content of Yellow Pages listings, including the following restrictions which directly parallel the AMA Guidelines:

B. Listings may include the following ONLY: Name, address, and phone number, office hours, an 'if no answer' number, physician's or surgeon's home address and telephone number.

C. Listings may be made ONLY as follows: 'Practice limited to . . . ' (using only those specialties approved by the American Medical Association or as modified and approved by a special liaison group to be named by the Faculty to work with the C&P Telephone Company).

D. Listings must be uniform in size and type face.

E. Display or box advertisements are strictly prohibited. (RX 308, p. 34; CX 673D, E).

In October 1971, the Washington State Medical Association ("WSMA") informed Pacific Northwest Bell Telephone Company that, based on AMA's Principles of Medical Ethics and Opinions and Reports, it would be unethical solicitation for physicians to list the word "abortions," or related terminology, in addition to their regular medical specialty in the Yellow Pages (CX 637A). The WSMA asked the telephone company to report to it any physician who requested such a listing (CX 637A). In May 1973, in response to an inquiry from WSMA, the Director of the AMA Department of Medical Ethics sustained the State Association's ethics interpretation, stating: "The Principles of Medical Ethics provide that he [the physician] should not solicit patients. A statement in the Yellow Pages 'Practice Limited to Pregnancy Termination' seems clearly to be solicitation of patients" (CX 640B).

In November 1973, Pacific Northwest Bell wrote to the WSMA to ask whether any of a long list of physicians' services were approved and recognized by the State Association as medical specialties (CX 643). The list included "diseases of skin and skin cancer," "internal medicine and arthritis" and "pediatric and adolescent allergy" (CX 643). In accordance with additional advice from the AMA Department of Medical Ethics (CX 642), WSMA's Board adopted a resolution, in January 1974, that only those specialties approved by AMA or the State Association should be used by physicians in Yellow Pages listings (CX 644, 658F). The list of approved specialties attached to WSMA's letter included none of the physician services mentioned in the telephone company's letter (CX 644B, 643).

In April 1976, the WSMA sent a letter to Pacific Northwest Bell indicating that its January 1974, resolution on physician directory listings was still applicable (CX 658A). The letter stated that the resolution was based on, and derived from, the Principles of Medical Ethics of the AMA (CX 658A). The letter referred specifically to the ban on solicitation in Section 5 and to Opinion 11 of Section 5, "Solicitation of Patients or Patronage," in AMA's 1971 Opinions and Reports (CX 4622S-Z6), and enclosed copies of these provisions (CX 658).

In a 1976 letter to a Washington State physician, a WSMA official underscored the active regulatory nature of the Association's interest in physicians' Yellow Pages listings: "In the final analysis, we have found the 'management' of Yellow Page telephone directory listings is an ongoing proposition and one that seems to need constant scrutiny and surveillance from year to year as new directories come out" (CX 650).

6. Business and Consumer Directories

a. Dissemination of Consumer Information by State and Local Medical Societies

AMA contends that ethical considerations have not prevented services from being made available to consumers and, in support of this contention, AMA presented several witnesses to testify about the preparation and distribution of consumer directories.

Hennepin County Health Coalition

124. LuVerne M. Pearman, Executive Director of the Hennepin County Health Coalition ("Coalition"), a non-profit organization in Minneapolis composed of diverse interest groups in the health care field, testified in this proceeding (Tr. 5259, 5261-62, 5268). The Coalition was created in 1974 to improve primary health care in the county (Tr. 5260). Fifty percent of its funding comes from the county government, with the remaining funding coming from private donors, including hospitals and the Hennepin County Medical Society (Tr. 5261). Among the projects undertaken by the Coalition was the preparation of a directory of primary care physicians in Hennepin County (Tr. 5259, 5267; RX 267). Published in 1974 (Tr. 5269), this directory was prepared from responses to questionnnaires sent to all area primary care physicians (Tr. 5284). A representative of the Hennepin County Medical Society helped review drafts of the questionnaire (Tr. 5273-75). The directory had a response rate from physicians of approximately 80 percent (Tr. 5285).

The directory included information on the nature of each physician's practice, reimbursement mechanisms used, continuing medical education programs undertaken, teaching appointments held, hours of service, waiting periods for routine visits, house calls, location and accessibility of office, special services offered, procedures done in office, credit practices, prescription practices and a variety of other information (RX 267; Tr. 5277-79). Information on fees was published in aggregate form giving fee ranges existing in the community (Tr. 5280-82). Eight thousand copies of the directory were ultimately distributed to public libraries, referral areas and hospital waiting rooms (Tr. 5289).

The Hennepin County Medical Society did not oppose the development, preparation or dissemination of the directory, nor did it declare physician participation in the project to be unethical (Tr. 5271, 5276, 5283). Ms. Pearman testified that the Medical Society was "positive and supportive," both behind the scenes and publicly (Tr. 5272, 5283). It provided $5,000 annually for three years to help fund the Coalition (Tr. 5263, 5283-84) -- between five and six percent of its total operating budget. At the time the directory was published, there was no physician advertising in the community and the only directory of physicians available covered a small area of the county (Tr. 5291-93, 5300).

Whatcom County Medical Society

125. Kenneth L. Culver, Assistant Executive Secretary for the Whatcom County Medical Society (covering the northwestern corner of Washington State), testified in this proceeding (Tr. 5819 et seq.). Among the projects undertaken by the Medical Society under Mr. Culver's supervision was the preparation of a directory of physicians (Tr. 5821). In June 1974, several member physicians had received questionnaires from a local college (Tr. 5826; RX 402). At that time, the Medical Society sent a bulletin to its members asking them not to complete the questionnaire (Tr. 5827, 5830-31; RX 404). A special board meeting of the Society was then convened to discuss the subject of a physician directory (Tr. 5833). The Medical Society authorized its staff to contact the school, Fairhaven College, in order to coordinate a joint publication effort (Tr. 5832-33), and, subsequently, met with students from the college on several occasions to draft a questionnaire (Tr. 5837; RX 403A, 405). The questionnaires were sent to the members of the Whatcom

County Medical Society along with a Society bulletin requesting prompt completion and return. More than 90 percent of those physicians solicited responded with completed questionnaires (Tr. 5888). Fairhaven College students compiled the data, and Medical Society personnel reproduced the booklet (Tr. 5862, 5888). The directory (RX 407) was published in June 1975 (Tr. 5864). Information in the directory included facts about acceptance of walk-in and new patients, office location and accessibility to public transporation, after-hours coverage, languages spoken, prescription of generic drugs, availability of information on preventive medicine, prescription of contraceptives and minimum fees for office visits (RX 407). Of the 500 copies of the directory printed, half were given to the Medical Society and half to the College for their own distribution (Tr. 5864-65). The Medical Society distributed its 250 directories to its members, public agencies and the general public at no charge (Tr. 5865; RX 408).

There are 120 physicians in Whatcom County who belong to the local medical society; less than six physicians do not belong to the society (Tr. 5886). Although the Medical Society stated to its members that the directory would be kept up-to-date through future editions (RX 405A; Tr. 5890-91), the Society withdrew its support when the college proposed, and ultimately prepared, an updated directory (Tr. 5893-95). At the time the directory was published, there was no physician advertising in Whatcom County (Tr. 5886-87).

Pima County Medical Society

126. The Professional Guild of Arizona ("Guild") is a registered labor union of physicians created in 1974 to deal with the hours, wages and working conditions of practitioners of contract medicine (Tr. 7554). It enforces health care contracts and collects unpaid benefits from insurance companies or government agencies through group action claim review (Tr. 5757-58). The local medical association in Tucson is the Pima County Medical Society. In 1977, the Guild published a directory of physicians for the Tucson area (Tr. 5758; RX 526). The president of the Guild, Dr. William A. Davis, testified about the preparation of the directory (Tr. 5758 et seq.).

The Guild first prepared a questionnaire which was designed to elicit information to help a new resident choose a physician. The questionnaire was sent to every

physician and osteopath in Tucson, and the responses were reviewed for accuracy (Tr. 5762). The Guild did not consult with the Pima County Medical Society, the Arizona Medical Society or the AMA regarding its decision to publish the directory (Tr. 5763-64). However, after the questionnaire was distributed, the Guild contacted the Pima County Medical Society about the ethics of the directory project. The Society expressed the opinion that the project was ethical and stated no objection (Tr. 5765; RX 527). The Medical Society suggested to the Guild that one question on medical specialties be altered to restrict areas to those supported by a recognized board (Tr. 5765; RX 528). The Guild agreed and modified the directory accordingly (Tr. 5765; RX 529).

The Pima County Medical Society had no direct role in the publication and distribution of the directory (Tr. 5789). Its secretarial staff was instructed to advise the numerous callers to the Society (Tr. 5786) that the directory was going to be published, it was not unethical and participation was a matter of individual choice (Tr. 5766, 5790; RX 527). The directory, which is divided into sections by geographical region and specialty (Tr. 5768-70), includes information on each physician's specialty, patients treated, medical school and other training, board certification, hospital affiliations, language spoken, office location and hours, accessibility by bus and fees for office visits and certain special procedures (Tr. 5770-72; RX 526). Fifty-five percent of the area physicians responded to the questionnaire and were listed in the directory (Tr. 5772-73). Four thousand copies of the directory were published, and more than 2,000 were distributed through drugstores and physicians' offices (Tr. 4773-74).

The Lane County Medical Society

127. Bruce S. Strimling, M.D., a pediatrician practicing in Eugene, Oregon, is a member of the Lane County Medical Society, the Oregon Medical Association, the AMA and other professional societies (Tr. 5400-01). In 1974 and 1975, Dr. Strimling was Chairman of the Public Health and Low Income Care Committee of Lane County Medical Society (Tr. 5403-04). As part of its goal of promoting maximum access to health care (Tr. 5405, 5407-16), the Committee developed a consumer directory of physicians in Lane County, Oregon (Tr. 5409). The idea for a directory was prompted by articles in American Medical News (RX 462) and a local newspaper concerning a directory of physicians in Prince Georges County, Maryland (Tr. 5410-13). Dr. Strimling testified in this proceeding as a witness for AMA (Tr. 5400 et seq.).

The directory concept was presented to the Medical Society membership as a means of acquainting consumers with the available facilities in the community, including information about the Society's referral system, emergency care in the area and how to use it (RX 463B). The project was first discussed at a general meeting of the Society (Tr. 5415-16; RX 463); the directory project was approved at a subsequent meeting (Tr. 5420). The Medical Society initially sought a consumer organization that would be willing to assist in management of the project and to publish it in conjunction with the Medical Society (Tr. 5428-29). When no offers were forthcoming, the Medical Society began preparation of the directory in conjunction with other interested organizations including CARES, an agency of the County Health Department (Tr. 5434).

The committee first accumulated information about prior directory projects to aid in drafting an appropriate questionnaire (Tr. 5420-23; RX 464, 466, 369, 475, 476). Due to concern that a directory might violate state law or medical ethics (Tr. 5426-27; RX 465), the committee wrote for guidance to the State Board of Medical Examiners (Tr. 5435; RX 468; CX 2125), the Oregon Medical Association (Tr. 5437-38; RX 470) and the AMA (Tr. 5441). The State Board of Medical Examiners concluded that publication of such a directory was a proper function of the society but requested the opportunity to review it prior to publication (Tr. 5436-37; RX 472). The ethics committee of the Oregon Medical Association found no ethical problems relating to the medical society, but also requested the opportunity to review the directory prior to publication (Tr. 5436, 5437; RX 472). The AMA referred the Medical Society to the American Medical Directory as to the types of information and specialty designations that should be used in community directories (Tr. 5441; RX 473).

A questionnaire was ultimately developed by all interested parties (Tr. 5450-52, 5460; RX 482H-J, 488). At the suggestion of various Society members, a question about areas of special interest was deleted (Tr. 5457, 5459, 5487-88; RX 478; CX 2129). The final questionnaire (CX 2132) listed 35 specific questions, but did not request fee information. "Almost all" physicians in the area are members of the local society (Tr. 5470). Of the 290 members of the Society, 244 elected to participate in the directory (Tr. 5471; RX 489). The information on the returned questionnaires was summarized by CARES (Tr. 5464-65), and 1,000 copies of the directory were published at county expense (Tr. 5468-69). The directory (RX 489), published in January 1976 (Tr. 5467), includes

information about a physician's specialty, type of practice, medical school, internship, residencies, fellowships or other training, board eligibility or certification, hospital staff appointments, personnel and facilities, special services provided, languages spoken, office location and hours, after-hours coverage, acceptance of new patients, treatment of welfare patients, wait for appointments, time for an office visit, payment arrangements and handling of complaints; however, it provides no fee information (RX 489). The directory also includes an introduction that gives the background of the directory as well as physician participation, information on medical education and credentials, advice on how to find a physician, a list of medical resources in Lane County and a short note explaining the doctor-patient relationship (RX 489).

The Clear Creek Valley Medical Society

128. The Clear Creek Valley Medical Society is a local society covering the northwestern metropolitan areas of Denver (Tr. 7528-29). In April 1975, the Society organized its Consumer Directory Publication Committee (Tr. 7530), chaired by Dr. Joel M. Kaplin, who testified about the directory effort (Tr. 7526 et seq.). The Committee was formed because the members of the Society believed that a consumer oriented directory of medical care would be both beneficial to the public and a good public relations effort for the physicians (Tr. 7530; CX 2303A).

The first step taken by the Committee was to contact the local and state medical societies and the AMA to determine if medical ethics or state law would be violated by the publication of a directory (Tr. 7531). The Committee also contacted the Consumer Research Council in Washington, D.C., a Ralph Nader organization, for guidance and for a sample questionnaire (Tr. 7532). This questionnaire was modified and sent to all area physicians and osteopaths (Tr. 7536). The questionnaire included 22 specific inquiries concerning the physician's practice, education, appointments and affiliations (RX 656X). The Medical Society deleted questions relating to acceptance of Medicaid or Medicare patients (Tr. 7532-33). Requests for fee information were also omitted (Tr. 7533). In order to achieve a good response rate, the Society called physicians who did not initially respond to the questionnaire (Tr. 7537). The overall response rate was 76 percent of Medical Society members and 45 percent of nonmembers (Tr. 7551-52).

In March 1976, the Judicial Council of the Colorado Medical Society approved publication of the directory. The state medical society also recommended that information on fees and on acceptance of Medicaid and Medicare patients be excluded (Tr. 7550; CX 2304). The local society was aware that physician directories were not contrary to AMA ethical principles from articles published in the American Medical News, an AMA newspaper (CX 2301, 2300).

The directory was published in March 1977 (Tr. 7551). Broken down by specialty, it includes information about a physician's area of practice, education, teaching positions, affiliations with hospitals and medical societies, location of offices, waiting time for appointments, hours, office personnel, special services provided, languages spoken and payment and billing practices (RX 656). Also included is a section on public programs offered by the Medical Society, a section on private health insurance companies to give the public an idea of what to look for in obtaining health insurance and a section on how to use the directory (Tr. 7540-41; RX 656). Five thousand copies of the directory were published at a cost of $11,000 (Tr. 7551, 7554-55). Despite excellent media coverage (Tr. 7552, 7554) and an adequate distribution network, fewer than 2,000 copies of the directory were sold (Tr. 7552-53).

The Allegheny County Medical Society

129. The Free Clinic of Pittsburgh is an organization funded from private foundation and government grants. It provides care to indigent persons (Tr. 5913-14). At the end of 1974, the Free Clinic invited the Allegheny County Medical Society to participate in the publication of a consumer directory of physicians in Pittsburgh (Tr. 5916). The Allegheny County Medical Society has approximately 2,450 members of the 3,100 licensed physicians in Allegheny County. Of these 2,450, 80 percent are members of the AMA. (Tr. 5912). The Medical Society concurred with the Free Clinic that there was a community need for such a physician directory, and agreed to cooperate and contribute to the format and content of the directory (Tr. 5958-59; CX 2179). H. David Moore, Jr., Executive Director of the Medical Society, testified about the preparation of the directory (Tr. 5910 et seq.).

In the summer of 1975, officers of the Free Clinic and the Medical Society met to discuss the idea of a directory and to develop a questionnaire (Tr. 5916, 5919-20). Draft questionnaires (RX 675; CX 2180) were supplied by the Free Clinic, and certain modifications were made (Tr. 5916, 5919-20). The Medical Society suggested deletion of certain questions (Tr. 5921-24); some of the suggestions of the Medical Society were followed and some were not (Tr. 5921-24). It was the Medical Society's initial position that there would be "no mention" of specific fees (CX 2303B). There was a continuing controversy between the Free Clinic and the Medical Society over publication of fee information (Tr. 5975). The questionnaire was mailed to all licensed physicians providing primary care within the city of Pittsburgh, including both members and nonmembers of the Medical Society (Tr. 5737, 5739).

The questionnaire was distributed in July 1975 (Tr. 5939). Approximately 60 percent of the physicians surveyed responded (Tr. 5940). The information received from responding physicians was compiled; printing costs were divided between the two groups (Tr. 5941; RX 671). The directory (RX 666) was published in February 1977 (Tr. 5942). It is prefaced by a letter to the reader, signed by officers of the Medical Society and the Free Clinic, identifying the organizations involved and describing the scope of the directory. This material is followed by a table of contents and a list of groups contributing to the directory. These groups helped the Free Clinic pay for its portion of publication costs (Tr. 5947). An introduction explaining the purpose and form of the directory appears next, along with information on how to use the directory, what to look for in a medical check-up and a position on physician-patient communications. These sections were all reviewed and approved by the Medical Society before they were included in the directory (Tr. 5947-48).

The body of the directory is divided into five sections: family practitioners, general practitioners, gynecologists, internists and pediatricians. Individual listings include information on a physician's location, type of practice, age, years in practice, specialty, treatment of new patients and walk-ins, house calls, age limits on patients, after hours coverage, affiliation with specific hospitals, office hours, acceptance of Medicare or Medicaid patients, billing practices, prescription of contraceptives, itemization of bills, average waiting time for appointments and tests performed at the office (RX 666). Some individual

listings also include fee information (RX 666). Physicians could choose to provide specific fees, a range of fees or indicate from whom this information might be secured (Tr. 5950). An appendix to the directory includes the letter and questionnaire mailed to physicians, a family guide to immunizations, a table of fees providing the average fees and fee ranges for each of six specialties and 16 specific procedures and an index of physicians listed by zip code (RX 666).

Five thousand copies of the directory were published and were divided equally between the two organizations for distribution (Tr. 5952, 5954-95). The cost to the Medical Society of its participation in the directory project amounted to approximately $13,000, including printing costs and staff time (Tr. 5958).

New Haven Medical Directory

130. In 1975, Dr. Hans Neumann, the Medical Director of the New Haven Health Department, decided that it would be useful for the city health department and various social agencies to have a directory of physicians that could be used to refer patients for primary care (Tr. 8595-97, 8622). Dr. Neumann testified about the preparation and publication of the directory (Tr. 8590 et seq.).

The city health department staff discussed the idea of a directory and decided that it should be limited to primary care physicians. They concluded, in the interest of time and the desire for a large response rate to the questionnaires, to include in the directory only essential information about physicians and their practices. Due to financial constraints and the fact that the original purpose of the directory was as a patient referral aid, the health department staff planned to publish only about 50 copies of the directory and distribute them to senior citizen centers, housing projects, the visiting Nurse Association and other social agencies (Tr. 8598-8602).

The city health department staff prepared a questionnaire to send to physicians requesting information as to the physician's name, address, telephone number, section of city, type of practice, office hours, hospital affiliation, acceptance of Medicare assignment, acceptance of Medicaid patients, acceptance of new patients for primary care and basic fees for a first visit and a follow-up visit. The staff included on the questionnaire a statement that, while it may seem awkward to state a standard fee, such information would be useful, and noted that fees vary according to circumstances. The staff added this statement to the questionnaire to indicate recognition of the fact that fees depend on the treatment required (Tr. 8603-08; RNHX 143).

Thereafter, Dr. Neumann initiated communication with the New Haven Medical Association ("city association"), an independent city medical association (a different organization than NHCMA, and not affiliated with the respondents herein). The city association agreed to cosponsor the project (Tr. 8594, 8608-09, 8613).

Dr. Neumann wrote a cover letter to accompany the questionnaire; in July 1976, both the letter and questionnaire were sent to physicians in New Haven who were listed in the telephone directory as practicing internal medicine, general practice or pediatrics. Dr. Neumann included in the cover letter a reference to the AMA's newly issued guidelines on physician directories. This reference was included independently by Dr. Neumann (Tr. 8609-12; RNHX 144). Dr. Neumann's staff sent out 100 to 150 questionnaires and received approximately 80 to 100 responses. None of the physicians receiving the questionnaire asked Dr. Neumann whether it was ethical to participate in the directory (Tr. 8609, 8614-17).

In late 1976, the directory was compiled, typed and photocopied. Approximately 50 copies of the "Primary Medical Care Directory" were printed and distributed without charge to the various social agencies in New Haven that would be likely to refer patients to primary care physicians. The 1976 directory includes an explanatory foreword written by Dr. Neumann and his staff. The directory is divided into four sections--family practice, internal medicine, pediatricians and health care centers. The listings include all the information requested in the questionnaire, including basic fee (Tr. 8617-20; RNHX 109).

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

Dr. Neumann's staff sent out approximately 100 to 120 questionnaires and received about a 90 percent response rate. None of the physicians objected that participation in the

directory would be unethical. At the time of Dr. Neumann's testimony at trial, the directory had been compiled and typed, and was ready for photocopying and distribution to social agencies. The revised directory had the same format and information as the 1976 edition (Tr. 8627-29; RNHX 149A-Z15). There were no objections to the publication or distribution of the directories from any medical societies (Tr. 8622, 8629).

b. Medical Society Opposition to Business and Consumer Directories

131. AMA and its members societies have limited the publication of information on physicians in business and consumer directories. Opinion 18 of Section 5 of the 1971 Opinions and Reports declares that, "[m]ost, if not all, listings of physicians by specialty in directories published by commercial concerns, are but subtle ways of avoiding the pronouncement of the Principles of Medical Ethics concerning solicitation of patients" (CX 46229). Opinion 18 of Section 5 of the 1971 Opinions and Reports also states that if a physician permits the use of his name in a commercial directory that does not include on like terms the names of all licensed physicians in the directory area, he "has the burden of proving that his action is in keeping with the Principles" (CX 46229).

The 1971 Opinions and Reports recommends that local medical societies enforce an ethical policy that "the listing of physicians in directories of participating members [in bank credit card programs] is contrary to the ethics of the medical profession" (CX 462222 [Sec. 7, Op. 13]). In an August 1976 compilation of ethics interpretations, the state medical society in Maryland endorsed this AMA Judicial Council ethical standard and recommended its implementation and application by county medical societies (RX 308, p. 61).

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

Payne Avenue Business Directory

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

Attorney McCullough, working on the project, contacted the Minnesota State Medical Society concerning "possible ethical considerations" about the proposed list (CX 34B). The state society then sought the opinion of the AMA Department of Medical Ethics (CX 34A). The Director of the AMA Department of Medical Ethics replied that, under the applicable Judicial Council ruling, the list would be unethical if it included only those physicians who were members of the business association and was not open "to all physicians on like terms" (CX 33). Even if all the doctors in the neighborhood were to be included, the AMA letter questioned whether the list would be "in keeping with the ideals of the medical profession" (CX 33). The letter stated that "the wishes of all the physicians in Ramsey County should be taken into consideration" (CX 33). Inclusion, in the directory, of all the physicians in the county would have defeated the purpose of the plan, which was to serve the Payne Avenue neighborhood in particular (Tr. 381-82). As a result of the AMA letter, the proposed directory of businesses and services was dropped (Tr. 378, 380-82).

Prince George's County, Maryland, Directory

133. In the summer of 1973, Public Citizen's Health Research Group of Washington, D.C. [a Ralph Nader-affiliated organization, Tr. 2126], undertook the compilation of a directory of physicians in Prince George's County, Maryland (Tr. 2126, 2136). Approximately 80 percent of the practicing

physicians in Prince George' County belong to the Prince George's County Medical Society. All members of the local society belong to the state society, the Medical and Chirurgical Faculty of the State of Maryland (Tr. 7405-06), and 95 percent of all physicians practicing in Maryland are members of the state society (CX 679C).

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

The Health Research Group did not notify the county medical society or the state medical society of its plan to compile a directory prior to initiating its survey of physicians (Tr. 2203-04, 7467, 7479). In mid-July, the consumer group undertook its own questionnaire survey of Prince George's County physicians after its preliminary search for information on physicians practicing in the county had produced only the names, addresses, telephone numbers, specialty certifications, local medical society memberships and some information on physicians' educations (Tr. 2128-29, 2132-38, 2141; CX 679D-H, 2032). The questionnaire, developed without consulting with the medical societies (Tr. 2203, 7407; CX 2032), included questions on specialty, type of practice, teaching or staff appointments, medical education, Board certification, hospitals used, office hours, after-hours coverage, support personnel, average waiting time for appointments, acceptance of new and walk-in patients, treatment of Medicaid and Medicare patients, time for examination, languages spoken, house calls, fee and billing information, tests available, prescription of birth control and various specific drugs, immunizations and handling of complaints (CX 2032). Physicians were then contacted in a telephone survey (Tr. 2138). Where no response was given by the physician to a particular question, a space was provided labeled, "would not answer." If the physician declined to participate at all, the questioner was directed to inform him or her that the

survey was a consumer effort and that "refusal to cooperate" would be published in the directory (CX 2032; Tr. 2218-19). Many physicians phoned the local medical society for information about the survey and the organization sponsoring it, and were disturbed by the Group's threats to list physicians as uncooperative (Tr. 7406-11).

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

The Health Research Group contacted the local society after the first week of the telephone survey (Tr. 2148), informing them of the identity of the organization and the nature of the survey (Tr. 7423). In a letter to the Health Research Group, the society enclosed the relevant ethical and legal regulations and referred the Group to the Board of Medical Examiners or the Commission on Medical Discipline for consultation (CX 681). A copy of the questionnaire was subsequently sent to the society (CX 632). Upon reviewing the questionnaire, the society had further concerns with the questions asked (Tr. 7430-31). The questionnaire was sent to each physician with a cover letter which demanded that the questionnaire be completed, verified and returned within a week, or else the original response would be deemed correct and published in that form. Physicians were again told that if any questions remained incomplete, the directory would note that the physician "would not answer" (CX 683).

The local society thereupon circulated another message to its members (CX 684), which stated that the legal and ethical considerations raised by the questionnaire had not been resolved. Member physicians were advised that if they declined to participate in the directory, they should do so by stating "the information returned for review is incomplete and inaccurate and that the physician does not consent to publication" (Tr. 7442-43; CX 684).

At the suggestion of the local society, the consumer group contacted the state medical society (Tr. 2148, 2150). The state medical society advised the consumer group by

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

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

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

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

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

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

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

> It is not unethical for a physician to authorize the listing of his name and practice in a directory for professional or lay use which is intended to list all physicians in the community on a uniform and non-discriminatory basis. The listing shall not include any self-aggrandizing statement or

qualitative judgment regarding the physician's skills or competence. The American Medical Directory provides an example of the kind of information that may be properly listed in national as well as community directories for health service personnel. Likewise, specialties or specialty practices used in the American Medical Directory should set the pattern for specialty designations (RX 5).

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

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

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

Catawba County, North Carolina, Directory

135. In the fall of 1974, a sociology class at Lenoir Rhyne College decided to prepare a directory of physicians in Catawba County, North Carolina (Tr. 2366). The course instructor, Professor Daniel C. Bruch, who testified in this proceeding, assigned one student to contact the president of the Catawba County Medical Society ("CCMS") to determine whether the society would endorse the project. Another student was asked to write to the AMA to determine its position on the question of physician directories (Tr. 2371; CX 1835). Sometime in late September 1974, several students met with J. Thomas Foster, M.D., president of CCMS. Dr. Foster also testified in this proceeding. The students sought Dr. Foster's reaction to the preparation of a consumer directory of

physicians in Catawba County, North Carolina. Dr. Foster stated that, in his opinion, the general idea of a physician's directory was a good one (Tr. 2372-73, 7363). Shortly thereafter, the class sent a questionnaire to each of the physicians practicing in Catawba County (CX 698A-G; Tr. 2374, 7364). The questionnaire requested such information as the physician's name, address, specialty, fee-for-service or prepaid group practice status, number and type of support personnel in office, medical education and post-graduate training, board certification, hospital and teaching appointments, standard fees for phone consultations and office visits, billing procedures, willingness to make house calls, average waiting room time, acceptance of the Medicare reimbursements schedule as payment in full and willingness to show patients their medical records on request (CX 698).

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

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

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

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

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

There is no evidence of any other communication with AMA. By letter of November 14, Dr. Foster informed Professor Bruch of the society's decision. The letter stated, in part: "the Catawba County Medical Society declines to ask its members to answer the questionnaire on the basis that the answers could be considered to be construed as unprofessional self-aggrandizement. The answers that might be considered ethical would be of no value in a Consumers' Directory" (CX 890). Following the society's action, the college class received only one additional completed questionnaire from a physician, the family pediatrician of the professor directing the project (Tr. 2396). Overall, the class received completed questionnaires from only approximately one-fourth of the physicians surveyed (Tr. 2397).

7. Direct Contact with Institutions and Physicians

Dr. Harry G. Browne

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

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

Before acting on Dr. Browne's proposal, the hospital administrator gave Dr. Freeman a copy of it (Tr. 305-06). Dr. Freeman submitted a counter-proposal to the hospital which was almost identical to Dr. Browne's offer (Tr. 306). The hospital thereafter decided to renew Dr. Freeman's contract, and Dr. Freeman immediately began providing the hospital with significantly improved services (Tr. 306-07, 312-14; CX 1864-65). Prior to Dr. Browne's proposal, Dr. Freeman had never discussed with the hospital adminstrator possible improvements in his services to the hospital (Tr. 313); furthermore, until Dr. Browne made his pre-survey, Mr. Crowell was unaware that improvements could be made in the hospital's laboratory and pathology services (Tr. 314).

In early 1974, Dr. Freeman sent a copy of Dr. Browne's proposal (CX 4) to the Chairman of the Ethics Committee of the Nashville Academy of Medicine (CX 3, 12), the local AMA component society (CX 1825B, E). Dr. Freeman objected that Dr. Browne's proposal was unethical (CX 3), and indicated that he would also start soliciting business if Dr. Browne's conduct were considered proper (CX 3). The Nashville Academy wrote to the Director of the AMA Department of Medical Ethics for advice (CX 12). The AMA official responded that solicitation of patients or patronage was forbidden, and that Opinions 6, 9, 11 and 20 of Section 5 of the 1971 Opinions and Reports (CX 462Z5-Z6, Z9) governed the matter (CX 11). The Nashville Academy then informed Dr. Browne that it had received a

complaint about his proposal to Lewis County Hospital (CX 7). The Academy stated that it had obtained an ethics opinion from AMA and recommended that Dr. Browne read the Opinions and Reports provisions cited by AMA (CX 7, 11). The Academy also stated that it had referred the matter to the Tennessee Medical Association's ("TMA") Judicial Council for its further review (CX 7).

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

> If a pathologist asks a hospital for the opportunity of providing pathological services and laboratory services, I would think this is solicitation. It is solicitation of patronage--of business. . . . I do not believe it is acceptable, usual or customary for any physician to solicit referrals or to solicit or offer consultative services to fellow physicians . . . . (CX 9) (emphasis in original).

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

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

Other Incidents Involving Direct Contacts with Potential Users of Medical Services

137. A pathologist in San Antonio, Texas, wrote to the Board of Censors of the Bexar County Medical Society in early 1972 to request an ethics investigation of the solicitation activities of a clinical laboratory and its two associated pathologists (CX 2062D). The inquiring pathologist stated that the laboratory and its two pathologists had already obtained as clients a hospital and several physicians whom he had been serving (CX 2062D). The executive director of the Medical Society referred the pathologist's complaint to the Society's attorney for an opinion as to the legality and ethics of the alleged solicitation (CX 2062A). The attorney replied that, because the Medical Practice Act did not prohibit solicitation by physicians unless it was misleading to the public, the laboratory's solicitations really raised questions of ethics (CX 2063).

The Medical Society's Board of Censors then called the two accused pathologists to its April 1972 meeting (CX 2064A). The Board decided to inform the pathologists that they were in violation of the AMA ethics provision on solicitation of patients by groups and that they should immediately stop soliciting physicians' business through the laboratory's use of their names (CX 2064A). Shortly thereafter, the chairman of the Board of Censors sent a letter to the two pathologists quoting Opinion 8 of

Section 5 of AMA's 1971 Opinions and Reports, entitled "Solicitation of Patients by Groups" (CX 2065A, 4622S). A few days after their meeting with the Board of Censors, and again following their receipt of the Board Chairman's letter, the pathologists wrote to the director of the laboratory with which they were associated and requested that their names not be used in contacts with hospitals or other prospective customers (CX 2066A-B).

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

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

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

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

8. Open Houses

138. Opinion 13 of Section 5 in AMA's 1971 Opinions and Reports states that if a physician holds an "open house" with the intent of directly or indirectly soliciting patients, he is acting contrary to the Principles of Medical Ethics. The opinion makes it incumbent on physicians to discuss their plans for open houses with their component medical societies before implementing them (CX 4622Z).

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

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

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

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

9. Other Methods of Soliciting Patients

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

Opinion 14 of Section 7 in AMA's 1971 Opinions and Reports states that it is unethical for physicians to use their participation in bank credit card programs to solicit patients and, in particular, to list themselves in any bank credit card directory of participating members. Physicians are also prohibited from displaying outside their offices plaques or signs indicating their participation in such credit card plans (CX 462Z22-23). In August 1976, the state medical society in Maryland published a similar ethical rule, citing the AMA Judicial Council as authority (RX 308, p. 61).

E. Advertising by Fringe Medical Practitioners

1. Health Quackery

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

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

Professor Young testified that the misleading advertising of medical products and services remains a serious problem for several reasons. The ignorance of consumers is a major cause of the problem, since most laymen do not have sufficient medical expertise to recognize the deceptive nature of some medical advertising. Fear also plays a significant role in quackery, particularly with regard to an individual with a disease which medical science cannot cure or control. Individuals who are

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

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

2. Cosmetic Surgery Advertising in California

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

Advertising by cosmetic surgeons in California began two to three years ago in the form of small, infrequent notices in the classified ads (Tr. 7050). In the past two years, the advertisements have become larger and more frequent (Tr. 7050-51). The record contains numerous examples of recent advertisements by plastic surgeons in California (Tr. 6964; RX 268, 269, 680, 682-85, 781, 783-87, 797, 800, 801). Some advertisements contain false promises about the physical results of surgery (Tr. 6933), inaccurate statements about the surgical procedure (Tr. 6975; RX 269),

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

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

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

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

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

3. Consumer Witnesses in California Who Experienced Cosmetic Surgery

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

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

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

4. Advertising by Bariatric Physicians

143. Bariatric medicine deals with people who have weight problems (Tr. 7137). The purpose of bariatric treatment is not merely to promote a change in weight, but also to help the patient live a longer, healthier and more useful life (Tr. 7145). A decrease in weight may also cure or control such serious physical problems as high blood pressure, hypertension, diabetes and heart disease (Tr. 7145-46). There are about 560 members of the American Society of Bariatric Physicians (Tr. 7140). This organization, which is not related to the American Medical Association, strives to encourage a high level of bariatric medical care through continuing medical education programs, seminars and scientific publications (Tr. 7140-41). Approximately 60 members of the Society are certified by the American Board of Bariatrics (Tr. 7139).

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

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

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

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

5. Evaluation of Advertising By Fringe Medical Practitioners

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

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

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

XI. ETHICAL RESTRICTIONS ON PHYSICIANS' CONTRACTUAL ARRANGEMENTS

A. Contract Practice of Medicine

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

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

B. The Restrictions and their Background

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

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

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

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

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

(e) When there is solicitation of patients directly or indirectly */ (CX 462Z12-13).

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

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

(a) Opinion 5 of Section 6 of the 1971 Judicial Council's Opinions and Reports states: "A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee" (CX 462Z13).

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

(c) Opinion 4 of Section 6 states:

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

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

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

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

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

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

> [T]hat member of the profession hired by the month or year for definite, stipulated wages, by individuals, families, railroad or manufacturing corporation, or any other money-making institution whatever, for ordinary medical and surgical practice (always excepting benevolent and eleemosynary institutions and medical officers of the Army and Navy), are to be classed as irregular practitioners (CX 1435Q).

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

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

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

destructive competition among professional groups . . . and demoralization of the profession" (CX 2085Z6), and that "able physicians outside of the groups are being pushed to the wall" (CX 2085Z7).

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

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

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

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

C. Application of the Restrictions

148. AMA and its member societies have utilized the above described ethical restrictions on contract practice (F. 146, pp207-09) to proscribe contracts under which hospitals, group prepaid health plans and other lay organizations employ physicians to care for patients, especially where the physicians are employed for a fixed salary. In a number of instances, AMA and its member societies have counseled physicians to refrain from actions contrary to the contract practice ethical restrictions.

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

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

In 1965, AMA responded to an inquiry from the California Medical Association asking whether a physician could ethically compete with other physicians, through competitive bidding, to obtain an employment contract to perform physical examinations (CX 1158A, 539A). In its

response, AMA relied on the first three paragraphs of Opinion 3 of Section 6 of the Opinions and Reports governing contract practice (F. 146, pp. 2-7-08), including the provision barring "underbidding by physicians" (CX 1158A-C). The AMA letter stated:

> The guidelines as to what would be proper bidding could be indirectly resolved from points 1 and 2 [the first and second subparagraphs of the third paragraph of Opinion 3 of Section 6 of the 1964 Opinions and Reports (CX 465V) and later in the 1971 Opinions and Reports (CX 462Z12-13)]. That is, when the bid is below what is the usual fee paid for the same kind of medical service in the locality and when the remuneration is so low as to make it impossible to render competent service [it is unethical]. ...
>
> ...[As to] whether or not an affirmative response to such a general invitation to bid for use of the physician's professional services would [it] be within keeping of the dignity of the medical profession? Secondly, a doctor, would know by the type of request tendered to him that he probably is going to be competing against many of his associates for a specific contract or employment. Wouldn't this be a competitive force of so great a magnitude that it would cause a deterioration of the quality of medical service rendered? ...
>
> Thirdly, wouldn't such a request, if answered, make an inroad into the concept of professionalism in that it reduces the profession to a business? (CX 1158C-D).

In the mid 1960's, corporate plantations in Hawaii were contracting with physicians, on salaried and other fixed compensation bases, to provide medical care for their workers and retirees (CX 852A, 850C). When the plantations' retirees began obtaining coverage under the

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

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

The Honolulu County Medical Society adopted, as "clear and unequivocal," AMA's position on the plantations' contractual proposal and declared unethical any arrangement violating the policies set forth in the AMA letter (CX 846). The

Secretary of the AMA Judicial Council then wrote to the county society, praising it for "using the Opinions and Reports of the Judicial Council [to take] a stand" (CX 845). The AMA letter, which quoted a portion of an earlier AMA Judicial Council report, stated:

> 'The Judicial Council believes that the remedy for the evils associated with contract practice resides in the county societies, and that these societies should use their influence and power . . . to prevent underbidding for these contracts below what would give a fair reward for medical services rendered . . . . .'
>
> It seems to me that the Honolulu County Medical Society is observing the spirit of ethical principles . . . . (CX 845A-B).

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

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

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

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

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

The model contract also provides that the physicians "shall organize and operate the Emergency Department or Section and engage in medical practice therein in accordance with the ethical and professional standards of the American Medical Association . . ." (CX 954D). As recently as June 1974, the Secretary of the AMA Judicial Council sent a copy of the model contract to a hospital which had requested guidance in staffing an emergency room (CX 868, 869A-D).

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

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

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

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

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

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

In December 1969, the Secretary of the AMA Judicial Council responded to a physician's inquiry by sending a letter to an AMA field representative (CX 812, 459D). The letter stated: "If the salaried physician is being paid by the hospital for medical care given patients the hospital is practicing medicine through a licensed employee . . . . [This activity] is contrary to AMA policy. See opinion 4 and 5 on page 32, Opinions and Reports of the Judicial Council [CX 463V]" (CX 812A).

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

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

A hospital in Indianapolis paid an internist a fixed stipend to direct an arthritis treatment clinic which collected fees from patients for the services it rendered (CX 799). In 1974, a member of the medical staff of the hospital wrote to the AMA Judicial Council to ask whether the arthritis clinic was "in violation of ethics and policies of the AMA" (CX 799). In its response, the AMA Judicial Council questioned the propriety of the clinic selling its contract physician's services for a fee, stating that "[t]he policy of the American Medical Association is that the physician should set his own fees and bill his own patients" (CX 798).

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

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

Florida Health Care Plan

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

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

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

In 1972, the FMA published an ethics opinion stating:

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

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

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

In May 1977, two of FHCP's physicians applied for malpractice insurance coverage (CX 2558, 2566) from an insurance carrier established and controlled by FMA (CX 2540C, D, 2539C). The only other source of malpractice insurance in Florida was a program run by the State of Florida. The rates for this plan were substantially higher than the FMA carrier's rates (Tr. 9198-99, 9202, 9210).

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

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

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

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

D. The Connecticut Respondents

150. The AMA House of Delegates has adopted a resolution declaring that no state or local society which has not adopted AMA's Code of Ethics shall be entitled to

representation in AMA (CX 1435Z15-16). CSMS has adopted the AMA's Principles of Medical Ethics to govern the conduct of its members (CX 991D, L-M; CX 1404I-J). NHCMA has also adopted the AMA's Principles of Medical Ethics (CX 1404I). NHCMA's bylaws declare that members can be expelled for violating AMA's Principles of Medical Ethics, "as reflected in the [AMA] Judicial Council" (CX 1404I).

CSMS adopted a resolution in 1962 condemning as "corporate practice of medicine" hospitals' receipt of fees from government health programs and other third-party payers for services which the hospitals' staff physicians were providing to certain beneficiaries (CX 1344A, Z9-Z11). The resolution declared that such beneficiaries "shall have the status of private patients of privately practicing physicians" and that "no fees paid by any third party agency for services rendered by such physicians shall be paid directly or indirectly to any hospital . . ." (CX 1344Z9, Z11). This resolution is similar to Opinion 5 of Section 6 of AMA's Opinions and Reports (CX 462Z13). Copies of the resolution were distributed to general community hospitals throughout Connecticut (CX 1344Z10).

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

separate billing requirement to the ethical proscription regarding salaried medical practice (CX 820, 830, 831, 806C, G, 813A-B, 798, 799).

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

In 1974, NHCMA wrote to the Secretary of HEW to criticize an HMO's application for a federal grant (CX 966). In a December 1976, newspaper interview, the president of NHCMA associated HMOs with socialized medicine and otherwise disparaged them (CX 2440, 2441).

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

E. Physicians' Arrangements with Nonphysicians

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

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

In 1975, AMA sent an advisory letter to Dr. Paul D. Saville, a West Virginia rheumatologist, who testified in this proceeding (Tr. 2705), informing him that it would be neither ethically nor legally acceptable to form a business partnership or income-sharing arrangement with a

physician's assistant for the purpose of delivering health care (CX 1196). After receiving the AMA advice, Dr. Saville and the physician's assistant, Helen Kramer, formed an income-sharing arrangement; however, fearing physician hostility, they have kept the arrangement secret from everyone except their spouses (Tr. 2727-30). Physician's assistant Kramer, who also testified in this proceeding, brought administrative and patient-relations skills to the private practice of Dr. Saville, who lacked such skills (Tr. 2758-59, 2717). The result was a maximal effective practice which enabled the physician always to see new patients who came to his office and to treat a large group of people at minimal cost to them (Tr. 2717-19). Explaining the benefits of the income-sharing arrangement, Dr. Saville testified:

> [W]e both contribute something, and it is to our mutual advantage that we both do well.
>
> And the better we do, the harder Helen works, the harder I work, the more income there is, and the more load on Helen's back. It is a better incentive to share in the profits rather than be fixed salary, in my opinion (Tr. 2720-21. See also Tr. 2762).

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

In 1974, Dr. Kenneth Pitts, a psychiatrist residing in Hillsboro Hills, Michigan, first considered the possibility of establishing a psychiatric out-patient center in surburban Detroit. He discussed the matter over a period of months with Dr. Marvin Hyman, a clinical psychologist with whom Dr. Pitts had worked in the past. Dr. Hyman shared Dr. Pitts' enthusiasm for the project and the two men set out to establish a new out-patient center (Tr. 3166-68). Dr. Pitts and Dr. Hyman each invested an initial sum of $10,000 and, in late 1974, the Orchard Hills Psychiatric Center was organized under Michigan law as a professional corporation (Tr. 3167-70; CX 2102). Each of the men received 50 percent of the corporate shares (Tr. 3171). Dr. Pitts is medical director of the Center and Dr. Hyman serves as its

administrative director (Tr. 3164, 3170). All medical decisions at the Center are made by staff psychiatrists. Psychologists and social workers do not have authority to prescribe drugs, hospitalize patients or sign patient termination forms (Tr. 3173).

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

In April 1975, Dr. Pitts, who testified in this proceeding, wrote to the Michigan State Medical Society concerning the ethical propriety of forming a mixed professional corporation with a psychologist and a social worker (CX 1183B). The Medical Society deferred its decision until it had obtained the opinion of the AMA Judicial Council (CX 1184). The AMA Judicial Council told the Medical Society that Opinions 14 and 15 in Section 6 of AMA's Opinions and Reports prohibit a psychiatrist from owning jointly with a psychologist a professional corporation for the delivery of mental health services, notwithstanding the legality of the arrangement under state law (CX 1185, 1183, 2102N). In October 1975, the Medical Society conveyed the AMA ethics interpretation, which had confirmed its own opinion, to Dr. Pitts, and stated that the prohibition would apply to partnerships of otolaryngologists-audiologists, pathologists-medical technologists, ophthalmologists-opticians, radiologists-physicists, family physicians and paramedical personnel or physician assistants (CX 1186). In May 1976, the Medical Society's Judicial Council reaffirmed that physician-nonphysician partnerships are unethical (CX 1729).

The Medical Society's October 1975, letter led Dr. Pitts to incorporate the AMA ethics opinions in the standards for out-patient psychiatric clinics which he subsequently drafted for the Michigan Psychiatric Society (Tr. 3189-90; CX 2054C). These standards for out-patient psychiatric clinics, published in April 1977, quote Opinions 13 and 15 of Section 6 of AMA's 1971 Opinions and Reports (CX 462Z15, Z16), and state that any out-patient psychiatric clinic organized as a professional corporation must be solely owned by physicians (CX 2054A, C). The Michigan Psychiatric Society

promulgated these standards to its members, advising them that it would enforce the standards through peer review and ethics committee activities (Tr. 3191; CX 2054C).

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

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

XII. ABANDONMENT OR DISCONTINUANCE

152. The Principles of Medical Ethics of the American Medical Association (RX 1) consist of a preamble and 10 short paragraphs setting out basic principles or standards by which a physician may determine the propriety of his or her conduct in relationships with patients, colleagues, allied health personnel and the public (Tr. 3940-44, 4289; RX 1). The 10 basic sections of the Principles were approved by the AMA's House of Delegates in 1957 (Tr. 3940, 4289; RX 1).

The Opinions and Reports of the Judicial Council are a collection of opinions and statements of the Council on a variety of subjects which have come before it (CX 462; RX 1). Some of these opinions and statements involve interpretations of the Principles of Medical Ethics; the opinions, statements and interpretations are modified from time to time to meet changing conditions of medical practice (RX 1, p. 1; Tr. 4290). The Judicial Council's interpretations of the Principles of Medical Ethics are contained in a booklet, entitled Judicial Council Opinions and Reports (Tr. 3982; CX 462; RX 1). The Opinions and Reports are distributed to anyone requesting a copy (Tr. 3982). The Judicial Council opinions and statements circulated by AMA

prior to the issuance of the complaint in this proceeding were the 1971 Opinions and Reports, which were published in booklet form and distributed commencing in 1972 (CX 462). Subsequent to issuance of the complaint, the Judicial Council, in 1976, issued revised opinions and statements which were published in booklet form in 1977 (RX 1). The Principles of Medical Ethics remained unchanged (RX 1, pp. 4-5). Some of the activities of AMA officials and the Judicial Council which preceded publication of the 1977 Opinions and Reports are described in the following paragraphs.

In September 1975, the Secretary of the Judicial Council wrote to a state medical society: "It was not felt that a major revision of the profession's position on advertising was necessary or advisable, but that an updating of the Judicial Council's previous opinions and reports on advertising might be helpful in the near future" (CX 627A-B). He further stated that any updating would uphold, in general, "reasonable restrictions" on advertising (CX 627B). The proposal for a new "updated" edition of the 1971 Opinions and Reports was formally sanctioned at a meeting of the Judicial Council in November 1975 (Tr. 4336; RX 621). Thereafter, on April 9, 1976, four months after the complaint in this proceeding was issued, the Judicial Council issued a revised statement on physician advertising and solicitation (CX 502A, H-K). The content and format of a new edition of Opinions and Reports was approved by the Judicial Council on June 26, 1976 (CX 501F). This revised statement was included in a revised edition of the Opinions and Reports which was published by the Judicial Council in March 1977, well over a year after the complaint herein was issued (RX 1, pp. 30-31; Tr. 4335). The AMA Judicial Council issued the revised statement on advertising and solicitation and the 1977 edition of Opinions and Reports largely because "changing legal considerations," represented by the Supreme Court decision in Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975) (Tr. 4337), and administrative agencies' consideration of physician advertising and solicitation (CX 502A, E-H) had, in the view of the Judicial Council, rendered some provisions in the earlier [1971] edition of Opinions and Reports "legally inappropriate" (Tr. 4338, 4335; CX 503I).

For a number of months following issuance of the complaint in this proceeding, AMA continued to distribute excerpts from the 1971 Opinions and Reports, as well as its "Guidelines on Telephone Directory Listings" and the 1974 Report on Physician-Hospital Relations (CX 1790A, 1788, 501D-E). Through at least the beginning of the trial

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

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

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

Physician publicity and announcements which constituted "infractions of good taste" were disapproved under the 1971 Opinions and Reports (CX 462Z5 [Sec. 5, Op. 6], Z7 [Sec. 5, Op. 14]; Tr. 741; F.99, pp. 130-31). Dr. Robert B. Hunter, the Chairman of AMA's Board of Trustees, called as a witness by AMA, testified that AMA officials have made public utterances that it is AMA's position that physician advertising must not be only factual, but also "tasteful," and that most state and local medical societies also have that policy (Tr. 9660-61. See also Tr. 4870-72). Dr. Stephen C. Biering, Dean of the School of Medicine, University of Indiana, called as a witness by AMA regarding its position on physician advertising and solicitation (Respondent American Medical Association's List of Witnesses For Its Surrebuttal Case, dated April 21, 1978, p. 3), testified that it is appropriate for a medical society to reprimand or expel a member who has advertised in the newspaper in a truthful fashion but in "bad taste" (Tr. 9533-34).

The 1977 Opinions and Reports declares that "local, state, specialty medical associations...may have ethical restrictions on advertising, solicitation of patients, or other professional conduct of physicians that exceed the Principles of Medical Ethics" (RX 1, p. 30). AMA has made all such supplementary ethical principles binding upon the respective medical societies' members, provided that the principles are not inconsistent or in conflict with AMA's constitution and bylaws (CX 1435Z20). AMA

also has declared that when a physician disregards "local custom," as determined by the local society, he has acted unethically and may be subject to disciplinary action (CX 462Z9-10, Z7, I-J, 1349; RX 1, p. 9).

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

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

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

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

AMA has not specifically rescinded the 1971 Opinions and Reports or the 1974 Report on Physician-Hospital Relations (CX 959, 461Z156). AMA has not specifically rescinded the "Guidelines on Telephone Directory Listings" (CX 673B-I), which were adopted and approved by the AMA House of Delegates (CX 663, 673A). In June 1977, the AMA House of Delegates adopted a resolution commending the Judicial Council for "updating" the Opinions and Reports (RX 4, p. 52); however, the resolution did not rescind the House's earlier adoption of provisions in the 1971 Opinions and Reports and of other AMA restrictions on advertising and solicitation (CX 463), and remained silent on the relationship of the 1977 Opinions and Reports to those earlier provisions and restrictions (RX 4, p. 52). While the 1977 Opinions and Reports does state that the

Judicial Council has "suspended the distribution of the previous edition of Opinions and Reports" (RX 1, p. 1), it does not state that the 1971 or other preexisting AMA ethical restrictions on advertising and solicitation have been rescinded or superseded (RX 1, p. 1). There is no evidence that AMA has advised or requested component and constituent societies to revise or update their own codes or guidelines.

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

CONCLUSIONS

I. FACTUAL SUMMARY

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

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

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

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

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

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

Having resolved the jurisdictional questions against respondents, the substantive issues of respondents' acts and practices must be considered. Complaint counsel contend that respondents and other medical societies have acted to place restraints on physicians' solicitation and advertising activities. The Commission argues that these restraints

constitute unfair methods of competition in violation of Section 5. Complaint counsel also contend that respondents and others have acted anticompetitively with respect to physicians' contractual arrangements, also in violation of Section 5.

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

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

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

Each of the respondents is a nonprofit corporation, comprised primarily of physicians engaged in the private practice, fee-for-service delivery of medical care (F. 1, p. 5; 9, p. 8; 12, p. 9). Respondent AMA is a national organization, with its basic make-up that of a federacy of

its state medical societies, which are termed constituent societies. The constituent societies, in turn charter local medical societies, which are termed component societies. In most instances, a physician must be a member of a component society to be a member of a constituent society, and a member of a constituent society to be a member of AMA. A substantial majority of all physicians retain membership in the AMA and in their constituent and component medical societies. */

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

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

There is also little merit to AMA's contention that it abandoned or discontinued any anticompetitive acts or practices by the issuance and publication of its 1977 Opinions and Reports (RX 1). There is no policy statement by AMA to the effect that the 1971 or any other preexisting AMA ethical restrictions have been rescinded

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

**/ See Appendix A, pp. 306-09.

or superseded; nor is there any evidence that AMA's constituent and component medical societies have revised or otherwise departed from the ethics strictures of their own codes and guidelines. There is only an unbroken continuum of ethical pronouncements, and enforcement of those pronouncements, that will perpetuate the anticompetitive effects amply established in the record absent a remedial order (see discussion on Abandonment or Discontinuance, pp. 290-92 , infra, and on Remedy, pp. 293-98, infra).

II. JURISDICTION

A. Nonprofit Exemption

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

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

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

Respondents are organized as nonprofit corporations; no part of their funds has ever been distributed to their members, the largest single source of funds are dues from

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*/ 15 U.S.C. § 44.

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

their members and each respondent is exempt from the federal income tax. Respondents argue that, under the rationale of the decision in Community Blood Bank of the Kansas City Area v. FTC, 405 F.2d 1011 (8th Cir. 1969), they are exempt from Federal Trade Commission jurisdiction. It is clear, however, that in reviewing a jurisdictional challenge under Section 4 of the Federal Trade Commission Act, the form of incorporation is not controlling. Id. at 1018-19. The crucial consideration is whether each of these respondents is carrying on business "for its own profit or that of its members" (15 U.S.C. §44). This determination must be made on an ad hoc basis depending on the facts of each case. Id. at 1018.

While this is a case of first impression involving professional associations claiming the nonprofit exemption under Section 4, there are, nevertheless, some guidelines that are helpful in resolving the controlling issue. In Community Blood Bank, the court recognized that Congress did not intend to provide a blanket exclusion for all non-profit corporations, for it was aware that corporations ostensibly organized not-for-profit, such as trade associations, were merely vehicles through which a pecuniary profit could be realized. Id. at 1017. The court also accepted, as settled law, the principle that the Commission does have jurisdiction over nonprofit organizations engaged in activities that produce a pecuniary profit. Id. at 1019. */

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

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

In Ohio Christian College, the Commission pierced the corporate veil of a nonprofit corporation to assert jurisdiction over the corporation where it provided the individual respondents with much of their subsistence and shelter. Ohio Christian College, 80 FTC 815, 847 (1972). In a recent decision, the Commission asserted jurisdiction over a nonprofit corporation "existing in substantial part for the pecuniary benefit of the egg industry." National Commission on Egg Nutrition, 88 FTC 89, 177 (1976), aff'd, 570 F.2d 157 (7th Cir. 1977), cert. denied, 47 U.S.L.W. 3218 (October 2, 1978). In determining that the National Commission on Egg Nutrition was subject to Commission jurisdiction, the Commission looked at the record as a whole. This required analysis of a large number of possible indicia of commercial purpose, such as origin, character of membership, source of funding, relationships with profit oriented groups, nature of publications and stated purpose. Id. at 177, 178.

The facts determinative of jurisdiction in the present proceeding do not fit into the exact pattern of any previously decided matter. It is therefore incumbent that the entire record be examined to determine if respondents' activities are entirely charitable or if their activities are infected with a commercial purpose. In National Commission on Egg Nutrition, a decision rendered several years subsequent to the Community Blood Bank decision, the Commission stated that the respondent existed in "substantial part" for the pecuniary benefit of the egg industry. At another point in its decision, the Commission stated that the respondent "exists in principal part" for the benefit of the egg industry. The Commission also stated that an organization which engages primarily in noncommercial activity and incidentally performs a function valuable to commercial interests might not be subject to its jurisdiction. Further, the Commission indicated that the presence of only one possible indicia of commercial purpose might be an insufficient basis for asserting jurisdiction. National Commission on Egg Nutrition, 89 FTC at 177-79. The conclusion to be drawn from this imprecise language would seem to be that the Commission will assert jurisdiction over nonprofit organizations whose activities engender a pecuniary benefit to its members if that activity is a substantial part of the total activities of the organization, rather than merely incidental to some noncommercial activity.

Respondent AMA contends that the test of whether a corporation is organized for profit within the meaning of Section 4 is whether it pays dividends or other pecuniary

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

The respondents contend that for an organization to be subject to the jurisdiction of the Commission, profit-seeking must be the reason that it was organized and must play a dominant role in its activities (AMA Conclusions of Law, p. 20). While admitting that some parts of their budgets are devoted to activities that confer economic advantages upon their members, respondents argue that such activities are incidental or subordinate to the scientific, educational and public health activities in which they are primarily engaged (AMA Conclusions of Law, p. 25; CSMS Conclusions of Law, pp. 11-12, 14; NHCMA Conclusions of Law, pp. 4-6).

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

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

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

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

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

In the field of public health, the AMA engages in a wide variety of activities, such as testifying on many legislative bills and administrative regulations, conducting programs to upgrade the quality of health care in jails, assisting United States medical efforts in South Vietnam and later the Vietnamese physicians who fled South Vietnam to this country

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

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

and instituting a program to reduce the amount of violence on television (F. 16(f), pp. 15-16; 17(c), pp. 17-18; 17(e)-(g), pp. 18-23; 18, pp. 25-29). AMA distributes hundreds of pamphlets and posters on health care matters to the general public (F. 17(c)-(d), pp. 17-18; 17(f), p. 20; 17(g), pp. 21-23). It also responds to calls and letters from the public asking general medical questions (F. 17(c), p. 17; 19, p. 32). It gathers and publishes data on physicians and health care; such data is utilized not only by AMA, but also by scholars and governmental units (F. 16(e), p. 15; 17(d), p. 18; 17(g); 19, pp. 29-32).

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

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

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

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

While it can be argued that the above described activities of respondents have, at most, indirect or incidental economic benefits to members, a closer examination of many of

respondents' activities reveals a clear, direct economic purpose and effect. These activities which have a pecuniary benefit to members have been set forth in detail in respondents' proposed findings (See RAF, pp. 11-77; RCF, pp. 7-34; RNF, pp. 7-24). These activities combined with other characteristics of respondents, leave no doubt that while respondents do engage in educational, scientific and public health activities, a significant part of their time and resources are devoted to obtaining, protecting and furthering the economic interests of their members.

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

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

AMA told its membership that because of activities undertaken by AMA certain things did not happen to physicians: precertification of hospital admissions; a national health insurance plan which physicians cannot live with; price controls on physicians' fees; sweeping HMO grants; national relicensure of physicians; unrealistic restrictions on physician discretion in prescribing drugs; mandatory government service for all medical school graduates; and, premature HEW establishment of consumer-run program review teams for Medicare and Medicaid. AMA has stated to its

membership that other things did happen for physicians because of AMA: modification of the Keogh law; development of a universal health insurance claim form; American Hospital Association acceptance of the concept that the medical staff should be represented on hospital boards; and, model state legislation to safeguard medical information (CX 245D).

AMA has told its members that certain key benefits of membership are insurance programs at a lower cost then is available anywhere else, a membership retirement fund, physician placement service, leading scientific publications, authoritative legal information and guidelines on every aspect of medical practice, professional management information and guides "to increase the productivity and profitability of medical practice," the resources of the nation's greatest medical library and comprehensive scientific programming at conventions (CX 245D).

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

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

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

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

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

AMA lobbying activities which have had substantial economic impact on physicians include the removal of price controls on physicians' fees (F. 25, p. 43); assurance that physicians receive their usual, customary, and reasonable fees under the Medicare program F. 26, pp. 43-44); opposition to national health insurance programs that do not meet AMA's physician reimbursement standards **/ (F. 27, p. 44); opposition to federal funding of HMOs and opposition to liberalization of existing HMO legislation (F. 28, p. 45; 102, p. 134); suppor for passage of the Keogh Act (F. 29, p. 45); work to solve the malpractice insurance crisis facing physicians (F. 24, p. 41; 30, p. 46; 43, p. 54); support for pay increases for physicians in the Armed Forces and the Veterans Administration (F. 38, p. 49); and opposition to legislation requiring relicensure, retraining recertification or continuing medical education of physicians (F. 31, p. 46). In support of its efforts to influence legislation, AMA organized, and now supports and controls, a political organization, American Medical Political Action Committee, which engages in political education activities and provides financial support for political candidates (F. 22, pp. 35-37; 39, p. 50).

There are other AMA activities which provide a direct economic benefit to AMA members. AMA is very active in dealings with third-party payers, having been instrumental

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

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

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

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

Lastly, AMA's ethical restrictions on advertising, solicitation and contract practice insulate physicians from competition and have a substantial economic benefit to AMA members. The economic effects of these restrictions are discussed in a separate section of this decision at pages 254-79, infra.

The evidence unquestionably establishes that AMA has engaged in the listed activities and that they do have a substantial pecuniary benefit for AMA members. AMA has,

in fact, represented to its members that these are important benefits to the membership; there is no evidentiary basis in this record on which to doubt these statements. Being a membership organization supported by membership dues, it is neither illogical nor derogatory of the organization to conclude that AMA provides substantial economic benefits for its members. */

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

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

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

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

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

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

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

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

The Connecticut respondents engage in substantial activities which have a pecuniary benefit for their members. In the first instance, one must be a member of a local and state society before being eligible to become an AMA member (F. 4, p. 6). The pecuniary benefits which AMA provides its members are key benefits which are available to CSMS and NHCMA members upon joining AMA through their local and state societies. In 1975, 81.6 percent of the physicians registered in Connecticut were members of CSMS; over 50 percent of CSMS members were also members of AMA (F. 9, p. 8). Approximately 71 percent of all physicians registered in New Haven County are members of NHCMA; over 90 percent of NHCMA members are also members of CSMS, and approximately 40 percent are also members of AMA (Tr. 8439). Membership in NHCMA provides an opportunity for a physician to become a member of CSMS and receive the pecuniary benefits offered by that society.

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

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

CSMS has lobbied for legislation having significant economic benefits for physicians. CSMS opposed price controls on physicians' fees. CSMS pressed for repeal of the Connecticut law requiring physicians to pay a $150

annual registration fee. CSMS has lobbied for adoption of malpractice insurance legislation that would forestall premium increases as well as make it more difficult for plaintiffs to prevail in malpractice litigation and reduce the size of possible malpractice liability awards against physicians. CSMS has supported increases in and faster payment of physicians' claims under Medicaid, and has opposed the charging of fees by the State Health Laboratory and legislation expanding the practice of podiatrists and chiropractors (F. 66, pp. 88-89).

In support of its legislative activity, CSMS has organized and financially supported Connecticut Medical Political Action Committee to serve as the political "arm" and "tool" of the medical profession in Connecticut (F. 58, pp. 80-82; 67, p. 89).

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

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

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

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

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

NHCMA also operates a public relations program, sponsors insurance programs for members and intervenes with local hospitals on behalf of physicians to assist them in obtaining hospital privileges (F. 83, p. 101).

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

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

The record clearly establishes that respondents are engaged in a substantial number of activities that have a direct economic benefit for their members. It is equally clear from the record that respondents are engaged in a substantial number of activities of an educational, scientific or charitable nature which benefit their members, if at all, in an indirect manner. It is virtually impossible to precisely measure which activities predominate in respondents' overall operations. Such a determination is unnecessary, however. Neither the courts nor the Commission has ever held that Commission jurisdiction is limited to nonprofit organizations whose sole raison d'etre is to

serve as a conduit for the commercial interests of members. Nor is there any precedent for the proposition that business activity conducted by a nonprofit organization for economic objectives as distinguished from charitable objectives, is exempt. To the contrary, the legislative history of the Federal Trade Commission Act discloses that, in 1914, Joseph E. Davies, Commissioner of the Bureau of Corporations (predecessor to the Federal Trade Commission) informed Senator Newlands, the Senate manager of the Federal Trade Commission Act, that trade associations should be covered notwithstanding the fact that "no question as to their propriety can be raised." Community Blood Bank, v. FTC, 405 F.2d 1011, 1017 (8th Cir. 1969).

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

B. Commerce

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

The Connecticut respondents also argue that the fact that some members may occasionally treat patients who reside in other states and the fact that some medications are

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

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

The great majority of licensed physicians in Connecticut and New Haven County, respectively, belong to CSMS and NHCMA and have agreed to abide by the AMA ethical code. Because this code of ethics restrains, hinders and deters these Connecticut physicians from advertising, soliciting patients and engaging in the proscribed forms of contractual relationships, it necessarily affects the volume, destination and amounts of interstate payments into Connecticut for medical services. A physician who does not seek new patients by advertising must obviously forego the reimbursements he would receive if he attracted such new patients. Similarly, the ultimate destination of interstate insurance payments is necessarily affected when physicians

are restrained from competing with one another through advertising. For example, a physician in New Haven restrained by respondents' ethical restrictions from advertising physical examinations is likely to receive less patronage than if he had been able to advertise his prices and services. Accordingly, the physician will automatically receive a lesser volume of interstate Medicare, Medicaid and private insurance payments for his services. If the physical examinations are performed by other doctors, then the destination of the interstate payments has been affected. In Hospital Building Co. v. Trustees of Rex Hospital, 425 U.S. 738 (1976), the Supreme Court held that interference with revenue received by a hospital from out-of-state insurance companies affects interstate commerce. Whether the conduct affecting interstate commerce was directed at, or intended to affect, interstate commerce, is irrelevant. It is sufficient that interstate commerce has been affected. Hospital Building Co., Id. at 744-45.

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

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

Use by the Connecticut respondents of the United States mails and other interstate transportation and communications facilities in transmitting and receiving interpretations of the challenged ethical restrictions and copies thereof and in attending AMA conventions where many of the challenged ethical restrictions have been discussed and approved, provide "an adequate basis for Commission jurisdiction." Tysons Corner Regional Shopping Center, 85 F.T.C. 970, 988, 1015 (1975).

The Connecticut respondents have joined together with otherstate and local medical societies to form AMA and have adopted, as have these other societies, the AMA Principles of Medical Ethics to govern the conduct of their members. By

participating in concerted activities which restrain commerce throughout the country, CSMS and NHCMA have subjected themselves to Commission jurisdiction. As the Supreme Court has observed: "The Commission would be rendered helpless to stop unfair methods of competition in the form of interstate combinations and conspiracies if its jurisdiction could be defeated on a mere showing that each conspirator had carefully confined his illegal activities within the borders of a single state." FTC v. Cement Institute, 333 U.S. 683 696 (1948). See also United States v. Wilshire Oil Co., 427 F.2d 969, 974-75 (10th Cir.), cert. denied, 400 U.S. 829 (1970).

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

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

A. The Restrictions and their Anticompetitive Effects

It is not disputed that the AMA has made a significant public contribution through its health related activities from the date of its first meeting in 1847 to the present. Furthermore, it is not possible to give the AMA its just credit by a mere listing of the tremendous inroads it has made in the areas of medical education, medical licensure standards and public health programs, to name but a few. However, the history of the AMA is largely irrelevant for the purposes of this proceeding, which deals not with whether the AMA is deserving of public admiration but, rather, with what effects AMA ethics policies have had on physician competition in recent years. Moreover, the AMA's history is not untainted, as evidenced by the criminal conviction over 30 years ago of the AMA and the

Medical Society of the District of Columbia for conspiring to restrain and obstruct the development of a group prepaid health plan. American Medical Association v. United States, 317 U.S. 519 (1943), aff'd 130 F.2d 233 (D.C. Cir. 1942).

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

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

Complaints about health maintenance organizations' advertising and solicitation activities have been registered with local medical societies by physicians openly concerned about HMO competition with their fee-for-service practices.

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

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

Complaints about HMOs have also been made by competing health plans, including foundation health plans sponsored by local medical societies. (F. 104, pp. 137, 138). In response to these complaints, the medical societies have taken restrictive ethics actions regarding the accused HMOs and their physicians. */

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

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

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

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

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*/ F. 102-07, pp. 134-43.

**/ See F. 123, p. 174; 148, pp. 212-13; CX 759, 764B, 2119B.

Respondents' ethical restrictions on advertising and solicitation seek to prevent any doctor from presenting his name or information about his practice to the public in any way that sets him apart from other physicians. AMA's 1971 Opinions and Reports allows the limited publication of information on physicians only in media which are open to all physicians on like condition (CX 46226 [Sec. 5, Op. 11]). AMA has declared that it is not unethical for a physician to authorize the listing of his or her name in a physician directory which is intended to list all physicians in the community on a uniform and nondiscriminatory basis. AMA's Guidelines for Telephone Directory Listings prohibit box advertisements by physicians in the Yellow Pages and require uniformity of size and face of type among the physician listings. AMA's position on listing physician's names in credit card plans is that the plan must be available to all physicians in an area (CX 98C, 100A). In 1973, AMA wrote to the Bergen County [New Jersey] Medical Society about the ethics of a preventive medicine clinic's magazine article describing its services. AMA stated:

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

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

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

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

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*/ F. 98, pp. 124-29.

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

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

In 1973, Medi-Call, Inc., a firm located in Johnson County, Kansas, near Kansas City, Missouri, began offering a commercial physician house-call service. For a $50 annual charge, subscribers would receive two night house-calls by a physician; subsequent visits would cost $25 each. At the time, physicians were reluctant to make house-calls in the area Medi-Call planned to serve. Medi-Call began advertising its services through radio, television newspapers and billboards; without such advertising, the firm could not hope to attract clients. Subsequently, the Area Medical Council, composed of the top officers of four AMA component medical societies in the area, informed Medi-Call that its advertising was unethical. The firm ceased promoting its services. The action of the medical societies led to the financial failure and termination of Medi-Call's physician house-call service. **/

Dr. Edward Diethrich, an eminent cardiovascular surgeon, established the Arizona Heart Institute in 1971, in Phoenix. The Institute offered the latest methods for the study and treatment of cardiovascular problems, and charged fees which were often lower than similarly situated cardiovascular surgeons. Dr. Diethrich began promoting the Institute through various public media in order to get it off the ground. Dr. Diethrich received adverse reactions from the Maricopa County Medical Society, the AMA, the

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*/ F. 114, pp. 150-52.

**/ F. 117, pp. 154-56.

American College of Surgeons and the Society of Thoracic Surgeons (the latter two are specialty societies). He was denied membership in both the MCMS and the AMA, and was placed on three years' probation by the two specialty societies. Dr. Diethrich and the Institute have since become less visible and have experienced difficulty in raising funds. */

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

In 1973, Public Citizen's Health Research Group of Washington, D.C. (a Ralph Nader-affiliated organization) undertook the compilation of a physician directory in Prince George's County, Maryland. The project was begun in light of the dearth of accessible consumer information regarding physician providers of medical care in the area. The response from the local and state medical societies was one of noncooperation and opposition; the consumer group was advised that a physician who supplied more than his identity, specialty and office hours would be acting unethically. As a result, the Health Research Group obtained a minimal response rate from physicians, thereby depriving consumers of worthwhile and beneficial information that would aid them in choosing a physician. ***/

In 1973, Dr. Harry Browne, a Nashville, Tennessee, pathologist, submitted a written proposal to Lewis County (Tennessee) Hospital. The proposal detailed how

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*/ F. 120, pp. 160-66.

**/ F. 121, pp. 167-68.

***/ F. 133, pp. 187-91.

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

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

Dr. James Warren is head of the Department of Obstetrics and Gynecology at Washington University Medical School in St. Louis. He is also medical director of the Washington University Center for Outpatient Gynecological Surgery.

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*/ F. 136, pp. 194-97.

**/ F. 103, pp. 135-37; 149, pp. 220-21.

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

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

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*/ F. 99, pp. 130-31.

**/ F. 106, pp. 140-41.

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

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

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

B. Justifications for the Restrictions

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

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

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

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

AMA's experts testified that widespread advertising by physicians would have a deleterious effect upon the practice of medicine. For example, if physicians were allowed or encouraged to disseminate "objective" information concerning the number of cases of a particular disease which they have treated, inexperienced or unqualified physicians might well be encouraged to treat more cases of the disease. Similarly, allowing physicians to advertise the mortality or complication rates of their patients might discourage them from treating more difficult cases. Such advertising might also encourage overutilization of medical care, since physicians might tend to perform more and more relatively easy procedures or treatments on patients who did not necessarily require them. A physician might also choose to advertise the number of operations which he or she has performed. If the physician is being judged publicly on such a criterion, he might tend to "accummulate" a large string of operations. This motivation could also result in overutilization of medical services (Tr. 7695-97, 5332, 6089).

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

Dr. Cooper testified that advertising of physicians' services also has the potential for consumer deception. Consumers are more vulnerable to deceptive advertising when they are sick than when they are well. A misleading

advertisement on behalf of a physician may lure a patient away from a source of responsible, continuing care to someone who may be less responsible (Tr. 6083-84, 6089). A physician's advertising of his medical credentials may result in consumer deception.

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

Dr. Ingelfinger testified that fee advertising has the potential for bait and switch tactics because the initial fee will often not cover further tests necessitated by complications or the need to confirm inconclusive results. He stated that advertising of the fee for a physical examination is misleading unless disclosure is made of the amount of time the physician spends with the patient, the thoroughness of the examination, whether the fee includes the taking of a history and what other tests and procedures are included in the fee (Tr. 5340-42, 5346). Advertising of new techniques which have not been generally accepted in the medical community can be deceptive and hazardous. An example of such a situation is the Wagenstein method of treating ulcers by freezing the stomach, which was highly touted at first but which subsequently proved to be harmful (Tr. 5336-38).

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

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

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

In testifying about HMOs, Dr. Ebert stated:

> ...it is very difficult for the general public to appreciate what is available in various kinds of systems. For example, it is now mandatory, I guess, through recent legislation that there should be [a] choice in any firm of over 25 if an HMO exists in a region, that there should be at least a freedom of choice between that and an ordinary Blue Cross-Blue Shield or whatever commercial carriers may be offering. One of the great difficulties with this is it is not easy to get the best information about that choice. One gets some general descriptions of it

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

but very often it is not considered proper to list the physicians, who they are and what their background is and so on. It does seem to me the kinds of things that can be put into advertising that lists the services, that lists the costs, that lists the people and their qualifications, is valuable in terms of educating the public (Tr. 9321-22).

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

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

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

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

. . . .

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

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

Dr. Ebert further believes that the public is capable of evaluating and utilizing physician advertising, physicians are not going to engage in making exaggerated claims in advertisements, advertising will not adversely affect the physician-patient relationship or affect a patient's confidence in a physician, advertising will not lead to overutilization of those medical facilities that are under the control of the physician, price advertising by physicians will not lead them to cut corners in the treatment or

diagnosis of patients, advertising may or may not cut medical costs, and advertising by legitimate physicians may actually dilute the effect of advertising by fringe practitioners (Tr. 9333, 9341-58, 9409-10. See also Tr. 7001-02, 5361-62). He stated that directories of physicians are helpful, but there is need to advertise that such directories are available to patients (Tr. 9354-55). Dr. Ebert believes that the majority of physician advertising will center around systems of health care rather than the sole practitioner (Tr. 9377, 9409).

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

> JUDGE BARNES: The issue here is whether to take all control away from the medical society as to advertising?
>
> THE WITNESS: Yes.
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> JUDGE BARNES: That is the basic issue and I think that is what Mr. Costilo is seeking an answer to. The question is do you support that view?
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> THE WITNESS: Yes, I do. I support the view not (sic) to take away overall advertising because I think it now is ineffective in controlling a group of physicians who are operating outside of the framework of organized medicine anyway and it is limiting the information that can be given to the public by perfectly legitimate groups of physicians, therefore I do think the relief sought is proper and it should be taken away.
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> . . . .
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> A. I think that what is important here is not the advertising per se, but what the physician does. I would think that untruthful advertising would certainly be the signal to find out whether his behavior as a physician was unethical in terms of his practice. Certainly, if it were, he should be expelled.
>
> Q. But with respect to his advertising, should the local medical society regulate his advertising as advertising?

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

. . . .

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

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

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

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

C. The Justifications are Without Merit

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

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

The record in this proceeding demonstrates the substantial anticompetitive effects of respondents' restrictions on physician advertising and the free flow of commercial information to the public. Physicians have been prevented from seeking customers by advertising or offering to provide services at a particular price, or by advertising their

services, availability or qualifications. As a result, it is more difficult for consumers to comparison shop for physicians' services, to locate physicians upon first arriving in a community, to change physicians, to find physicians who will accept the Medicare reimbursement schedule as payment in full, to become informed about group practices and HMOs and to benefit in many other ways from competition among the providers of health care services. The challenged restrictions have hindered the entry of new providers into the physicians' services market, including private practitioners, prepaid health care plans such as HMOs and other organizations and programs using innovative or alternative approaches in the delivery of health care. Physicians, prepaid health care plans and other medical organizations and programs that have been prevented and deterred from advertising and soliciting patronage have been injured economically, and the restrictions have made it more difficult for these physicians and organizations to continue to offer their services to the public and to compete effectively.

The Supreme Court has declared that there is no longer any automatic immunity from the antitrust laws based on the mere fact that a group constitutes a "learned profession." The Court stated: "[T]he cautionary footnote in Goldfarb, 421 U.S. at 788-89, n. 17 ... cannot be read as fashioning a broad exemption under the Rule of Reason for learned professions." Professional Engineers, 98 S. Ct. at 136. See also Goldfarb, 421 U.S. at 787-88.

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

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

Further, high professional standards, including standards against dereliction in performance, are assured by state medical licensing boards */ and state statutes regulating physician conduct, including advertising and solicitation. **/ Moreover, false or deceptive advertising is already prohibited in every state and the District of Columbia in enacted laws preventing deceptive and unfair trade practices. Ophthalmic Rule, 43 Fed. Reg. at 23997, n. 89. The substantial penalties provided for under the Federal Trade Commission Actare a substantial deterrent to false or deceptive advertising. (15 U.S.C. 45(1). Since not all physicians are members of medical societies, and therefore not subject to medical society ethical rules, those fringe practitioners who might be more likely to commit abuses remain unaffected by present ethical restrictions. ***/ "Restraint on advertising ... are an ineffective way of deterring shoddy work. An attorney who is inclined to cut quality will do so regardless of the rule on advertising." Bates, 433 U.S. at 378 "The advertising ban does not directly affect professional standards one way or the other." Virginia State Board of Pharmacy, 425 U.S. at 769. The same reasoning holds true for physicians.

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*/ See F. 88, pp. 108-10

**/ See Appendix B, pp. , infra.

***/ See discussion at F. 144, p. 206.

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

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

The Court's response applies with equal force to the case of physician advertising. Services such as routine examinations, laboratory and diagnostic tests, immunizations and other short, simple procedures do lend themselves to meaningful advertising. The Relative Value Guides */ promulgated by many medical societies indicate that there are base fees that can serve

*/ See F. 33, p. 46; 60, p. 83; 63, pp. 85-86.

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

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

To say that physicians are above "trade," and to assert that they are entitled to preserve their basic ethical values despite deleterious effects on

*/ During the period of federal price controls in the 1970's, federal regulation required all medical practitioners to post a sign in their facilities announcing the availability for public inspection of a schedule showing their customary prices for those services which accounted for 90 percent of their aggregate annual revenues (CX 2602). From this evidence, it can be inferred that physicians' fees are readily capable of being publicized in a nondeceptive manner.

competition, would be to completely remove physicians from a marketplace setting, rather than admit that the services they offer, the delivery of which are both highly necessary and equally highly respected, might better comport with the public's needs were they subject to appropriate competitive factors, i.e., advertising, solicitation and contract practice.

Respondents also argue that they do not proscribe advertising per se, but only that advertising which is misleading or deceptive. */ The actual occasions on which medical societies interceded and effectively curtailed various forms of physician advertising show the fallacy of this argument. Dr. LaDou desired to acquaint the public with the advantages of preventive medicine and industrial medical services; he intended for his advertising to accomplish this objective. **/ He had hoped to bring his services to the attention of business executives, a knowledgeable consumer group. Dr. Browne's proposal, stating the nature of and price for the laboratory and pathology services that he could offer, was intended to show that improved services did not require any increase in price. ***/ Dr. Browne was dealing with hospital executives, again a knowledgeable group. These physicians, Dr. LaDou and Dr. Browne, and others posed obvious economic threats to medical societies and their members, who viewed the fee-for-service, private practice physician, in a noncompetitive setting, as the only viable means for delivering medical services. Neither Dr. LaDou, Dr. Browne nor the greater majority of physicians who engaged in advertising or who proposed to engage in some form of advertising, as recounted in the record evidence, misled or deceived the public. The information they hoped to

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

**/ See discussion at p. 258, supra, and at F. 98, pp. 124-29.

***/See discussion at pp. 260-61, supra, and at F. 136, pp. 194-97.

disseminate would only contribute to the pool of information on medical services available to the public, and thereby add to the breadth of the system of health care delivery in this country.

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

The record evidence in this proceeding is overwhelming in establishing the anticompetitive effects of respondents' ethical restrictions, their economic motivations and their consequent harm to the public interest. The unreasonableness of the restraints on competition imposed by respondents AMA, CSMS, NHCMA and other AMA constituent and component medical societies needs no further elucidation. The ethical restrictions which the medical societies have imposed heavily tip the balancing scales against the needs of the public and in favor of the maintenance of the financial security of physicians. In such instance, the Rule of Reason is clearly violated. Since a record has been made that clearly demonstrates the unreasonableness of respondents' ethical restrictions, it is unnecessary to consider whether such activities also fall within a per se ban.

Respondents' ethical restrictions on advertising, solicitation and contract practice are also unfair under Section 5 of the Federal Trade Commission Act. A practice is unfair and violates Section 5 if it results in substantial

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

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

IV. RESPONDENTS HAVE ENGAGED IN A CONSPIRACY TO RESTRAIN COMPETITION

The record evidence establishes the existence of a conspiracy between the AMA and its constituent and component medical societies, including respondents CSMS and NHCMA. The degree and pattern of reliance by state and local medical societies upon the AMA for statements of official ethics policy, as well as for advice on ethical matters as they arise or are likely to arise, and the dependence by the AMA upon the state and locals to implement and enforce those ethics policies become manifest in the internal structure and organization of the AMA and its constituent and component societies and in their working interrelationships. The prescriptions and proscriptions of AMA, as set forth in AMA's Principles of Medical Ethics, Judicial Council Opinions and Reports and other official pronouncements represent a pervading force in virtually all disciplinary actions undertaken by medical societies. To conclude, from respondents' admissions and from the parallelism between the nature of official policy on ethical issues as articulated by the AMA and as implemented and enforced by AMA member medical societies, that the striking uniformity of medical societies' positions

on ethics matters should have come about by mere chance or coincidence, as respondents have argued, rather than based on a common understanding and concerted activity is to adopt the impractical and ignore the reality.

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

A. The Conspiracies Being Challenged

The complaint alleges that respondents and others have agreed to prevent and hinder competition among physicians (Comp. ¶¶ 6 and 7). Respondents have engaged in two types of unlawful agreements. First, AMA has agreed with all of its constituent and component medical societies, including the Connecticut respondents, to promulgate and enforce ethics restrictions on physicians' advertising, solicitation and contractual relations. Second, each respondent medical society has engaged in concerted activity with its members by adopting the ethics restrictions, disseminating them to its members and agreeing to abide by them.

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*/ Rule 801(d)(2)(e) of the Federal Rules of Evidence, states:

> "A statement is not hearsay if the statement is offered against a party and is a statement by a co-conspirator of a party during the course and in furtherance of the conspiracy."

B. The Legal Standard Governing Respondents' Activities

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

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

In Interstate Circuit, 306 U.S. at 226-27, the Supreme Court held that where concerted activity is contemplated and invited by a central, coordinating party and such

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

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

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

anticompetitive activity, and in that posture cannot claim it is beyond the reach of the Sherman Act." Id. at 791-92. The parallelism between Goldfarb and the instant set of facts is clear.

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

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

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

The structural hierarchy of the AMA and its member societies and the organizational network that allows them to function in an efficient and integrated manner reveal a close working relationship. */ AMA is a federation of constituent (state) medical societies which, in turn, charter component (county and district) medical societies.

*/ See discussion at pp. 234-35, supra.

In most instances, a physician must join his or her state medical society to be eligible for AMA membership. Membership in a local society is usually a prerequisite to membership in a state society (F. 4-5, p. 6; 9, p. 8). The state societies usually collect AMA membership dues on behalf of AMA.

The local societies select the members of the state societies' governing bodies, and the state societies select the members of the AMA ruling body, the House of Delegates. The House of Delegates, representing the medical societies in the AMA federation, has adopted the Principles of Medical Ethics and has made adherence to them a condition of membership in AMA. The House has approved and specifically adopted many of the ethical restrictions on physicians' advertising, solicitation and contractual relations that are contained in the Opinions and Reports. The House has declared it a prime purpose of AMA to maintain "ethical" standards among all members of the medical profession (CX 990Z10). Promulgation and enforcement of its code of ethics has been a principal function of AMA since its founding (CX 959Z28). The House of Delegates elects the members of the AMA Judicial Council. The Judicial Council issues interpretations of the Principles (Judicial Council Opinions and Reports), is empowered to institute disciplinary proceedings at the request of state societies against physicians who violate the Principles and has appellate jurisdiction over cases originated by constituent and component societies in ethical matters (F. 6, p. 7; 8, pp. 7-8; 85, p. 101; 86, pp. 105-06).

Often, the constitutions and bylaws */ of constituent and component medical societies expressly state that a primary purpose of existence is to form and maintain, along with other medical societies, the AMA (F. 5, p. 6). The bylaws of these medical societies provide that AMA's Principles of Medical Ethics shall govern the conduct of their members (See Appendix A, infra). The AMA House of Delegates has adopted a resolution making state medical societies' own ethical principles binding upon the respective societies' members, provided that the principles are not inconsistent or in conflict with the Constitution and Bylaws of AMA (CX 1435Z20). AMA has also declared that when a physician disregards "local custom," as determined by the local medical society, he has acted unethically (F. 86, p. 104; CX 1349). Furthermore, AMA has declared it the duty and

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

obligation of its local medical societies to insure full compliance with the spirit and intent of the AMA Principles of Medical Ethics (CX 46229 [Sec. 5, Op. 20]), and has frequently urged its constituent and component medical societies to fulfill this obligation (CX 46221 [Sec. 4, Op. 9], Z2 [Sec. 4 Op. 14], Z5-6 [Sec. 5, Op. 9], Z6, [Sec. 5 Op. 11], Z6-7 [Sec. 5, Op. 12], Z7 [Sec. 5, Op. 13], Z9 [Sec. 5, Op. 20], Z10 [Sec. 5, Op. 23], Z40 [Sec. 10 Op. 4], Z45 [Sec. 10, Op. 13]; 26B, 54, 488B-C, 662B-C, 673A, E, 845, 1392C, 1810). AMA has also stated that the application of all of the opinions in the Opinions and Reports is the obligation of county medical societies (CX 489).

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

The hierarchy of the medical societies, their common members, the bylaws of the state and local societies, combined with AMA's Principles and its Opinions and Reports, constitute a prima facie showing of the conspiracy between AMA and its constituent and component societies, including the Connecticut respondents. Moreover, the actual restrictive practices, including the constant flow of communications between AMA, its member medical societies and individual physicians concerning ethics policy and ethics enforcement, further demonstrate the existence and extent of the conspiracy. AMA has prompted its constituent and component medical societies to apply its restrictions on physician advertising, solicitation and contractual arrangements to particular physicians and medical care organizations, has offered guidance to its member societies in interpreting and applying the restrictions and has expressed after-the-fact approval of specific restrictive actions taken by its member societies. */ State medical societies including CSMS,

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

ve prompted and participated with their local medical societies including NHCMA, in specific actions to interpret and enforce AMA's ethical restrictions on solicitation, advertising and contractual arrangements. Apparently feeling less qualified and less expert in the application of ethical pronouncements than the AMA, local societies have written to AMA to solicit its advice and opinions on numerous occasions. AMA's responses often take the form of advisory opinions, ethical policy statements and, where appropriate, have usually resulted in the informal enforcement by the local societies of the restrictions on physicians' advertising, solicitation and contractual relations contained in the Principles. Where the AMA receives communications from sources other than member medical societies, it often responds by referring ethical complaints and inquiries to the appropriate component medical society for action.

In sum, AMA acts as a clearinghouse for the dissemination of policy on ethic matters and, frequently, for the resolution of ethics complaints. AMA field officials, under the direction and guidance of the AMA Judicial Council and its staff, act as intermediaries on matters of medical ethics between AMA and its constituent and component medical societies and others. In so doing, AMA field officials engage in many of the same activities as the AMA Judicial Council and its staff and routinely, in formal and informal ways, interpret and enforce, and assist and advise AMA's constituent and component medical societies and others in the interpretation and enforcement of, AMA's Principles of Medical Ethics and AMA's Judicial Council interpretations thereof. */ The incessant obedience of the locals and their members to AMA's ethical dictates belies the possibility of mere coincidence. Instead, such concerted actions bespeak of a common conspiratorial undertaking.

Evidence independently admissible against the Connecticut respondents establishes their prima facie involvement in a conspiracy with AMA and other constituent and component societies.**/ NHCMA members are directly represented in the CSMS House of Delegates which, in turn, sends delegates to the AMA House of Delegates. Both CSMS and NHCMA have adopted, published and distributed to their members the AMA's Principles of Medical Ethics and interpretations of them; both have made adherence to the

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

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

Principles a condition of membership. NHCMA has explicitly provided that its members are bound by the AMA Principles as reflected in the opinions of the AMA Judicial Council (F. 86, p. 104). Both Connecticut respondents have communicated with AMA about matters relating to the Principles and, thereby, to the aforementioned restrictions on physicians, and both have engaged in informal enforcement of the AMA Principles (F. 95, pp. 119-20; 112, p. 147; 119, p. 160; 121, pp. 167-68; 123, pp. 172-73; CX 136A-F, 137). This is more than the "slight evidence" that is needed to connect a particular party to an ongoing conspiracy.

The record evidence */ evinces, beyond any reasonable doubt, a "unity of purpose" and a mutual understanding on the part of the AMA, its constituent and component societies and the individual physicians that comprise the membership of those medical societies to promulgate, disseminate and enforce ethical restrictions on advertising, solicitation and contract practice. The orchestration of activities that effectively restrain physician competition throughout the United States is too harmonious to be suggestive of anything other than concerted action - a conspiracy - among physicians and their medical societies.

D. Third-Party Medical Society Documents

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

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

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

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

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

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

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

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

Since many of the third-party documents refer explicitly, as well as implicitly, to the AMA's Principles of Medical Ethics and to the Opinions and Reports, they constitute

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

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

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

The only question lies in the reliability of the documents. However, the documents largely consist of minutes of official meetings and correspondence generated during the normal course of operations and prepared contemporaneously with the transactions described therein. Documents such as these are akin to business records which are routinely admitted into evidence under an exception to the hearsay rule. **/ Evidence of this nature is traditionally accorded a high degree of reliability arising

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*/ § 3.43(b) reads as follows:

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

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

t of the fact that such documents are among the types of materials that reasonable persons will rely upon in their daily business affairs. The authenticity of these documents has not been challenged. Therefore, they are admissible under Rule 3.43(b) and provide further evidence of conspiracy.

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

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

V. ABANDONMENT OR DISCONTINUANCE

Respondent AMA contends that the basis for any decision in this case should be AMA's current position on advertising, solicitation and contract practice as reflected in the 1977 Opinions and Reports (RX 1), and that there is no need to inquire into the antitrust implications of earlier editions of the Opinions and Reports (AMA Conclusions of Law, pp. 72-76, 120-122; AMA Post-Trial Brief, pp. 29-36). AMA contends that the Commission should determine the lawfulness, not of obsolete statements of the AMA, but of the current position of the Association. A ruling based on outdated statements in the 1971 edition would amount to "a sterile exercise of the Commission's power, an exercise engaged in simply to have an order on record" (AMA Post-Trial Brief, p. 34). */

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

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

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

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

There has never been any communication from AMA to its constituent and component societies to revise or update their own ethical codes or guidelines so as to conform with the 1977 edition of the Opinions and Reports. The record is devoid of evidence that constituent and component societies

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

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

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

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

VI. THE REMEDY

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

Recent Supreme Court decisions have emphasized the need for the free flow of commercial information. Commercial speech serves to inform the public of the availability, nature, and prices of products and services, and thus performs an

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

indispensible role in the allocation of resources in a free enterprise system. In short, such speech serves individual and societal interests in assuring informed and reliable decisionmaking. Bates v. State Bar of Arizona, 433 U.S. 350, 364 (1977); Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc. 425 U.S. 748, 765 (1976).

In acknowledging the significance of commercial speech to the public, the Court has not hesitated to strike down barriers that inhibit the dissemination of commercial information. The Court has also made it abundantly clear that Congress did not intend to exclude professional associations from antitrust regulation. Professional Engineers, 98 S. Ct. at 1362-68; Goldfarb v. Virginia State Bar, 421 U.S. 773, 787 (1975). Virginia State Board of Pharmacy at 766-770.

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

AMA argues that it is not opposed to the dissemination of truthful, objective information about physicians' services that will be helpful to consumers. AMA contends that its position on advertising and solicitation is reasonable in that it combats deception, enhances the physician-patient relationship, and guards against a lowering of the quality of medical care received by patients (AMA Reply Brief, p. 54-55, 66). Even assuming that AMA's intentions are altruistic, the record shows that its restrictions have had the effect of depriving consumers of the information necessary to make an informed choice of health care and insulating physicians from the give and take of the marketplace. New methods of health care have been discouraged, restricted and, in some instances, eliminated. That some of the effects of respondents' ethical restrictions may have been to prevent inferior services or insure ethical behavior is not a sufficient justification for permitting respondents

to impose continuing restrainst on competition. There are other methods to accomplish respondents' purported objectives without the substantial restraints on competition which inherently flow from respondents' ethical restrictions.

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

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

The history of the Federal Trade Commission over the years is replete with proceedings concerning false and deceptive advertising and promotional practices involving drugs, cosmetics, devices and medical services, including such items as bust developers, hair preparations, bed-wetting devices, arthritis cures and weight reducing and control devices and remedies. */ The Wheeler-Lee amendment to the Federal Trade Commission Act, **/ passed in 1938, was enacted to broaden the powers of the Commission so as to provide more effective control over false advertisements of foods, drugs, devices and cosmetics.***/ For the first time, the Commission was given authority to enjoin false and deceptive advertising. Recent actions by the Commission in

*/ See CCH Trade Reg. Rep. ¶¶ 7739, 7741, 7743, 7745, 7747, 7749, 7751, 7780-85.

**/ 52 Stat. 114, 15 U.S.C. § 52 et seq.

***/ H.R. Rep. 1613, 75th Cong., 1st Sess.

this area of regulation include proceedings entitled Simeon Management Corporation, Docket 8996 (weight reduction clinics), Travel King Inc., et al. Docket 8949 (physic surgeons), Porter & Dietsch, Inc., Docket 9047 (weight control products), American Home Products Corp., Docket 8918 [Initial Decision, Administrative Law Judge Hyun, dated September 1, 1978] (headache or pain remedies), and Karr Preventative Medical Products Inc., Docket 9109 [Complaint issued April 26, 1978] (acneremedy). The penalties provided for in the Federal Trade Commission Act may well be a substantial deterrent to false and deceptive advertising by physicians. As noted by the Commission in the recently issued trade regulation rule on the advertising of ophthalmic goods and services, all of the 50 states have laws prohibiting false and deceptive advertising. Advertising of Ophthalmic Goods and Services, 43 Fed. Reg. 23992, 23997 n. 89 (FTC June 2, 1978). Thus, it cannot be concluded in this proceeding or, indeed, in any proceeding that governmental regulation of false and deceptive advertising, although at times perhaps imperfect, must give way to private regulation to protect the public.

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

Respondents have contended throughout this proceeding that the only restrictions they have imposed on their members were intended to prevent deception of the public and to protect the quality of medical care, and that they have not opposed the dissemination of truthful information which will assist consumers in making an informed choice of a physician. The record evidence is otherwise, however, it establishes with clear conviction that respondents have prevented the dissemination of truthful, objective information that could provide substantial benefits to the public. These restrictions have been carried out over a long period

of time as a common understanding between AMA, CSMS and NHCMA and over 2,000 other medical societies throughout this country and their members. These restrictions must be completely eliminated and physicians must be given the unfettered opportunity to present to the public information which the public needs and is entitled to receive, subject only to governmental, not medical society, restrictions.

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

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

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

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

Accordingly, the Order found to be necessary to remedy the unlawful conduct disclosed by the record and entered herein will require respondents to cease and desist from the practices found to be unlawful, to revoke and rescind any existing ethical principles or guidelines which restrict physicians' advertising, solicitation or contractual relations, to provide adequate notification to its members and affiliated societies of the terms of the Order and to deny affiliation to any society that engages in any practices which violate the terms of the Order. The Order will permit respondents to issue ethical guidelines affecting advertising and solicitation relations by physicians in the future with permission of and approval by the Federal Trade Commission, which has the organizational flexibility and know how to work with respondents and assure that such guidelines as are approved are in the public interest.

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

ORDER

I.

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

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

B. Restricting, regulating, impeding, declaring unethical, interfering with, or advising against the solicitation through

advertising or by any other means, of patients, patronage, or contracts to supply physicians' services, by any physician or by any organization with which physicians are affiliated;

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

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

E. Inducing, urging, encouraging, or assisting any physician, or any medical association, group of physicians, hospital,

insurance carrier or any other nongovernmental organization to take any of the actions prohibited by Paragraphs A through D above. Provided, however, that nothing in this Order shall be construed to prohibit respondents, their constituent or component organizations or their members from reporting in good faith to governmental authorities any alleged violation of law, including but not limited to:

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

(2) Reporting to appropriate governmental authorities any case of uninvited, in-person solicitation of actual or potential patients who because of their special circumstances are vulnerable to harassment or duress.

Provided, further, that after this Order has become final for two years, nothing herein shall prohibit respondents from formulating, adopting and

disseminating to their constituent and component medical organizations and to their members ethical guidelines governing the conduct of their members in respect to advertising and solicitation activities, if respondents first obtain permission from and approval of the guidelines by the Federal Trade Commission.

II.

IT IS FURTHER ORDERED that respondents:

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

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

C. Remove from respondent American Medical Association's Principles of Medical Ethics and the Judicial Council Opinions and Reports, and from the constitution and bylaws and any other existing policy statement or

guideline of respondents, any provision, interpretation or policy statement which is inconsistent with the provisions of Part I of this Order.

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

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

III.

IT IS FURTHER ORDERED that, within sixty (60) days after this Order becomes final:

A. Respondent American Medical Association publish a copy of this Order in the Journal of the American Medical Association and in American Medical News;

B. Respondent Connecticut State Medical Society publish a copy of this Order in Connecticut Medicine; and

C. Respondent New Haven County Medical Association, Inc. publish a copy of this Order in Issues and Insights.

IV.

IT IS FURTHER ORDERED that respondents, within ninety (90) days after this Order becomes final, file a written report with the Federal Trade Commission setting forth in detail the manner and form in which they have complied with this Order.

Ernest G. Barnes

Ernest G. Barnes
Administrative Law Judge

November 13, 1978

APPENDIX A

Constitutions and Bylaws of AMA's constituent and component medical societies providing that AMA's Principles of Medical Ethics shall govern the conduct of their members and that unethical conduct shall be grounds for expulsion:

Medical Society	Constitution and/or Bylaws
Allegheny County Medical Society	CX 2185, pp. 10, 13, 15, 17, 40, 42
Arizona Medical Association, Inc.	1871I, K-L
Bexar County Medical Society	472C, G
California Medical Association	477I, L, Z-6
Camden County Medical Society of the State of New Jersey	747L-M, R
Catawba County Medical Society	2226C, G
Chattanooga and Hamilton County Medical Society, Inc.	1904I, M, V
Chicago Medical Society: The Medical Society of Cook County	2025M, N
Colorado Medical Society	2307Z-9, Z-22, Z-27
Connecticut State Medical Society	991D, L-M (See 1404I, J)
Dallas County Medical Society	1905D, F, W-X
Medical Society of the District of Columbia	1976R-S, V

Medical Society	Constitution and/or Bylaws
Florida Medical Association	2543C, K
Hampden District Medical Society	1990E, I
Hartford County Medical Association, Inc.	1657A, G
Honolulu County Medical Society	1828G, S
Illinois State Medical Society	1915C, P, Q
Jackson County Medical Society	1908A, D
Jefferson County Medical Society	1872E, I-J
Johnson County Medical Society	2020L, G-H
Kentucky Medical Association	1827H-I, J
King County Medical Society	1979E, R
Kitsap County Medical Society	474B, G, J
Knoxville Academy of Medicine	47G, H-I
Lane County Medical Society	2131D, H, R
Lehigh County Medical Society	2017H, F
Los Angeles County Medical Association	476G, J, Z-15
Louisiana State Medical Society	1901Q, Z-33
Maricopa County Medical Society	1568E

Medical Society	Constitution and/or Bylaws
Medical and Chirurgical Faculty of the State of Maryland	2050Z-22, Z-24
Massachusetts Medical Society	885E, Y
Michigan State Medical Society	1833K, M
Missouri State Medical Association	1877I
Multnomah County Medical Society	1874E, L, Z-5
Nashville Academy of Medicine and Davidson County Medical Society	1825E, M
Medical Society of New Jersey	18890-P, U-V
New Mexico Medical Society	1883Y, Z-14
New Haven County Medical Association	1404I
Medical Society of the County of New York	1876T, X
Pennsylvania Medical Society	1886H, J, R
Philadelphia County Medical Society	756A, M, N
Pierce County Medical Society	135A-B, F, H
Prince George's County Medical Society	689K, D
Santa Clara County Medical Society	748N
St. Louis Medical Society	983E
Tarrant County Medical Society	1894A, E

Medical Society	Constitution and/or Bylaws
Tennessee Medical Association	14H, L
Texas Medical Association	1899D, U
Travis County Medical Society	1882B, N, Z-9
Medical Society of Virginia	1879Z-8, O-P, Z-5
Volusia County Medical Society	1961K, P, D-E
Washington State Medical Association	475G-H, O, M-N
State Medical Society of Wisconsin	1912B, G

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APPENDIX B

State Statutes Regarding Physician Advertising and Solicitation

In 1975, at the commencement of the proceedings in this case, a substantial majority of states had statutes which prohibited or restricted advertising by physicians. Ten states declared any form of physician advertising to be illegal:

(a) Arixona, Ariz. Rev. Stat. §32-1401 (10)(C), §33-1451 (1976)(RX 706);

(b) Arkansas, Ark. Stat. Ann. §72-613(m) (1975) (RX 707);

(c) Florida, Fla. Stat. Ann. §458.1201(1) (f) (1976) (RX 710);

(d) Georgia, Ga. Code Ann. §84-916(a)(6) (1976) (RX 711);

(e) Louisiana, La. Stat. Ann. §37-1285(19) (1976)(RX 717);

(f) Michigan, Mich. Stat. Ann. §14.542(11) (1), (11)(27)(g), (1976) RX 719);

(g) Missouri, Mo. Ann. Stat. §334.100(12) (1976) (RX 721);

(h) Ohio, Ohio Rev. Code Ann. §4731.22(b)(5) (1975) (RX 727);

(i) Tennessee, Tenn. Code Ann. §63-619 (1976) (RX 734); and,

(j) Utah, Utah Code Ann. §§58-12-36(4), 58-1-25(1) (1973)(RX 736).

Eight states prohibited advertising in an "unethical" manner:

(a) Delaware, Del. Code Tit. 24, §1741(9) (1974) (RX 709);

(b) Idaho, Idaho Code §54-1810(c) (1976) (RX 713);

(c) Maine, Me. Rev. Stat. tit. 32, §3282(A)(B) (1977) (RX 718);

(d) Nebraska, Neb. Rev. Stat. §71-147(11)-(13) (1976) (RX 722);

(e) North Dakota, N.D. Cent. Code §43-17-31(11) (1960) (RX 726);

(f) Rhode Island, R.I. Gen. Laws §§5-37-4, 5-37.1-5 (1976) (RX 731);

(g) South Carolina, S.C. Code Ann. §40-47-200 (7) (1975) (RX 732); and,

(h) Wyoming, Wyo. Stat. §33-340 (1975) (RX 740).

Four states prohibited all advertising except notices of openings or closings of a practice or listing in a directory:

(a) Alaska, Alaska Stat. §§08.64303(b)(1), 08.64.380(3)(D) (1977) (RX 705);

(b) Illinois, Ill. Rev. Stat. ch. 91, §§16a(13), 16a-1 (1976) (RX 714);

(c) New Jersey, N.J. Stat. Ann. §45.9.16 (1976) (RX 723); and,

(d) Oklahoma, Okla. Stat. Ann. tit. 59 §§503, 509(2) (1977) (RX 728).

Sixteen states made it illegal for a physician to engage in misleading or deceptive advertising:

(a) Alabama Ala. Code §§34-24-90 (1975) (RX 704);

(b) Connecticut, Conn. Gen. Stat. §20-44 (1958) (RX 708);

(c) Hawaii, Haw.Rev.Stat. §§453-8, (5) (6) (1975) (RX 712);

(d) Iowa, Iowa Code Ann. §§147.55-(7) (1976) (RX 715);

(e) Kansas, Kan. Stat. §§65-2836(b), 65-2837(g) (1976) (RX 716);

(f) Mississippi, Miss. Code §73-25-29(8)(c) (1976) (RX 720);

(g) New Mexico, N.M.Stat.Ann. §§67-5-9(9), (B)(9) (1975) (RX 724);

(h) North Carolina, N.C.Gen. Stat. §§90-14, 9014(8) (1975) (RX 725);

(i) Oregon, O.Rev.Stat. §677.190(10) (1971) (RX 729);

(j) Pennsylvania, Pa.Stat.Ann. tit. 63, §421.15 (a)(92) (1976) (RX 730).;

(k) Rhode Island, R.I.Gen.Laws §§5-37-4, 5-37.1-5 (1976) (RX 731);

(l) South Dakota S.D. Codified laws §§36-4-29, 36-4-30 (5) (1977 (RX 733);

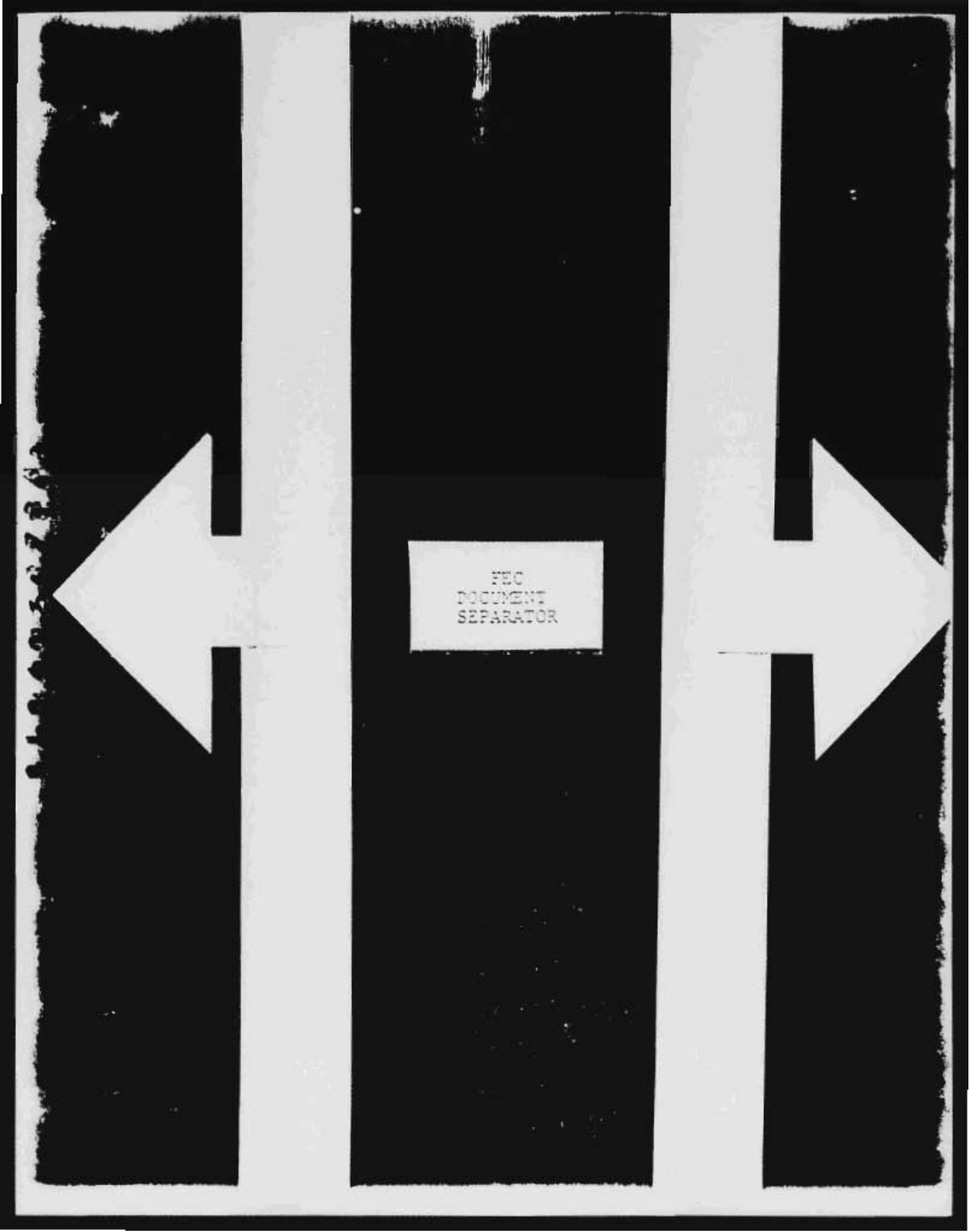
(m) Texas, Tex. Rev. Civ. Stat. Ann. art. 4505(6) (1976) (RX 735);

(n) Vermont, Vt. Stat. Ann. tit. §§ 1353(2), 1361 (1977) (RX 737);

(o) Virginia, Va. Code §§54-316, 54-317(4) (1977) (RX 738); and,

(p) Washington, Wash.Rev.Code §§18.72.030(4), 18.72.250 (1975) (RX 739).

Alabama also provides for suspension or revocation of a medical license for any violation of the Principles of Medical Ethics as set forth in the Opinions and Reports of the Judicial Council of the AMA (RX 704B).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Ex #15

CX 541A

JUDICIAL COUNCIL

AMERICAN MEDICAL ASSOCIATION

MINUTES OF MEETING, JUNE 20 AND 22, 1964

SAN FRANCISCO, CALIFORNIA

FEDERAL TRADE COMMISSION
File No. 9064 Commission Investigational Exhibit No. 541A
In the matter of: AMA
Date 10/13/71 Witness —
Reporter T.P.
By Lm

The Judicial Council of the American Medical Association held a regular meeting on June 20 and 22, 1964, in the Fairmont Hotel, San Francisco, California. The meeting was called to order at 9:00 a.m. on June 20th by James H. Berge, M.D., Chairman. Present, in addition to the Chairman, were E. G. Shelley, M.D., J. Morrison Hutcheson, M.D., Robertson Ward, M.D., Walter H. Judd, M.D., members; William J. McAuliffe, jr., Secretary; A. M. Edwards, Field Service Representative and Rosemary Calcaterra, Recorder.

II. MINUTES OF MEETING OF APRIL 16-17, 1964. On motion duly made, seconded and carried, the minutes of the meeting of April 16-17, 1964, were approved.

III. APPEAL OF [redacted], M.D. The appeal of [redacted], M.D. of Austin, Texas, was heard beginning at 9:30 a.m.

Present, in addition to the members of the Council and the staff, were Phillip W. Gilbert, the attorney for Doctor [redacted], James Sammons, M.D., Secretary for the Board of Councilors, Texas Medical Association, Ruth M. Bain, M.D.,

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Chairman of the Board of Censors, Travis County Medical Society, Philip R. Overton, General Counsel for the Texas Medical Association and Roy J. Cates, Executive Director of the Travis County Medical Society.

A transcript of this hearing was made and is on file at AMA Headquarters.

The hearing lasted about two and one-half hours.

Doctor [redacted] had been found guilty by the Travis County Medical Society of violating Chapter I, Section 9 of the Society's Bylaws which provides as follows:

> "To practice in or be a member of the Staff of any hospital where the professional care is not under the supervision of a Doctor of Medicine and a member in good standing in the county medical society in whose jurisdictional area the hospital is located."

This decision was affirmed by the Texas Medical Association.

After the hearing, the Council agreed that, contrary to the Bylaws of the Travis County Medical Society:

> (1) Doctor [redacted] did not receive fourteen days' notice of the hearing by the Board of Directors of his appeal from the decision of the Board of Censors.

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(2) The Travis County Medical Society did not make a verbatim transcript of the testimony before the Board of Censors.

The Council, therefore, ordered and directed that the case be remanded to the Texas Medical Association for a new hearing.

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Reporter T.P.
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XI. REPORT OF SECRETARY. (A) The Secretary distributed copies of Formal Opinion 311 of the American Bar Association Committee on Professional Ethics rendered on April 8, 1964. This opinion concerns the propriety of retirement plans by attorneys for themselves and their employees under the Self-Employed Individuals Tax Retirement Act of 1962.

(B) The Secretary reported that he had met with Willard Wright, M.D., Chairman, Council on Medical Service, Irvin E. Hendryson, M.D., member of the Council, Raymond L. White, M.D., Secretary of the Council, Charles C. Edwards, M.D., Acting Director of the Department of Hospitals and Medical Facilities, John Gartland, Assistant Director of Hospitals and Medical Facilities, Robert B. Throckmorton and Warren E. Whyte, to discuss the 186 page report on Physician-Hospital Relations.

At this meeting, Doctor Wright agreed to amend the report as follows:

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CX 541E3 - p 5.

(1) To substitute the following for recommendation C-1 and C-2, appearing on page 30:

> "It is recommended that it be the policy of the American Medical Association that a physician should not bargain or enter into a contract whereby any hospital, corporation or lay body by whatever name called or however organized may offer for sale or sell for a fee the physician's professional services. Further, it is recommended that it be the policy of the American Medical Association that a physician shall not enter into a contract or agreement with a hospital whereby the hospital acts as the agent of the medical staff. The physician and the medical staff, as principals, should not approve any contract whose terms or conditions are inconsistent with the 'Principles of Medical Ethics' and established policy of the American Medical Association."

(2) To add the following sentence in Section G on page 35 at the end of the paragraph immediately preceding Recommendation G-1:

> "A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee."

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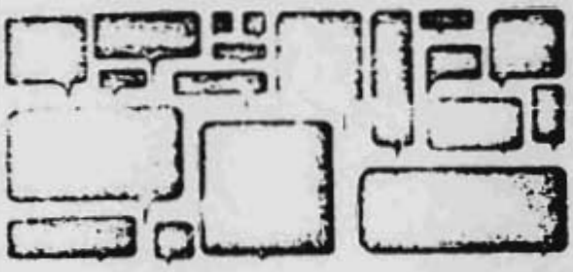

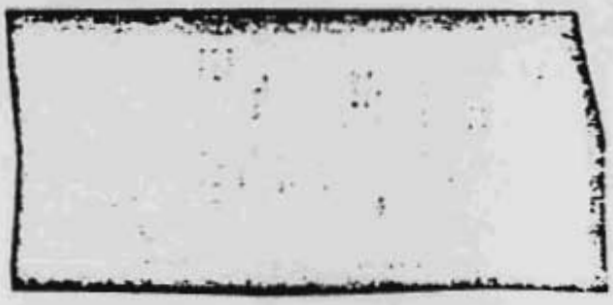

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In the matter of: AMA
Date 9/7/77 Witness Schaller
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By D.K.

JUDICIAL COUNCIL OPINIONS AND REPORTS

AMERICAN MEDICAL ASSOCIATION

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OPINIONS AND REPORTS

OF THE

JUDICIAL COUNCIL

Including the PRINCIPLES OF MEDICAL ETHICS
and RULES of the JUDICIAL COUNCIL

Prepared and Approved by
the JUDICIAL COUNCIL

E. G. Shelley, M.D., Chairman
Walter H. Judd, M.D., Vice Chairman
Henry I. Fineberg, M.D.
George W. Petznick, M.D.
Charles C. Smeltzer, M.D.
Edwin J. Holman, Secretary

AMERICAN MEDICAL ASSOCIATION
535 North Dearborn Street
Chicago, Illinois 60610

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INTRODUCTION

The Judicial Council, a standing committee of the House of Delegates, consists of five active members of the AMA elected by the House on nomination by the President for terms of five years. The duties of the Council, as defined in Section 11 (A) of Chapter XI of the AMA Bylaws, are set forth in the appendix. The Council's Rules of Procedure follow. Opinions of the Judicial Council and actions of the House of Delegates relating to the Principles of Medical Ethics are then set forth.

Ethical principles are basic and fundamental. Men of good conscience inherently know what is right or wrong, and what is to be done or to be avoided. Written documents attempt to express for the guidance of all what each knows to be true. Thus the Principles of Medical Ethics are truly guides to good conduct.

The Judicial Council presents this guide as a practical usable reference for all who wish to use it. As problems arise, the Council will consider them in the light of basic principles for the benefit of all members of the public and the profession.

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HISTORY

The earliest written code of ethical principles for medical practice was conceived by the Babylonians around 2500 B.C. That document, the Code of Hammurabi, was indeed a *code of* conduct, setting forth in considerable detail for that era of history the nature of conduct demanded of the physician. Today that code would be subject to criticism because it went into too much detail. It may be doubted that it could have continued, as a practical document, through the centuries because, as medical science and cultural patterns became more complex, it would have required one skilled in jurisprudence to codify and interpret the myriad situations covered by it.

The Oath of Hippocrates, a brief statement of principles, has come down through history as a living and even workable statement of ideals to be cherished by the physician. This Oath was conceived some time during the period of Grecian greatness, probably in the fifth century B.C. It protected rights of the patient and appealed to the inner and finer instincts of the physician without imposing sanctions or penalties on him. Other civilizations subsequently developed written principles, but the Oath of Hippocrates (Christianized in the tenth or eleventh century A.D. to eliminate reference to pagan gods) has remained in Western Civilization as an expression of ideal conduct for the physician.

The most significant contribution to ethical history subsequent to Hippocrates was made by Thomas Percival, a physician, philosopher, and writer of Manchester, England. In 1803, he published his *Code of Medical Ethics*. His personality, his interest in sociological matters, his close association with the Manchester Infirmary, led to the preparation of a "scheme of professional conduct relative to hospitals and other charities," from which he drafted the code which bears his name.

At the first real meeting of the American Medical Association in Philadelphia in 1847, the two principal items of business were the establishment of a code of ethics and the creation of minimum requirements for medical education and training. Although the Medical Society of the State of New York and the Medico-Chirurgical Society of Baltimore had had formal written codes of medical ethics prior to this time, it is clear from the records and the preface to AMA's first adopted Code of Ethics that it was based on Percival's Code.

In general, the language and concepts of the original Code adopted by the Association in 1847 remained the same throughout the years. There were revisions, of course, which reflect the temper of the times and the eternal quest to express basic concepts with clarity. Major revisions did occur in 1903, 1912, and 1947. In 1957 the language of the chapter dealing with compensation of physicians, contract practice, conditions of medical service, free choice of physician, and purveyal of medical services was redrafted.

In December, 1955, an attempt was made to distinguish medical ethics from matters of etiquette. A draft of a two-part code seeking to accomplish this was submitted to the House of Delegates at that time but was not accepted. This proposal was, in effect, a segregation of

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then existing statements, found in the *Principles*, into two categories. Little or no change was made in the language of the forty-eight sections of the *Principles*.

Subsequently, in June, 1956, a seemingly radical proposal was submitted to the House of Delegates for consideration. This proposal, a short version of the *Principles*, was discussed at the following session of the House, in December, 1956, after having had wide publication and broad consideration among members of the medical profession. It was then laid over for final consideration at the June, 1957, meeting of the House of Delegates, at which meeting the short version was adopted.

The format of the *Principles* adopted in June, 1957, is a change from the format of the *Principles* promulgated by Percival in 1803 and accepted by the Association in 1847. Ten short sections, preceded by a preamble, "succinctly express the fundamental concepts embodied in the present [1955] Principles," according to the report of the Council on Constitution and Bylaws. That Council assured the House of Delegates in its June, 1957, report that "every basic principle has been preserved; on the other hand, as much as possible of the prolixity and ambiguity which in the past obstructed ready explanation, practical codification and particular selection of basic concepts has been eliminated."

Almost immediately after the 1957 edition of the *Principles of Medical Ethics of the American Medical Association* was adopted, the Judicial Council of that Association expressed its formal opinion that:

> ". . . the 1957 edition of the *Principles* was not intended to and does not abrogate any ethical principle expressed in the 1955 edition of the *Principles of Medical Ethics of the American Medical Association*. The format and language of the 1955 and 1957 editions differ; certain items dealing with professional manners and etiquette have been eliminated. However, the basic ethical concepts they include are identical. Therefore, no opinion or report of the Council interpreting these basic principles which were in effect at the time of the revision has been rescinded by the adoption of the 1957 edition . . . "

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PRINCIPLES OF MEDICAL ETHICS

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1

The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2

Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3

A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5

A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he

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may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7

In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8

A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10

The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

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PREAMBLE

THESE principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

1. PURPOSE

These principles are intended to serve the physician as a guide to ethical conduct as he strives to accomplish his prime purpose of serving the common good and improving the health of mankind. They provide a sound basis for solution of many of the problems which arise in his relationship with patients, with other physicians, and with the public. They are not immutable laws to govern the physician, for the ethical practitioner needs no such laws; rather they are standards by which he may determine the propriety of his own conduct. Undoubtedly, interpretation of these principles by an appropriate authority will be required at times. As a rule, however, the physician who is capable, honest, decent, courteous, vigilant, and an observer of the Golden Rule, and who conducts his affairs in the light of his own conscientious interpretation of these principles will find no difficulty in the discharge of his professional obligations.

2. PRINCIPLES APPLICABLE TO ALL

There is but one code of ethics for all, be they group, clinic or individual and be they great and prominent or small and unknown.

3. ETHICS ARE PRINCIPLES

The wide extent of an unethical practice does not make it ethical. Ethics has to do with principles, not numbers or locality. A procedure unethical in one part of the country cannot be ethical under the same circumstances in another.

4. USE OF TERMS "ETHICAL" AND "UNETHICAL"

Historically, the term "ethical" has been used in opinions and reports of the Judicial Council and in resolutions adopted by the House of Delegates to refer to matters involving (1) moral principles or practices; (2) customs and usages of the medical profession; and (3) matters of policy not necessarily involving issues of morality in the practice of medicine. The term "unethical" has been used to refer to conduct which fails to conform to these professional standards, customs and

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usages, or policies, as interpreted by the American Medical Association.

Unethical conduct involving moral principles, values and duties calls for disciplinary action such as censure, suspension, or expulsion from medical society membership.

Failure to conform to the customs and usages of the medical profession may call for disciplinary action depending upon the particular circumstances involved, local attitudes, and how the conduct in question may reflect upon the dignity of and respect for the medical profession.

In matters strictly of a policy nature, a physician who disagrees with the position of the American Medical Association is entitled to freedom and protection in his point of view.

5. INTERRELATIONSHIP BETWEEN LAW AND ETHICS

The following statements are intended to clarify the interrelationship between law and ethics.

Ethical standards of professional conduct often exceed but are never less than those required by law.

Violation of governmental laws may subject the physician to civil or criminal liability. Expulsion from membership is the maximum penalty that may be imposed by a medical society upon a physician who violates ethical standards involving a breach of moral duty or principle. However, medical societies have a civic and professional obligation to report to the appropriate governmental body or state board of medical examiners credible evidence that may come to their attention involving the alleged criminal conduct of any physician relating to the practice of medicine.

Although, a physician charged with alleged illegal conduct may be acquitted or exonerated in civil or criminal proceedings, this does not discharge a medical society from its obligation to initiate a disciplinary proceeding against a member with reference to the same conduct where there is credible evidence tending to establish unethical conduct.

Ethical pronouncements of the Judicial Council and the House of Delegates should not be so interpreted, construed or applied as to encourage conduct which violates a valid law.

6. PRINCIPLES GOVERNING GROUPS AND CLINICS

The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

7. MEMBERSHIP IN A CLINIC

Associate membership, no matter by what name called, in a clinic, of a physician who lives in anotner town from that in which the clinic is located, and who sends patients to this clinic for treatment and receives

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compensation therefore, is practicing unethical medicine as well as the physicians who own the clinic. In fact, a physician who does this and lives in the same town where the clinic operates would be unethical if he practices in this manner.

A patient is entitled to the best treatment possible and a physician referring a patient to a consultant should select the consultant because of his ability and not because of pecuniary gain to the physician referring the patient.

8. CLINIC

Under the ethical principles of medicine no use may properly be made of the word clinic that would mislead or deceive the public, or would tend to be a solicitation of patients to the particular group of physicians holding themselves out as a "clinic."

In connection with any definition of the word "clinic," it should be clear that regardless of how clinic is defined each physician-member of the clinic must act, in his relations with his patients and his colleagues, in accord with all the Principles of Medical Ethics. No physician member of a clinic may permit the clinic to do that which he may not do. Each physician must observe all the Principles of Medical Ethics.

9. PHARMACISTS—PRACTICE OF PHARMACY

Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharamacist in education of the public concerning the practice of ethical and scientific medicine.

10. ABORTION, POLICY ON

The Judicial Council is charged with interpreting the Principles of Medical Ethics as adopted by the House of Delegates of the American Medical Association.

The Principles of Medical Ethics of AMA do not prohibit a physician from performing an abortion that is performed in accordance with good medical practice and under circumstances that do not violate the laws of the community in which he practices.

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SECTION 1

THE PRINCIPAL objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

1. CHARACTER OF THE PHYSICIAN

The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates, "He should also be modest, sober, patient, prompt to do this whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

2. ABILITY OF PATIENT TO PAY

One of the strongest holds of the profession on public approbation and support has been the age-old professional ideal of medical service to all, whether able to pay or not. That ideal is basic in our ethics. The abandonment of that ideal and the adoption of a principle of service only when paid for would be the greatest step toward socialized medicine which the medical profession could take. All our arguments as to better service to the people, freedom of choice of physician, individual service, and maintenance of high grade medical service by highly qualified physicians would be as naught if such service were not available to a vast proportion of the people.

3. FREE CHOICE OF PHYSICIAN

Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or volition, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

4. FREE CHOICE OF PHYSICIAN

The American Medical Association believes that free choice of physicians is the right of every individual and one which he should be free to exercise as he chooses;

Each individual should be accorded the privilege to select and

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change his physician at will or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives;

Lest there be any misunderstanding, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites of optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows or abridges such freedom of choice and such competition.

5. **SUBSTITUTION OF SURGEON WITHOUT PATIENT'S KNOWLEDGE OR CONSENT**

The Principles in Section 1 state that the principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. To have another physician operate on one's patient without that patient's consent, and without his knowledge of the substitution, is a fraud and deceit and a violation of a basic ethical concept. The patient as a human being is entitled to choose his own physician and he should be permitted to acquiesce in or refuse to accept the substitution.

The surgeon's obligation to the patient requires him to perform the surgical operation: (1) within the scope of authority granted him by the consent to the operation; (2) in accordance with the terms of the contractual relationship; (3) with complete disclosure of all facts relevant to the need and the performance of the operation; and (4) to utilize his best skill in performing the operation.

It should be noted that it is the operating surgeon to whom the patient grants his consent to perform the operation. The patient is entitled to the services of the particular surgeon with whom he contracts. The surgeon in accepting the patient obligates himself to utilize his personal talents in the performance of the operation to the extent required by the agreement, creating the physician-patient relation. He cannot properly delegate to another the duties which he is required to perform personally.

Under the normal and customary arrangement with private patients, and with reference to the usual form of consent to operation, the surgeon is obligated to perform the operation himself, and he may use the services of assisting residents or other assisting surgeons to the extent that the operation reasonably requires the employment of such assistance. If a resident or other physician is to perform the operation under the guidance of the surgeon, it is necessary to make a full disclosure of this fact to the patient, and this should be evidenced by an appropriate statement contained in the consent.

If the surgeon employed merely assists the resident or other physician in performing the operation, it is the resident or other physician who becomes the operating surgeon. If the patient is not informed as to the identity of the operating surgeon, the situation is "ghost surgery."

An operating surgeon is construed to be a performing surgeon. As such his duties and responsibilities go beyond mere direction, supervi-

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sion, guidance, or minor participation.

He is not employed merely to supervise the operation. He is employed to perform the operation. He can properly utilize the services of an assistant to assist him in the performance of the operation. But he is not performing the operation where his active participation consists of guidance or standby responsibilities in the case of an emergency.

6. FREE CHOICE OF OPTICIAN, PHARMACIST, ETC.

One of the most important principles of the Association has been free choice of physician; the definition of free choice is "that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians." This principle should apply to choice of optician, choice of pharmacist, etc.

7. RELATIONSHIP WITH ANOTHER PHYSICIAN'S PATIENT

A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

8. SOCIAL CALLS ON ANOTHER PHYSICIAN'S PATIENTS

When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

9. SERVICES TO PATIENT OF ANOTHER PHYSICIAN

A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

10. CRITICISM TO BE AVOIDED

When a physician does succeed another physician in charge of a case he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

11. TREATING MEMBERS OF OWN FAMILY

As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the

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case. The family may ask the physician in charge to call in other physicians to act as consultants.

12. PROFESSIONAL COURTESY

The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy.

1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.

2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional ethical practice of physicians caring for the medical needs of colleagues and their dependents without charge.

3. In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.

4. Professional courtesy should always be extended without qualification to the physician in financial hardship, and members of his immediate family who are dependent upon him.

13. PROFESSIONAL COURTESY BEYOND FELLOW PHYSICIANS AND THEIR DEPENDENTS

Ethical custom and tradition have suggested the extension of professional courtesy to fellow physicians and members of their immediate families. As a matter of private determination some physicians have extended this practice variously to clergymen, teachers, nurses, assistants to physicians and others in the health care field. The extension of professional courtesy beyond fellow physicians and members of their immediate families is a matter of discretion to be decided by the individual physician in his own practice and in his own community.

14. ETHICAL RESPONSIBILITIES IN PRESCRIBING DRUGS AND DEVICES

It is unethical for a physician to be influenced in the prescribing of drugs or devices by his direct or indirect financial interest in a pharmaceutical firm or other supplier. It is immaterial whether the firm manufactures or repackages the products involved.

It is unethical for a physician to own stock or have a direct or indirect financial interest in a firm that uses its relationship with physician-stockholders as a means of inducing or influencing them to prescribe the firm's products. Practicing physicians should divest themselves of any financial interest in firms that use this form of sales promotion. Reputable firms rely upon quality and efficacy to sell their products under competitive circumstances, and not upon appeal to

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physicians with financial involvements which might influence them in their prescribing.

Prescribing for patients involves more than the designation of drugs or devices which are most likely to prove efficacious in the treatment of a patient. The physician has an ethical responsibility to assure that high quality products will be dispensed to his patient. Obviously, the benefits of the physician's skill are diminished if the patient receives drugs or devices of inferior quality.

Inasmuch as the physician should also be mindful of the cost to his patients of drugs or devices he prescribes, he may properly discuss with his patients both quality and cost.

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PHYSICIANS should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

1. THE PHYSICIAN'S RESPONSIBILITY

The avowed objective of the profession of medicine is the common good of mankind. Physicians faithful to the ancient tenets of this profession are ever cognizant of the fact that they are trustees of medical knowledge and skill and that they must dispense the benefits of their special attainments in medicine to all who need them. Physicians dedicate their lives to the alleviation of suffering, to the enhancement and prolongation of life, and to the destinies of humanity. They share whatever they have learned and whatever they may discover with their colleagues in every part of the globe. They recognize instinctively that the need for improvement of medical knowledge and skills is never at an end, and while they strive toward satisfaction of this need they are zealous in making available to physicians of good character who possess the desire and the ability to learn the aggregate of progress in medical education, research, and discoveries as they may exist at the time. They do not remain content to limit their activities to the care of the infirm, since they recognize also their useful rank among the vast concourse of citizens on whose shoulders the destiny of our nation rests. At the same time they will resist attempts to debase their services by diverting them to ignoble purposes. In their relationships with patients, with colleagues, and with the public, they maintain under God, as they have down the ages, the most inflexible standards of personal honor.

2. EXPERIMENTATION: NEW DRUGS OR PROCEDURES

In order to conform to the ethics of the American Medical Association, three requirements must be satisfied in connection with the use of experimental drugs or procedures:

(1) the voluntary consent of the person on whom the experiment is to be performed should be obtained;

(2) the danger of each experiment must be previously investigated by animal experimentation; and

(3) the experiment must be performed under proper medical protection and management.

3. ETHICAL GUIDELINES FOR CLINICAL INVESTIGATION

The following guidelines are intended to aid physicians in fulfilling their ethical responsibilities when they engage in the clinical investigation of new drugs and procedures.

(1) A physician may participate in clinical investigation only to the

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extent that his activities are a part of a systematic program competently designed, under accepted standards of scientific research, to produce data which is scientifically valid and significant.

(2) In conducting clinical investigation, the investigator should demonstrate the same concern and caution for the welfare, safety and comfort of the person involved as is required of a physician who is furnishing medical care to a patient independent of any clinical investigation.

(3) In clinical investigation *primarily for treatment* —

A. The physician must recognize that the physician-patient relationship exists and that he is expected to exercise his professional judgment and skill in the best interest of the patient.

B. Voluntary consent must be obtained from the patient, or from his legally authorized representative if the patient lacks the capacity to consent, following: (a) disclosure that the physician intends to use an investigational drug or experimental procedure, (b) a reasonable explanation of the nature of the drug or procedure to be used, risks to be expected, and possible therapeutic benefits, (c) an offer to answer any inquiries concerning the drug or procedure, and (d) a disclosure of alternative drugs or procedures that may be available.

i. In exceptional circumstances and to the extent that disclosure of information concerning the nature of the drug or experimental procedure or risks would be expected to materially affect the health of the patient and would be detrimental to his best interests, such information may be withheld from the patient. In such circumstances such information shall be disclosed to a responsible relative or friend of the patient where possible.

ii. Ordinarily, consent should be in writing, except where the physician deems it necessary to rely upon consent in other than written form because of the physical or emotional state of the patient.

iii. Where emergency treatment is necessary and the patient is incapable of giving consent and no one is available who has authority to act on his behalf, consent is assumed.

(4) In clinical investigation *primarily for the accumulation of scientific knowledge* —

A. Adequate safeguards must be provided for the welfare, safety and comfort of the subject.

B. Consent, in writing, should be obtained from the subject, or from his legally authorized representative if the subject lacks the capacity to consent, following: (a) a disclosure of the fact that an investigational drug or procedure is to be used, (b) a reasonable explanation of the nature of the procedure to be used and risks to be expected, and (c) an offer to answer any inquiries concerning the drug or procedure.

C. Minors or mentally incompetent persons may be used as subjects only if:

i. The nature of the investigation is such that mentally com-

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petent adults would not be suitable subjects.

ii. Consent, in writing, is given by a legally authorized representative of the subject under circumstances in which an informed and prudent adult would reasonably be expected to volunteer himself or his child as a subject.

D. No person may be used as a subject against his will.

4. GUIDELINES FOR ORGAN TRANSPLANTATION

The AMA offers the following statement for guidance of physicians as they seek to maintain the highest level of ethical conduct in the transplanting of human organs.

(1) In all professional relationships between a physician and his patient, the physician's primary concern must be the health of his patient. He owes the patient his primary allegiance. This concern and allegiance must be preserved in all medical procedures, including those which involve the transplantation of an organ from one person to another where both donor and recipient are patients. Care must, therefore, be taken to protect the rights of both the donor and the recipient, and no physician may assume a responsibility in organ transplantation unless the rights of both donor and recipient are equally protected.

(2) A prospective organ transplant offers no justification for a relaxation of the usual standard of medical care. The physician should provide his patient, who may be a prospective organ donor, with that care usually given others being treated for a similar injury or disease.

(3) When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. Death shall be determined by the clinical judgment of the physician. In making this determination, the ethical physician will use all available, currently accepted scientific tests.

(4) Full discussion of the proposed procedure with the donor and the recipient or their responsible relatives or representatives is mandatory. The physician should be objective in discussing the procedure, in disclosing known risks and possible hazards, and in advising of the alternative procedures available. The physician should not encourage expectations beyond those which the circumstances justify. The physician's interest in advancing scientific knowledge must always be secondary to his primary concern for the patient.

(5) Transplant procedures of body organs should be undertaken (a) only by physicians who possess special medical knowledge and technical competence developed through special training, study, and laboratory experience and practice, and (b) in medical institutions with facilities adequate to protect the health and well-being of the parties to the procedure.

(6) Transplantation of body organs should be undertaken only after careful evaluation of the availability and effectiveness of other possible therapy.

(7) Medicine recognizes that organ transplants are newsworthy and

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that the public is entitled to be correctly informed about them. Normally, a scientific report of the procedures should first be made to the medical profession for review and evaluation. When dramatic aspects of medical advances prevent adherence to accepted procedures, objective, factual, and discreet public reports to the communications media may be made by a properly authorized physician, but should be followed as soon as possible by full scientific reports to the profession.

In organ transplantation procedures, the right of privacy of the parties to the procedures must be respected. Without their authorization to disclose their identity the physician is limited to an impersonal discussion of the procedure.

Reporting of medical and surgical procedures should always be objective and factual. Such reporting will also preserve and enhance the stature of the medical profession and its service to mankind.

5. PATENT FOR SURGICAL OR DIAGNOSTIC INSTRUMENT

It is not unethical for a physician to patent a surgical or diagnostic instrument he has discovered or developed. Our laws governing patents are based on the sound doctrine that one is entitled to protect his discovery. Medicine, recognizing the validity of our patent law system, accepts it, but in the interest of the public welfare and the dignity of the profession insists that once a patent is obtained by a physician for his own protection, the physician may not ethically use his patent right to retard or inhibit research or to restrict the benefit derivable from the patented article. Any physician who obtains a patent and uses it for his own aggrandizement or financial interest to the detriment of the profession or the public is acting unethically.

6. SECRET REMEDIES

The prescription or dispensing by a physician of secret medicines, or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

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SECTION 3

A PHYSICIAN should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

1. STANDARDS, USEFULNESS, NON-SECTARIANISM

In order that a physician may best serve his patients he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma, or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought." A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training, and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

2. DEFINING "PHYSICIAN"

A physician is one who has acquired a contemporary education in the fundamental and special sciences, comprehended in the general term "medicine" used in its unrestricted sense, and who has received the degree of Doctor of Medicine from a medical school of recognized standing.

3. DEFINING "SECTARIAN"

A sectarian, as applied to medicine, is one who in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and experience.

4. THE RELATIONSHIPS OF PHYSICIANS AND CULTISTS

Communications have raised questions as to the relationships of physicians with cultists—the attitude that should be assumed by the physician called into a case under treatment by a cult practitioner—whether a pathologist in a hospital under the direction of regular physicians should refuse to examine material submitted by a cultist—and other questions of more or less similar nature. These are questions that are not sharply to be defined by words. In his relations with irregular practitioners, the physician should be bound by the Principles of Medical Ethics. In such matters the policy must be governed largely by the circumstances governing the individual case; by the conditions existing in the special community; and by the realization that the first duties

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SECTION 4

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THE MEDICAL profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

1. UPHOLDING THE HONOR OF THE PROFESSION

A physician is expected to uphold the dignity and honor of his vocation.

2. SAFEGUARDING THE PROFESSION

Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

3. RESPECT OF PATIENT'S TRUST

It is unethical and contrary to Section 4 of the Principles for a physician to be false in any manner to the trust imposed in him by his patients.

4. NEGLECT OF PATIENT

It is unethical and contrary to Section 4 of the Principles for a physician to neglect his patients.

5. UNNECESSARY SERVICES

It is unethical and contrary to Section 4 of the Principles for a physician to provide or prescribe unnecessary services or unnecessary ancillary facilities.

6. EXPOSURE OF UNETHICAL CONDUCT

A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided, such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

7. EVASION OF LEGAL RESTRICTIONS

An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

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8. MEMBERSHIP IN MEDICAL SOCIETIES

For the advancement of his profession, a physician should affiliate with medical societies and contribute his time, energy and means so that these societies may represent the ideals of the profession.

9. OBLIGATIONS OF COUNTY MEDICAL SOCIETIES TO UPHOLD HONOR OF THE PROFESSION

The county society is autonomous. Such autonomy imposes responsibilities. If medical societies fail to accept and discharge their obligations in matters of ethics, others will assume these obligations by default. The Judicial Council urges county and state societies to adopt critical attitudes toward their programs to "uphold the honor and dignity" of the profession of medicine. These programs must be based on a sound knowledge and understanding of ethical principles. As long as ethical principles are widely and sedulously observed, the reputation of the medical profession will be upheld. The reward will be commensurate with the services rendered in the observation of these ideals. On the other hand, if there is flagrant or even careless disregard of ethical principles, the reputation of the profession of medicine will suffer and its responsibilities and obligations will be usurped by others.

10. CIVIL RIGHTS—RIGHT AND DUTY OF COUNTY AND STATE MEDICAL SOCIETIES

The American Medical Association is unalterably opposed to the denial of membership privileges and responsibilities in county medical societies and state medical associations to any duly licensed physician because of race, color, religion, ethnic affiliation, or national origin.

The American Medical Association calls upon all state medical associations, all component societies, and all individual members of the American Medical Association to exert every effort to end every instance in which such equal rights, privileges, or responsibilities are denied.

11. DISPUTES BETWEEN PHYSICIANS

Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promptly adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

12. PROPRIETY OF AGREEMENT NOT TO PRACTICE IN DESCRIBED AREA FOR PRESCRIBED PERIOD

There is no ethical proscription against suggesting or entering into a reasonable agreement not to practice within a certain area for a certain time, if it is knowingly made and understood. Whether it is advisable as being in the best interest of the public is debatable. Perhaps such an agreement should not become operative until after one year and should expire after it has been in effect for a period of five or so years.

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Ethically such agreements are not forbidden, but they should be entered into with caution.

13. DISPOSITION OF DRUG SAMPLES

Physicians are given a considerable quantity of drugs which they do not request and for which they have no use. Most of these samples are received by mail.

Many problems are involved in the disposal of unwanted and unnecessary samples. Some enterprising individuals are collecting samples from physicians for repackaging and sale. The drugs so collected and repackaged have been found in many instances to be misbranded and contaminated to the detriment of the public.

The physician himself is responsible for the control and custody of drugs once they come into his possession and in the high tradition of the medical profession he should not dispose of these drugs in any way that could cause harm to others. The sale of these samples is unethical and the disposal of them to individuals, currently referred to as "drug scavengers," for repackaging and sale is also unethical. Physicians should cooperate with the Federal Food and Drug Administration and with others who seek to prevent misbranding and contamination of drugs.

Where it is not illegal, county medical societies should be encouraged to work out a system of collecting unwanted or unused drug samples so that these samples, under proper professional supervision, could be used for charitable purposes.

14. PREJUDGMENT OF PARTICULAR CASES

The Judicial Council cannot pass judgment in advance on a situation that may later come before it on appeal. The Council cannot be be an attorney for a society or a member thereof and later judge in the same factual situation. The component medical society has the obligation of determining whether or not the action described constitutes an infringement of ethical principles. Therefore, questions asking for a review of a proposed course of action or an evaluation of an existing factual situation should be presented to the appropriate official of the physician's component society.

15. "DUE PROCESS" IN THE MEDICAL PROFESSION

The basic principles of a fair and objective hearing should always be accorded to the physician whose professional conduct is being reviewed. These basic guarantees are: a specific charge, adequate notice of hearing, the opportunity to be present and to hear the evidence, and to present a defense. These principles apply when the hearing body is a medical society tribunal or a hospital committee composed of physicians.

These principles of fair play apply in all disciplinary hearings and in any other type of hearing in which the physician may be deprived of valu-

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able rights. Whenever physicians sit in judgement on physicians and whenever that judgment affects a physician's reputation, professional status or livelihood, these principles of fair play must be observed.

All physicians are urged to observe diligently these fundamental safeguards of due process whenever they are called upon to serve on a committee which will pass judgment on physicians. Medical societies and hospital medical staffs are urged to review the constitution and bylaws of the society or staff to make sure that these instruments provide for such safeguards.

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SECTION 5

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

1. CHOICE OF PATIENT; PATIENT MAY NOT BE NEGLECTED

A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

2. EMERGENCY CASES IN ABSENCE OF PERSONAL PHYSICIAN

When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

3. PRECEDENCE WHEN SEVERAL PHYSICIANS ARE SUMMONED

When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish some one other than him who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

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4. A COLLEAGUE'S PATIENT

When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy

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that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

5. SUBSTITUTION IN OBSTETRIC WORK

When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

6. SOLICITATION OF PATIENTS, DIRECT OR INDIRECT

Solicitation of patients, directly or indirectly, by a physician, or by groups of physicians, is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self-laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

7. ACCEPTABLE ADVERTISING

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct.

8. SOLICITATION OF PATIENTS BY GROUPS

Many of the questions submitted to the Council involve the subject of solicitation of patients. As is well-known, there is a tendency for physicians to organize themselves into so-called groups under various designations, such as group clinics, diagnostic clinics, group medicine, medical institutes, the (blank) medical academy, and similar names. Some of these groups are advertising in a manner that would be considered most reprehensible if done by an individual physician. The Council is unable to see any difference in principle between a group of physicians advertising themselves under whatsoever title they may assume and an individual physician advertising himself.

9. LOCAL SOCIETIES MUST REVIEW QUESTIONS CONCERNING SOLICITATION OF PATIENTS

A great many communications have been received with respect to advertisements used by individual physicians, groups, clinics, and hospitals owned by individuals or groups. Members of the state associa-

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tions who use objectionable advertising are responsible to and under the control of the censorial agencies of the societies of which they are members. Communications complaining about conduct of physicians who are thought to be soliciting patients should be directed to the secretary of the constituent medical association concerned, with the request that they be brought to the attention of the board of councilors, or through them to the attention of the board of censors of the component society concerned.

10. SOLICITATION OF PATIENTS AND REQUIREMENTS OF LAW

Complaint has come that physicians have permitted their names to be posted in factories and elsewhere in such a manner as to conflict with the Principles of Medical Ethics which prohibits solicitation of patients. Here again the laws of the states obtrude, since some of them specifically provide that an industry or an employer must post the names of physicians whose services are available to employees.

The determination of some questions of ethics must depend on the law; and the individual state medical association, as it holds original jurisdiction in such matters, must consider these questions, deal with them in the light of the law and seek to effect needed corrections.

11. SOLICITATION OF PATIENTS OR PATRONAGE

The Principles of Medical Ethics proscribe the solicitation of patients or patronage. Solicitation, as used in the Principles, means the attempt to obtain patients or patronage by persuasion or influence. However, the public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and the like. The doctor may ethically furnish this information through the accepted local media of communication, which are open to all physicians on like condition. Telephone listings, office signs, professional cards, dignified announcements, all are acceptable media of making factual information available to the public.

The particular use to be made of any medium of communication and the extent of that use are, however, matters to be determined according to local ideals. What constitutes an excess, what is not in keeping with the ideals of medicine and what amounts to solicitation are questions of fact. The application of this principle is to be made locally.

12. COMMERCIALIZATION OF MEDICAL PROCEDURE—ABORTION

The commercialization of the medical procedure of abortion is condemned in the strongest terms possible.

Regardless of one's convictions concerning abortion, either therapeutic or economic, all must unite in protesting commercialization and hucksterism in this sensitive area.

Even though laws have been liberalized and abortions are permitted for therapeutic or other reasons, the procedure remains a medical pro-

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cedure. If it is to be done, it must be done strictly in accord with the highest standards of medical practice. The rights of the patient must be respected and ethical principles observed just as in any other medical procedure.

The ethical principle remains: no physician may solicit patients. A physician may not do indirectly that which he may not do directly. He may not permit others to solicit patients for him.

The medical profession, county and state medical societies, and also the *public* must cooperate to preserve and protect the highest standards of medical practice in all its aspects. The establishment of abortion mills must not be permitted.

13. HOLDING "OPEN HOUSE" NOT IN ITSELF UNETHICAL

Section 5 of the Principles proscribes the solicitation of patients. If the intent for having the "open house" is to solicit patients, even indirectly, then it would be contrary to the Principles. If, however, motivation for holding open house stems from civic and natural pride in having made a contribution to the community and to medicine then the practice may not be objectionable. In the latter instance the holding of an open house might have the effect of acquainting the citizens of the community with some of the improvements developed for better patient care, comfort, and convenience. It might tend to convince the public that there is no apathy on the part of doctors when it comes to improving all facets of medical care.

Before a physician or a group of physicians hold such an open house, however, it is incumbent on him or them to discuss the proposal with appropriate officers of the component medical society. Communities and customs differ. The local society must assess local custom and usage and insure that neither the dignity of medicine nor local custom and tradition are offended by any particular practice of doctors.

14. FOLLOW-UP ANNOUNCEMENT

It is ethical for doctors to remind patients that certain follow-up examinations are needed or are desirable or that certain treatments should be taken care of. Of course, such announcements may be sent only to bona fide patients of the doctor. They should be in good taste and should not serve to advertise the doctor or extol his abilities. Certainly no ethical physician would wish to use this device as a subterfuge for solicitation of patients, nor would he wish to engage in this practice if it were considered contrary to local customs and usages. County medical societies might well establish a framework within which the sending of follow-up notices might be conducted.

15. REMOVAL NOTICE WHEN PHYSICIAN LEAVES COMMUNITY

Not only is it ethical for a physician to notify his patients of the fact that he is leaving his practice, it is necessary that he do so. The physician has an affirmative ethical obligation to notify his patients of this fact in sufficient time to permit them to obtain the services of other

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physicians before he leaves the community. A doctor must not abandon his patients.

16. ANNOUNCEMENTS CONCERNING THE OPENING OR REMOVAL OF A PHYSICIAN'S OFFICE

On opening an office a physician may properly send announcements to his colleagues, to his intimate personal friends not in the medical profession, and to those persons in allied fields with whom it may reasonably be expected he will associate. Announcements of the opening of an office should not be mailed indiscriminately to all persons in the community, nor should commercial mailing lists be utilized. A brief news item carried in the local press, in itself, is not unethical. Local societies may, however, in the exercise of good judgment determine and fix limitations in this regard.

On removing an office a physician may properly advise of this fact to the same persons and in the same manner as he may announce the opening of an office. In addition, he may, and should advise his patients of the essential facts concerning this removal. In any case, the physician is well advised to check with the appropriate officer or committee of his local medical society in order to conform his conduct with local practice.

17. FORM OF ANNOUNCEMENT CONCERNING THE OPENING OR REMOVAL OF A PHYSICIAN'S OFFICE

No form has been approved by the American Medical Association. Under the Principles of Medical Ethics and in keeping with the ideals of the profession, it would seem that no objection would be made to a simple statement of fact, without undue embellishment, e.g.:

> John Doe, M.D. announces the opening (the removal) of his office at (followed by location or locations, in case of removal). Office hours, telephone number, and a statement concerning limitation of practice, if applicable, may be included.

The above suggestion is to be understood as advisory only and is not to be considered an exclusive form that must be used. In all cases the local society can be looked to for an authoritative opinion.

18. LISTING OF NAME IN A COMMERCIALLY SPONSORED ADVERTISING DIRECTORY

The Principles proscribe the solicitation of patients directly or indirectly. The House of Delegates of the Association has expressed disfavor with the practice of permitting one's name to be listed in a commercial advertising directory because it is or may be interpreted to be the indirect solicitation of patients. In 1936, a resolution was introduced in the House of Delegates. It reads as follows:

> "Whereas, certain commercial interests are publishing medical directories, listing physicians by specialty and otherwise, as available for insurance and compensation work, and other professional services, and whereas, participating by listing in these lay publications merely serves for the profit of the promoters and is further

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more technically indirect solicitation of patients, be it Resolved that the Arkansas Medical Society condemns these practices as unethical and forbids its members to continue listing their names in such directories and be it further resolved that the Arkansas Medical Society requests the House of Delegates of the American Medical Association to take similar action."

Most, if not all, listings of physicians by specialty in directories published by commercial concerns, are but subtle ways of avoiding the pronouncement of the Principles of Medical Ethics concerning solicitation of patients, under a guise of buying a directory when the real intent is the purchase of the publication of the buyer's name in the directory for the purpose of obtaining patients.

A physician who uses or permits the use of his name in a commercial directory that fails to include on like terms and without discrimination the names of all licensed physicians practicing in the area served by the directory has the burden of proving that his action is in keeping with the Principles.

19. INDICATION OF MEDICAL SOCIETY QUALIFICATION

The physician should limit the use of statements of professional qualifications on letter and billheads and professional cards to the simple, dignified abbreviation "M.D." or the statement "Doctor of Medicine." It cannot be concluded, however, that it is unethical to use specialty designations in this manner.

20. USE OF PROPER ADVERTISING MEDIA

Publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local custom and offenses against recognized ideals are unethical. The component medical society must, in the final analysis, determine what practice is in accord with local custom, but in so doing, it should exercise great caution to insure full compliance with the spirit and intent of the Principles. The practice of medicine should not be commercialized nor treated as a commodity in trade. Respecting the dignity of their calling, physicians should resort only to the most limited use of advertising and then only to the extent necessary to serve the common good and improve the health of mankind.

21. USE OF MEDICAL EMBLEM ON AUTOMOBILE

Nothing in the Principles of Medical Ethics proscribes the use of a medical emblem by a physician on his automobile. It may be noted that it has long been the custom of the Association to provide for its member at cost, registered medical automobile insignia.

22. INSIGNIA FOR MEMBERS OF SPECIAL GROUPS

An organization having to do with the certification of physicians requested the opinion of the Judicial Council on the ethical standing

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of their credential holders should they carry or wear a key indicating their membership in that organization or show on their professional stationery a replica of the key together with initial letters indicating their membership. It was felt that approval of such procedure if given to one group of doctors of medicine could not well be withheld from any other body composed of doctors of medicine desiring to do likewise; that, if such a custom became prevalent, irregular practitioners and cultists would rapidly follow suit; that the display advertising of those least qualified to give good medical care to the public would be most apparent, and that the confusion in the lay mind would lead to much harm to the indiscriminating public.

23. USE OF SIGN

The Principles of Medical Ethics proscribe the solicitation of patients. It has been an accepted principle that the most worthy and effective advertising is the establishment of a well-merited reputation for professional ability and fidelity; and that disregard of local customs and offenses against recognized ideals are unprofessional. It is the opinion of the Judicial Council that local customs vary from community to community, and therefore it is the obligation of the component medical society to determine whether, in a given locality, the use of any sign by a physician would be an affront to the ideals of the community and bring discredit to the profession. It is the further opinion of the Council that both the physician who contemplates the use of such advertising and his component society should fully observe the precept of the Principles: "A physician is expected to uphold the dignity and honor of his vocation."

24. RETENTION OF NAME OF DECEASED PHYSICIAN BY GROUP OR PARTNERSHIP

The continued use of the name of a deceased member of a group or partnership by those who continue the medical practice of that group or partnership is not of itself a violation of the Principles, if such practice is not contrary to local custom or the law of the community. The practice becomes unethical if it misleads or deceives the public, if it offends against local custom and ideals, or if it is contrary to law. Whether such practice tends to or does deceive or mislead depends on all the facts of each situation and includes both the intent of the user and the anticipated effect such practice will have in the particular community. Only the component medical society can ascertain these facts and determine from them whether the practice is or is not in violation of the spirit and intent of the Principles. Better practice dictates, if the name may properly be used, some means to indicate that the former member is deceased; for example, John Doe, M.D., 1880-1954. In some exceptional situations the continued use of the name of the deceased by his surviving associates may well be a fitting tribute to the memory of one who contributed materially to the advancement of medicine.

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25. CONTINUED USE OF NAME OF DECEASED PHYSICIAN BY SUCCEEDING PHYSICIAN

The Judicial Council was asked if it is ethical for a new physician in a community, who purchased the practice of a deceased physician, to continue the use of the deceased physician's name in his practice, in telephone listings, etc.

In and of itself, it is not unethical for a new physician in a community, who has purchased the practice of a physician, whether the physician be deceased or not, to continue the use of the former physician's name in his practice for a reasonable length of time. It is preferable, however, for a new physician to establish his own name in the practice of the profession as quickly as possible.

26. ADVERTISEMENT ON PHYSICIAN'S APPOINTMENT CARD

Carrying or listing the name of an insurance company, drugstore, a business concern, or the like on a physician's professional medical appointment card is unprofessional.

27. DISTRIBUTION OF REPRINTS OF ARTICLES

One normally would not take it upon himself to mail reprints indiscriminately without sufficient reason. What constitutes a sufficient reason is impossible to define categorically. Certainly it would not be ethical for a physician to mail reprints if his intent was to solicit patients directly or indirectly or to attempt to bring undue attention to himself. The practice, therefore, cannot be recommended. This is not to say that the author of a medical article may not honor requests for copies of his article.

28. USE OF PHYSICIAN'S NAME IN CONNECTION WITH CIVIC ENTERPRISES

The use of a physician's name in connection with a civic project should not, in itself, be considered contrary to the Principles of Medical Ethics.

29. USE OF PHYSICIAN'S NAME IN NEWS STORY

The Principles of Medical Ethics prohibit the solicitation of patients. They do not prohibit the reporting of proper news. When an accident or event occurs which is newsworthy and if the facts surrounding it are published, there would be no way, and seldom any reason, to stop a newspaper from reporting as a matter of fact that the victim was taken to the offices of a named doctor for treatment. Should the newspaper so report, the doctor should not be criticized because the newspaper made this factual observation.

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SECTION 6

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A PHYSICIAN should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

1. CONDITIONS OF MEDICAL PRACTICE

A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

2. CONTRACT PRACTICE

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

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

3. CONTRACT PRACTICE

It will be observed that in the definition of contract practice submitted to the House in 1926 no mention is made of the ethics of the practice for the reason that contract practice *per se* is not an ethical question, ethics being concerned with the form of the contract and the conditions under which it is made. That there are many conditions under which contract practice is not only legitimate and ethical, but in fact the only way in which competent medical service can be provided, becomes evident on analysis.

It is perfectly evident, therefore, if we are to judge whether a contract is ethical or not, that we must know the form and terms of the contract as well as the particular circumstances under which it is made. As there is such a great variety of contracts, as their form and the circumstances under which they are made differ so widely, it seems impossible, or at least inadvisable, to attempt to define what constitutes an ethical contract. Each case must be judged on its own merits after all the facts pertaining thereto are known.

There are certain points, however, that may be formulated which, when present, definitely determine a contract to be unfair or unethical. These may be stated as follows:

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

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

3. When there is underbidding by physicians in order to secure the contract.

4. When a reasonable degree of free choice of physicians is denied those cared for in a community where other competent physicians are readily available.

5. When there is solicitation of patients directly or indirectly.

In the interpretation of the rules of ethics as applied to the practice of medicine: (1) By the word "practice" is meant the performance or application of medical knowledge; (2) by "solicitation" is meant to seek professional patronage by oral, written or printed communications either directly or by an agent; (3) by "patient" is meant any person ill or otherwise.

4. PURVEYAL OF MEDICAL SERVICE TO DIRECT PROFIT OF LAY GROUP

The privilege of healing the sick as a profession is a right granted only to those properly qualified and licensed by the state. It is a privilege belonging only to the medical profession. It is a sacrifice of professional dignity that this exclusive right of medicine is so often sold for individual gain or its possessor deprived of it against his will. In increasing numbers, physicians are disposing of their professional attainments to lay organizations under terms which permit a direct profit from the fees or salaries paid for their services to accrue to the lay bodies employing them. Such a procedure is absolutely destructive of that personal responsibility and relationship which is essential to the best interests of the patient.

Outstanding examples of this type of unearned gain are not difficult to find. There are insurance companies administering workmen's compensation benefits wherein the salaries or fees paid to the physician by the insurance company are so much below the legal fees on which the premium paid by the industry is based as to furnish a large direct profit to the insurance company. Certain hospitals are forbidding their staffs of physicians to charge fees for their professional services to "house cases" but are themselves collecting such fees and absorbing them in hospital income. Some universities, by employing full time hospital staffs and opening their doors to the general public, charging such fees for the professional care of the patients, as to net the university no small profit, are in direct and unethical competition with the profession at large and their own graduates. They are making a direct profit by a practice of questionable legality, from the professional care.

5. PHYSICIAN-HOSPITAL RELATIONS

A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers

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to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine.

A physician should not enter into a contract or agreement with a hospital whereby the hospital acts as the agent for a physician unless it is with the consent of the physician and of the medical staff. The physician and the medical staff, as principals, should not approve any contract whose terms or conditions are inconsistent with the "Principles of Medical Ethics" and established policy of the American Medical Association.

6. RELATIONSHIP WITH HOSPITALS OR UNIONS—PHYSICIANS, RESIDENTS OR INTERNS

Whatever an intern or resident's economic relationships with a hospital may be, his responsibility to patients is primary. No circumstance may be permitted to interfere and cause neglect of patients. Whether interns and residents are members of a union or not, they are bound by the Principles of Medical Ethics and whatever the interns' and residents' economic relationships with a hospital or union may be, their professional conduct must conform to ethical principles.

7. ANESTHESIA A MEDICAL SERVICE

Anesthesia is a medical service and therefore should always be under the direction and supervision of a physician who assumes the responsibility and who should present his bill for services. No hospital or individual without a license to practice medicine should be permitted to collect the fee for anesthesia.

8. PHYSICIANS EMPLOYED TO STAFF HOSPITAL EMERGENCY ROOM

The policy of certain hospitals under which physicians are employed on a salary to provide professional medical care in the emergency room on the theory that emergency service in the hospital appears to have developed as an essential hospital function has been considered.

The official policy of the American Medical Association as adopted by the House of Delegates in 1951 and reaffirmed as recently as June, 1964, states that a physician should not dispose of his professional services to any hospital, corporation or lay board by whatever name called under terms or conditions which permit the sale of the services of that physician by such agency for a fee. The action of a physician in accepting a salaried position offered by the hospital in a case such as described is not consonant with the policy of the AMA.

One possible solution to staffing an emergency room is to have the medical staff form itself together into a medical partnership for the

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purpose of employing a physician whose duties among others would include taking care of emergency cases in the hospital. The physician would be the employee or agent of the staff rather than the hospital.

9. ASSOCIATION OF PATHOLOGIST AND LABORATORY TECHNICIAN

An association between a pathologist and a licensed technician to operate a medical laboratory would involve an improper division of professional income with a lay person. Under such an arrangement, the lay technician would have a direct financial interest in the productivity and fees earned by the pathologist. For this reason such a plan would be unethical.

10. RELATION BETWEEN PSYCHIATRISTS AND PSYCHOLOGISTS

In relationships between psychiatrists and practicing, licensed psychologists, the physician should not delegate to the psychologist any matter requiring the exercise of professional medical judgment.

11. PRACTICE OF MEDICINE BY LAY CORPORATIONS

It was decided long ago that the practice of law by a lay corporation was against public policy and the same has been prohibited by law in many states. The relations between patient and physician are more intimate than are those between client and attorney. It is impossible for that intimacy of relationship to exist between an individual and a corporation and if it is against public policy for a corporation to practice law, how much more so must it be for a corporation to practice medicine.

12. LAY CORPORATIONS

The practice of medicine by lay corporations is detrimental to the best interests of scientific medicine and of the people themselves. When medical service is made impersonal, when the humanities of medicine are removed, when the coldness and automaticity of the machine are substituted for the humane interest inherent in individual service and the professional and scientific independence of the individual physician, the greatest incentive to scientific improvement will be destroyed and the public will be poorly served.

13. FORM OF MEDICAL PRACTICE

The House of Delegates affirms that it is within the limits of ethical propriety for physicians to join together as partnerships, associations or other lawful groups provided that the ownership and management of the affairs thereof remain in the hands of licensed physicians.

14. PROFESSIONAL ASSOCIATION LAWS

The so-called "professional association laws" permit doctors to form professional associations. It was asked whether or not associations of doctors formed under this law would conform to the American Medical Association's Principles of Medical Ethics.

In 1957 the House of Delegates of the Association declared that it is within the realm of ethical propriety for physicians to join together in partnerships, associations, or other lawful groups, provided that the

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ownership and the management of the affairs thereof remain in the hands of licensed physicians. In accordance with the policy of the House of Delegates, physicians may take advantage of "professional association laws" and may also ethically do those things which are necessary to reap the intended and proper advantage of such legislation.

15. PROFESSIONAL CORPORATIONS

If the laws of the state provide that physicians may organize professional service corporations for the practice of medicine, it is ethically permissible for physicians to form such corporations. It is implicit in such circumstances that the ownership and management of the affairs of the professional service corporation remain directly and solely under the control of licensed physicians, and that the attending physician remain responsible to his patient.

The ethical principles for the medical practice conducted under the form of a professional service corporation are exactly the same as for the individual physician. The professional service corporation and each physician member of the professional service corporation must observe and follow all the principles of medical ethics.

16. NAMES OF PROFESSIONAL CORPORATIONS

Groups of physicians who incorporate as professional service corporations or who form professional associations or partnerships may not choose a name for their group which aggrandizes the group, or is of such nature as to mislead the public. The name must be accurate.

17. AVAILABILITY OF MEDICAL SERVICES

Many forces are pressing for the adoption of new methods of medical practice and for changes in the relations of physicians, as individuals and as organized groups, toward the public and toward institutions and organizations, and also for revolutionary changes in the very traditions of the profession with respect to the obligations and privileges of physicians in their contacts with one another. These forces have in some instances been sadly misdirected and will result in disaster to medicine and to the public.

The complexities of modern society may make it imperative that some changes shall be made, but the duty of the organized profession is to see to it that any and all proposals for change, from whatever source, shall be scrupulously and deliberately examined with the view of determining their ultimate value. Decisions should not be made on the basis of feasibility for the immediate present but should be made in the light of the experience of the profession, the nature of its service, the imperative need for maintaining professionalism and the absolute necessity for unhampered scientific advancement, and with the utmost regard for the best interest of the people.

18. PERIODIC HEALTH EXAMINATIONS AND VENDING MEDICAL SERVICES

Individualism in the practice of medicine is essential to success if one has in mind the interest of the patient and the encouragement

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of medical progress. The relation between the patient and the physician is an individual matter, and anything that disturbs this relationship is detrimental to the best interests of the patient. We cannot help but feel that the service of periodic health examinations, as conducted by commercial institutions, must inevitably result in the undermining of the confidence of the people in the abi ity of the practitioner.

While it is true that periodical health examinations are often of value and are to be recommended in a general way, we are inclined to regard the indiscriminate communication of the results of such examinations to the examined in the form of the statements that are commonly made by these organizations as unwise and often injurious to the individual who applies for examination. No organization is medically qualified or, in our opinion, justified in issuing to individuals applying for examination a routine statement of the results of the examination.

We believe that enough has been said to show the importance of the subject, and feel that it is incumbent on this body to devise ways and means of setting the public aright on the question of periodic health examinations, and to convince the people that the proper person to make such examinations and to give advice relative thereto is the family physician, aided, when necessary, by local specialists.

19. PERIODIC HEALTH EXAMINATIONS BY LAY ORGANIZATIONS

The benefits of scientific medicine cannot be adequately delivered to the individual through the medium of a third party. Communication of results of physical examination and the general advice with which it should be associated should go directly from the individual physician to his patients. The relation between the patient and the physician is an individual matter, and anything that disturbs this relationship is detrimental to the best interests of the patient.

20. LABORATORY SERVICES

The following questions and answers are provided by the Judicial Council in response to inquiries raised by a number of medical societies:

(1) If a laboratory is owned by a physician who spends a small portion of his time directing and managing its financial and business affairs; if the laboratory work is performed by technicians and directly supervised by a medical technologist with little or no participation by the physician-owner; if the physician's name is used in connection with the laboratory in a manner to create the appearance that it is owned, operated and supervised by a doctor of medicine, is the physician engaged in an unethical activity? Would it make any difference if he were not the owner, but merely received compensation for his time? Or if he were a partner with the supervising technologist or participated without receiving any compensation or share of the profits?

In each of the situations set forth above the physician would be guilty of deception and unethical conduct in misrepresenting or

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aiding the misrepresentation of laboratory services performed and supervised by a non-physician, as physician's services.

(2) If a laboratory, owned, operated and supervised by a non-physician in accordance with state law, performs tests exclusively for physicians who receive the results and make their own medical interpretations, is it permissible for physicians to utilize the services of these laboratories?

The physician's ethical responsibility is to provide his patients with high quality services. This includes services which he performs personally and those which he delegates to others. A physician should not utilize the services of any laboratory, irrespective of whether it is operated by a physician or non-physician, unless he has the utmost confidence in the quality of its services. He must always assume personal responsibility for the best interests of his patients. Medical judgment based upon inferior laboratory work is likewise inferior. Medical considerations, not cost, must be paramount when the physician chooses a laboratory. The physician who disregards quality as the primary criterion or who chooses a laboratory because it provides him with low cost laboratory services on which he charges the patient a profit, is derelict in not acting in the best interests of his patient. However, if reliable quality laboratory services are available at lower cost, the *patient* should have the benefit of the savings. As a professional man, the physician is entitled to fair compensation for his services. He is not engaged in a commercial enterprise and he should not make a markup, commission, or profit on the services rendered by others.

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IN THE practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

1. PAYMENT FOR PROFESSIONAL SERVICES

The ethical physician, engaged in the practice of medicine, limits the sources of his income received from professional activities to services rendered the patient.

When patients are referred by one physician to another, it is unethical for either physician to offer or to receive any inducement other than the quality of professional services. Included among unethical inducements are split fees, rebates, "kickbacks," discounts, loans, favors, gifts, and emoluments with or without the knowledge of the patient. Fee splitting violates the patient's trust that his physician will not exploit his dependence upon him and invites physicians to place the desire for profit above the opportunity to render appropriate medical service.

Billing procedures which tend to induce physicians to split fees are unethical. Combined billing by physicians may jeopardize the doctor-patient relationship by limiting the opportunity for understanding of the financial arrangement between the patient and each physician. It may provide opportunity for excessive fees and may interfere with free choice of consultants, which is contrary to the highest standards of medical care.

2. AGREEMENT BETWEEN PHYSICIANS AS TO FEE—BILLING PROCEDURE

On no occasion has the Judicial Council expressed the opinion that it is unethical for physicians to consider the economic status of a patient in a conscientious endeavor to keep the total cost of medical and surgical care within the economic limitation of the patient. This practice, carried out in the interest of the patient, is the antithesis of unethical practices that increase the costs of medical care and cause deterioration of medical service. It is not unethical for physicians mutually to establish the relative value of their professional services, as such services relate to the economic ability of the patient to pay, but each physician should submit a bill for the service he has himself rendered and receive payment therefore directly from the patient.

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3. PHYSICIAN'S FEE IN RELATION TO PATIENT'S INCOME

The Principles of Medical Ethics are "standards by which a physician may determine the propriety of his conduct." They are guides to be observed, not laws to be enforced. The second sentence of Section 7, providing that physician's "fee should be commensurate with the services rendered and the patient's ability to pay" is such a guide. It is a general principle which should aid the physician in considering his fee. In addition to legal prohibitions, the very nature of medical practice prevents the rigid establishment of inflexible fees for the many services which may be rendered to any individual. This principle does not suggest, therefore, that a physician set his fee with mathematical accuracy nor does it impose on him an obligation to act contrary to conscience, reason, or experience.

"Commensurate with the services rendered" recognizes that although there are some services which are considered invaluable, nonetheless their practical value lies within a range—within limits above or below which a fee is unconscionable. A "patient's ability to pay" is a secondary factor, one to be considered after, not before, value "commensurate with the services rendered" is ascertained. It is not contrary to conscience for the physician to consider the patient's ability to pay if he fixes his particular fee within reasonable limits. The language used in this section is intended only to suggest that a physician try, in matters relating to fees, to the best of his ability to insure justice to the patient and himself and respect for his profession.

This section cannot properly be interpreted to mean that a physician or a group of physicians must fix average fees to be increased or reduced according to the patient's economic status, nor to imply that an arbitrary sliding scale of fees is to be adopted and applied individually or by the profession. It may not be used to justify an excessively high fee or to approve an inadequately low fee.

This subject is important enough to add the comment that the physician can obviate many fee-complaints (and consequent ill-will) by discussing fees with his patient so that the patient may understand and appreciate the value of the service for which the fee is paid.

4. EXCESSIVE FEE

The charging of an excessive fee is unethical and is contrary to Section 7 of the Principles. The physician's fee should be commensurate with the services rendered and the patient's ability to pay.

5. CHARGING FEE FOR ADMITTING PATIENT TO HOSPITAL

Charging a separate and distinct fee for the incidental, administrative, non-medical service the physician performs in securing the admission of a patient to a hospital is not in keeping with the traditions of the American Medical Association and is to be disapproved as unethical.

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6. BILLING FOR COMPLETING ROUTINE HEALTH INSURANCE CLAIM FORMS

The attending physician should complete without charge the appropriate "simplified" Health Insurance Council forms approved by the Council on Medical Service, and similar insurance claim forms as a part of the physician's service to the patient to enable him to receive his benefits.

A charge for more complex forms may be made in conformity with local custom. This suggestion is advisory. In all cases, the local medical society can be looked to for an authoritative opinion.

7. CHARGE FOR COMPLETING MULTIPLE INSURANCE FORMS

A statement of policy, by a group of physicians, reads: "Without charge we will fill out one insurance form. If you have more than one insurance company and bring all claim forms to our office at one time, they will be completed without charge. Should you bring additional forms for the same illness or injury at a latter date, there will be an appropriate charge to be paid in advance." There is nothing improper in this practice. The ordinary needs of the patient are provided for without cost. Patient is advised of additional cost if additional work is imposed on the doctor's office staff.

8. MISSED OR BROKEN APPOINTMENT

Charging for a missed appointment or for one not cancelled 24 hours in advance need not, in itself, be considered unethical if patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration of patient and his circumstances.

9. CHARGE FOR SERVICES PROVIDED FAMILY MEMBER

From time immemorial, it has been considered unwise and improper for a physician to treat members of his immediate family for other than minor health problems or in emergencies. For him to do so would be in violation of Section 6 of the Principles and therefore unethical.

Even if for some good reason it becomes necessary for the physician to treat a member of his immediate family, he should not charge, or make a claim for, or receive compensation for such service from patient or from a third party payor on patient's behalf.

10. USE OF COLLECTION AGENCY

The physician's ethical responsibilities in referring a delinquent account to a collection agency should include the following. He should first give due consideration to the patient's ability to pay the fee which is due. Secondly, he should not utilize the services of a collection agency whose tactics and methods of collection might bring the medical profession into disrepute. The physician may not "sell" his delinquent accounts to a collection agency and may not enter into any arrangement

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under which the physician would lose complete control of the delinquent account or the method of its collection.

11. PHYSICIANS' LIEN LAWS

It is not improper for a physician to use a physicians' lien law as a means of assuring payment of his fee, provided his fee is fixed in amount and not contingent on the amount of settlement of the patient's claim against a third party.

12. CHARGING PENALTY FOR OVER-DUE ACCOUNTS

It is not in the best interest of the public or the profession to charge interest on an unpaid bill or note or to charge a penalty on fees for professional services not paid within a prescribed period of time nor is it proper to charge a patient a flat collection fee if it becomes necessary to refer the account to an agency for collection.

13. PROGRAMS FOR FINANCING MEDICAL CARE

In 1934 the House of Delegates declared that "One of the strongest holds of the profession on public approbation and support has been the age-old professional ideal of medical service to all, whether able to pay or not. That ideal is basic in our ethics."

The medical profession cannot dictate to patients how they shall finance their medical bills. The medical profession must oppose any prepayment or postpayment program that might result in advertising or solicitation of patients by physicians, profit to the physician for other than professional services, exploitation of the patient, or unnecessary increase in the cost of medical care.

Any proposed program for financing medical care or parts of medical care, should be judged by the physician in light of the above criteria.

14. BANK CARDS

In connection with physician participation in bank card programs, the following principles are recommended to be implemented and applied as necessary by the county medical society for the guidance of physicians as these programs develop.

(1) The county medical society should be satisfied as to the financial and professional integrity of the plan. It should negotiate with the plan sponsors to insure that service charges to the physician are reasonable. It should insist that the plan be open to all physicians on the same terms and that it not exploit or capitalize on physicians' participation in the plan. It should advise the plan that the listing of physicians in directories of participating members is contrary to the ethics of the medical profession.

(2) The individual physician may not, because of his participation, increase his fee for medical service rendered the patient. He may not use the plan to solicit patients. He may not encourage patients to use the plan. His position must be that he accepts the plan as a convenience to patients who desire to use it. Plaques or other de-

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vices indicating participation in the plan within the physician's office shall be kept to a discreet and dignified minimum. Plaques, signs, or other devices indicating such participation visible outside the physician's office are unacceptable.

(3) The use of a bank card in connection with the payment of larger fees—which might normally be paid to the physician in installments—is not to be encouraged. All members of the Association are expected to continue the traditional practice of permitting patients of limited means to pay relatively large fees in installments without interest or carrying charges. Out of respect for the dignity and traditions of the medical profession, the physician may not relieve himself of his obligations "to render service to humanity, reward or financial gain being a subordinate consideration."

15. FEE CONTINGENT ON OUTCOME OF LITIGATION

The contracting for, or acceptance of, a contingent fee by a doctor, which is based on the outcome of litigation, whether settled or adjudicated, is unethical. The laborer is worthy of his hire and the physician, having only his services to sell, has an obligation to place a fair value on those services. Ethically this value should be based upon the value of the service rendered by the physician to the patient and not upon the uncertain outcome of a contingency that does not in any way relate to the value of the service. Furthermore, the physician's obligation to uphold the dignity and honor of his profession precludes him from entering into an arrangement of this nature because, if a fee is contingent upon the successful outcome of a claim, there is the ever-present danger that the physician may become less of a healer and more of an advocate—a situation that does not uphold the dignity of the profession of medicine.

16. FEE SPLITTING DEFINED

By the term secret splitting of fees is meant the sharing by two or more men in a fee which has been given by the patient supposedly as the reimbursement for the service of one man alone. By secrecy is meant that the division of the fee is done without the knowledge of the patient or some representative of the family. It includes those cases in which the term assistant is used as a subterfuge to obtain a part of the fee which otherwise could not be rightfully claimed.

17. FEE SPLITTING IS GIVING OR RECEIVING A COMMISSION

The giving or receiving of a commission constitutes fee-splitting and is unethical.

18. REBATES AND COMMISSIONS

The acceptance of rebates on prescriptions and appliances or of commissions from those who aid in the care of patients is unethical.

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19. REBATES FROM SALE OF MEDICINES OR APPLIANCES

A physician may receive no profit whatever from his patient other than payment for rendered medical services. Hence it should be apparent that no rebate of any kind, in any form or from any source can be accepted. This applies also to rebates coming from agents or owners of optical companies. They are, in every case, absolutely unethical.

20. LOCAL SOCIETIES MUST COMBAT FEE SPLITTING

Fee splitting is to be condemned wherever it may be found, and component societies and constituent associations must purge their membership of any who willfully refuse to desist from such practice, the continuance of which can only bring dishonor and reproach on the medical profession.

21. STOCK COMPANIES OF PHYSICIANS TO OPERATE CLINICS OR LABORATORIES

Several proposals looking to the organization of groups of physicians in cooperative projects have been submitted to the Judicial Council. In most instances these have been in the nature of stock selling and stock holding schemes whereby physicians interested would realize on investments in proportion to the amount of work referred by them to the "clinic" or laboratory operated under the particular scheme. After examination of these proposals, nearly all of them appear to be open to the criticism that they are, or may be suspected of being, essentially fee-splitting projects. The Council, therefore, has refused to give its approval to joint stock companies of physicians organized for the purpose of operating clinics or laboratories with the stock owned in part or in whole by physicans connected only as stockholders.

22. COOPERATIVE DIAGNOSTIC LABORATORIES

Concerns known as "cooperative diagnostic laboratories" have been organized in which practicing physicians participate as "members." Information indicates that organization is effected in such a manner that control will lie in the hands of the promoters and directors of these schemes and that practicing physicians are then expected to refer work to the laboratories operated by the concern. As a consideration for such referrals, the physician members receive from the laboratories compensation varying with the amount of work referred. Schemes of this kind are unethical and directly opposed to the interest of scientific medicine.

23. OFFICE SPACE RENTED FOR PERCENTAGE OF PHYSICIAN'S INCOME UNETHICAL

An arrangement by virtue of which a physician leases office space for a percentage of gross income is not acceptable; it is violative of ethical principles. The practice indirectly results in fee splitting and tends to exploit the practice of medicine. If the size of a doctor's prac-

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tice increases and imposes additional demands on the facilities of the building, these facts may be considered when the time comes to renegotiate the rental value of the leased premises, and a new fixed rental, taking these items into account, might be agreed upon.

24. RENTAL OF SPACE AS PHARMACY ON PERCENTAGE OF INCOME BASIS UNETHICAL

The rental of space by a physician or group of physicians as a pharmacy should be a fixed one. Were the rental to be based on the amount of business, it might well be argued, and indeed be the case, that fee splitting existed. In addition, the temptation would be ever present for the doctor-owner to encourage patients to take their prescriptions to that pharmacy. The evils inherent in such practice are too obvious to be mentioned.

25. RENTAL OF SPACE FOR FIXED SUM

An arrangement whereby space in a medical building owned by an ophthalmologist is leased on a fixed rental basis to an optician, provided patients are not "steered" to the optician, is not contrary to the Principles of Medical Ethics.

26. PURCHASE OF MEDICAL PRACTICE ON PERCENTAGE BASIS

The purchase of a medical practice on a percentage basis is contrary to and in violation of the Principles. A physician may pay anything he wants to for the practice as long as a set price is established, but it is unethical for a physician to pay a percentage of the income of the practice that he has purchased as payment for it. The use of a percentage of fees or an indefinite sum as the purchase price for a medical practice results in dividing fees paid for professional service with a third party—a stranger to the physician-patient relationship. Once a price has been established it may be paid according to the mutual agreement of the parties. Payment of such an established price predicated on a percentage of the income of the purchaser is not contrary to the Principles. It is axiomatic that a physician must bill a patient for professional services that he renders to the patient. He must not divide that fee with another. Such practice violates the physician-patient relationship and may be regarded as a commission for having referred the patient. Further, the use of a percentage arrangement indirectly tends towards solicitation of patients for or on behalf of the purchasing physician, because the seller clearly derives greater profit from greater income.

27. DIVISION OF PHYSICIAN'S FEE WITH HOSPITAL

The suggestion has been made by some hospitals that physicians who utilize the hospital facilities should pay to the hospital a percentage of the fees which they receive from their patients while being cared for in the hospital.

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The suggested proposal is clearly a case of splitting or sharing professional fees with a lay organization which should not render professional service in the first place, but which, in addition, has already levied its regular bill for the services which it legitimately rendered.

28. COMPULSORY ASSESSMENTS AND COMPULSORY AUDITS BY HOSPITALS

Neither the hospital management nor the medical staff has the privilege or the right to make compulsory assessments of members of the medical staff for building funds or to demand an audit of staff members' personal financial records as a requisite for staff appointment.

29. COMPULSORY ASSESSMENTS OF MEDICAL STAFF

Compulsory assessments, that is, assessments which if not paid, would automatically cause doctors to lose staff membership, are not in the best traditions of ethical practice. It is not proper to condition medical staff membership on compulsory assessments for any purpose.

30. HOSPITAL OR MEDICAL STAFF ASSESSMENTS

It is recommended that a mechanism be established, preferably at local level between medical and hospital associations, to review objectively and impartially questions predicated on the nature of hospital assessments. Education and liaison are the avenues by which physicians may properly correct the abuses which occur when hospitals seek funds from medical staff members for building or other purposes.

31. RETIREMENT PLANS

A retirement plan however classified under the Internal Revenue Code which also covers lay employees and which provides that the contribution made by a solo practitioner, a group of physicians, or a professional corporation will be based on a percentage of compensation of the participants, is ethically acceptable even though the contribution:

(1) is limited to a percentage of net income before taxes, or

(2) is payable only when net income exceeds a specified amount

33. EMPLOYEE BONUS

A physician may not pay his employees a bonus at the end of the year based upon a percentage of his increased income for the year. It would be improper for the physician to promise a bonus based upon a percentage of his increased receipts; this would constitute fee-splitting, which is universally denounced by medicine in all of its forms. If the physician wants to reward his employees for their greater or more effi-

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cient services through the year, which has resulted in an increase in the physician's gross receipts, he may take his increased receipts into consideration in determining the fixed amount of the bonus he wishes to pay his employees.

34. PROPRIETY OF PERCENTAGE ARRANGEMENT BETWEEN A SURGEON AND A CLINIC

Any arrangement by which a non-member of a group or clinic either (1) is paid for referring patients to the group or clinic, or (2) is given a title, such as associate member, in the group or clinic to induce the non-member to refer patients to the group or clinic, must be looked upon with disfavor.

35. DIVISION OF INCOME BY MEMBERS OF A GROUP

The division of income among members of a group, practicing jointly or in partnership, may be determined by the members of the group and may be based on the value of the professional medical services performed by the member and his other services and contributions to the group.

36. PHYSICIANS SHOULD RENDER SEPARATE BILLS

In many cases insurance companies insist on a joint or combined bill, but the bill is being paid in most instances by two checks. This is not considered unethical, and all insurance plans which do not pay the individual physician in this manner should be urged to do so.

When two or more physicians actually and in person render service to one patient, they should render separate bills. There are cases, however, in which the patient may make a specific request to one of the physicians attending him that one bill be rendered for the entire services. Should this occur, it is considered to be ethical if the physician from whom the bill is requested renders an itemized bill setting forth the services rendered by each physician and the fees charged. The amount of the fees charged should be paid directly to the individual physicians who rendered the services in question.

37. SEPARATE BILL FROM ANESTHESIOLOGIST

Medicine has always insisted that anesthesia is a medical service, which should be administered by a licensed, trained physician or by another adequately trained person who acts under the direction and supervision of a physician who assumes responsibility for the medical service rendered. A physician properly should present a bill for the services he renders to the patient.

38. COMBINED OR JOINT BILLS

When two or more physicians actually and in person render service to one patient, they should render separate bills. The Special Report of June, 1954 indicates two exceptions to this general rule, namely,

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when a patient requests a single bill or when an insurance company demands one. The Counci. has insisted, however, that these instances are to be recognized as exceptional cases and not routine.

39. ITEMIZED BILL

Nothing in the Principles of Medical Ethics proscribes the submission of an itemized bill by a physician to his own patient for medical service he actually rendered to the patient.

40. SURGICAL ASSISTANT'S FEE

The House of Delegates adopted the following five principles:

1. Each member of the AMA is expected to observe the Principles of Medical Ethics in every aspect of his professional practice.

2. Each doctor engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered.

3. No doctor should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received.

4. When services are rendered by more than one physician, each physician should submit his own bill to the patient and be compensated separately whenever possible.

5. It is ethically permissible in certain circumstances, however, for a surgeon to engage other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance, provided the nature of the financial arrangement is made known to the patient. This principle applies whether or not the assisting physician is the referring doctor.

41. PAYMENT OF PHYSICIAN FOR SERVICES PERFORMED BY INTERN UNDER HIS DIRECTION OR SUPERVISION

When a physician assumes responsibility for the services rendered to a patient by a resident or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction and supervision.

42. EMPLOYMENT OF PHYSICIAN BY CLINIC OR ANOTHER PHYSICIAN

It is not unethical in itself for a physician to accept part-time employment under another physician or in a clinic. The physician so employed and his employer must observe, however, all Principles of Medical Ethics in their relationship with each other and with their patients.

43. BILL FOR RESPIRATORY SERVICES PROVIDED BY LAY ORGANIZATION

It is not ethical for a physician to bill a patient for respiratory services provided by a lay organization. A physician should limit his income to services he actually renders to the patient. A physician should not collect for services he does not render.

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44. BILLING PROCEDURE FOR LABORATORY SERVICES

1. The practice of pathology is an integral part of the practice of medicine.

2. All physicians should bill their patients directly, and

3. In exceptional cases, when it is not possible for the laboratory bill to be sent directly to the patient, the referring physician's bill to the patient should indicate the charges for laboratory services, including the name of the physician director of the laboratory, as well as the charges for his own professional services.

45. INVESTMENTS BY PHYSICIANS

To preclude the appearance of conflict of interest many physicians voluntarily limit their financial investments to fields completely unrelated to medicine or the health care industry. Even though strict interpretation of ethical principles does not require such limitation on one's financial investments that are otherwise in accord with ethical criteria, prudence and good judgment suggest that physicians should be most circumspect in their financial investments out of respect for the trust which their patients repose in them. The profession is better served when physicians avoid any appearance of compromise with the Principles of Medical Ethics.

46. HOSPITAL OWNERSHIP BY PHYSICIAN

(1) It is not in itself unethical for a physician to own a for-profit hospital or interest therein. The use the physician makes of this ownership or interest may, however, be definitely unethical. For example, for a physician to send a patient to such a hospital or to prolong a patient's stay in the hospital for his financial benefit would be unethical.

(2) When a physician has an interest in or owns a for-profit hospital to which he sends his patients, he has an affirmative ethical obligation to disclose this fact to his patient.

(3) Under no circumstances may the physician place his own financial interest above the welfare of his patients. The prime objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration.

(4) When in the course of the physician-patient relationship a conflict develops between the physician's financial investments and the physician's allegiance to his patient, the conflict must be resolved to the patient's benefit.

(5) When questions arise regarding the use that a physician makes of his ownership or his interest in a hospital for-profit, the local medical society has the obligation to ascertain all the facts and, based on an analysis of the facts, to provide guidance to its membership.

47. PHYSICIAN OWNERSHIP OF DRUGSTORES, DRUG REPACKAGING HOUSES AND PHARMACEUTICAL COMPANIES AND DISPENSING OF GLASSES BY PHYSICIANS

Section 7 of the Principles of Medical Ethics provides: "Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient." Under this language

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it cannot be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patient.

It is unethical for a physician to have a financial interest in a drug repackaging company.

It is unethical for a physician to own stock in a pharmaceutical company which he can control or does control while actively engaged in the practice of medicine.

These practices are contrary to the best interest of the public and the medical profession.

The Council calls the attention of the House to the following statement concerning the meaning of the words "drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient" which was adopted by the Council on June 26, 1958.

It is the opinion of the Judicial Council that this language was adopted to permit both the practicing physician and the local medical societies to evaluate the many factual situations incident to prescribing and dispensing which are bound to arise in the practice of medicine. Under this language the doctor is permitted to exercise his own best judgment when caring for his patients. It is known that there will be situations when it is necessary or desirable for a physician to dispense or supply what he has prescribed. The Principles permit this to be done. On the other hand, this broad language provides a means by which a component medical society can inquire into the facts of a particular practice. The profession thus can act to prevent abuse of discretion and protect patients from exploitation. In essence this language means that a physician in the exercise of sound discretion may dispense "in the best interest of his patient"; it does not authorize him to dispense solely for his convenience or for the purpose of supplementing his income.

48. DRUGS, DISPENSING BY PHYSICIANS

Although there are circumstances in which physicians may ethically engage in the dispensing of drugs, the American Medical Association nevertheless urges physicians to avoid the regular dispensing and the retail sale of drugs to patients whenever the drug needs of patients can be met adequately by local ethical pharmacies.

49. DISPENSING OF PRESCRIPTIONS IN CODE

Physicians who enter into agreements with the pharmacists in the dispensing of prescriptions in code are guilty of unethical practices and should be disciplined by their local society.

50. DIRECT TELEPHONE LINE TO PHARMACY

The principle of free choice of physician applies as well to the choice of a pharmacy. Accordingly, the Council looks with disfavor upon the use of direct telephone lines between a physician and a pharmacist on the theory that a patient is entitled to a written prescription which he can take to the pharmacist of his choice.

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51. NAME OF PHARMACY ON PRESCRIPTION BLANKS

It is unethical for physicians to use prescription blanks with the name of a pharmacy printed thereon.

52. RIGHT OF PATIENT TO COPY OF PRESCRIPTION

A patient is entitled to a copy of his or her prescription for glasses, drugs, or appliances and he has the privilege of having the prescription filled wherever he wishes.

53. OWNERSHIP OF STOCK IN A NURSING HOME

It is proper for a physician to own or have a financial interest in a nursing home or similar facility providing the patient has free choice of physician.

54. OWNERSHIP OF OPTICAL DISPENSING SHOP

It is not improper for a physician to own an optical dispensing shop provided there is no exploitation of the patient.

55. DISPENSING DRUGS

Although there are circumstances in which physicians may ethically engage in the dispensing of drugs, the American Medical Association nevertheless urges physicians to avoid the regular dispensing and the retail sale of drugs to patients wherever the drug needs of patients can be met adequately by local ethical pharmacies.

56. DEFINITION OF A DRUG REPACKAGING COMPANY

The term "repackaging company" as used by the Judicial Council and approved by the House of Delegates refers to a drug company which markets under its own label or trade names drug products manufactured by others with the objective that physicians having a financial interest in the drug company will prescribe its drugs to the patient.

57. GIFTS FROM MANUFACTURER, DISTRIBUTOR

A physician may not accept a gift such as a radio, a compact refrigerator, or the like from a manufacturer or a distributor of drugs, remedies, appliances or services for prescribing these products for his patients. This amounts to rebating. It is ethically improper because it could influence the physician to prescribe the donor's product. If a product or service is prescribed for its effectiveness, it would be preferable that it be discounted so that the patient, rather than the physician, benefits.

58. RELATION OF PHYSICIANS TO COMMERCIAL ENTERPRISES

It is demeaning to the medical profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures outside the practice of medicine. However, out of respect for his profession, he should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises.

59. PHYSICIAN'S NAME AND COMMERCIAL ACTIVITIES

It would be improper for a physician who owned a fishing lodge or

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vacation spa to advertise to the general public that it is owned and operated under the direction of a physician or that it is owned and operated under the direction of Dr. John Brown or John Brown, M.D. A physician should not allow his name or the prestige of his professional status as a physician to be used in the promotion of a commercial enterprise. The physician is free to engage in business ventures outside of the practice of medicine, but such business ventures should not be permitted to trade on the reputation and standing of the medical profession. The public might well be misled by this type of advertisement into the belief that the physician's business operation is in some way medically beneficial, that the physician provides medical supervision or c..re, or that it is better than the competitor's because it is owned by a physician.

Whether justified or not, the plain fact is that the layman might well so reason, and conclude that the reference to the physician-owner indicates superiority and perhaps health benefits.

The physician's colleagues also may well contend that such advertisement is a patent solicitation of patients and, therefore, unethical.

For the foregoing reasons the advertisement would not be in the best interests of medicine and therefore would be improper.

60. ENTERTAINMENT EXPENSES

Expenditures made by physicians for the entertainment of other physicians are not *per se* unethical. There are circumstances under which a professional obligation may rest on a physician to entertain other physicians. It is a usual and necessary concomitant of the practice of medicine. It is certainly not an uncommon practice and is recognized by the profession generally as entirely proper and justifiable.

Governmental tax authorities in several jurisdictions have questioned the right of physicians to deduct entertainment expenses for income tax purposes, contending that such expenditures are unethical. The deductibility of similar expenditures has been permitted where the taxpayer is a lawyer. Why should a different ruling apply when the taxpayer is a physician?

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SECTION 8

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A PHYSICIAN should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

1. **CONSULTATIONS SHOULD BE ENCOURAGED**

In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

2. **CONSULTATION FOR PATIENT'S BENEFIT**

In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

3. **RESPONSIBILITY OF ATTENDING PHYSICIAN**

The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

4. **RELATIONSHIP OF ATTENDING PHYSICIAN AND CONSULTANT**

When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

5. **DISCUSSIONS IN CONSULTATION**

After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

6. **CONFLICT OF OPINION BETWEEN ATTENDING PHYSICIAN AND CONSULTANT**

Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the differ-

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ing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

7. CONSULTANT NOT TO TAKE CHARGE

When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

8. PUNCTUALITY IN CONSULTATION

All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

9. WITHHOLDING REPORT OF CONSULTATION UNTIL FEE PAID

A consulting physician may not withhold the results of his examination of a patient who has been referred to him until his invoice for the consultation has been paid. As soon as possible after the consulting physician has seen the patient he should address the physician in charge and advise him of the results of his investigation. The interest of the patient is paramount in the practice of medicine. Everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient. It would be improper and unethical for a consulting physician to withhold the results of his examination until his invoice has been paid.

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SECTION 9

A PHYSICIAN may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

1. PATIENCE, DELICACY AND SECRECY

Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances.

2. PROGNOSIS

The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

3. RECORDS OF PATIENTS AND SUCCEEDING PHYSICIANS

At the request of the patient, preferably in writing, reports should be immediately sent to the doctor then in charge of the patient. The diagnosis of the patient's ailment is paramount in arriving at the proper treatment to be rendered, and all information which aids the physician should be furnished so that proper treatment or advice can be given without delay. Whether the contents of the report are to be given to the patient rests with the decision of the doctor who knows all the circumstances involved in the situation.

4. COPY OF PHYSICIAN'S RECORD TO PATIENT

The Principles neither intend nor require that a physician give a copy of his records to his patient. These records are primarily the physician's own notes compiled during the course of diagnosis and treatment so that he may review and study the course of the illness and his treatment. The records are medical and technical, personal and often informal. Standing alone they are meaningless to the patient but of value to the physician and perhaps to a succeeding physician. The patient, however, or one responsible for him, is entitled to know the nature of the illness and the general course or regimen of therapy

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employed by his physician. The extent to which the physician must advise his patient may be limited by the nature of the illness and the character of the patient. The physician in advising his patient must always act as he would wish to be treated were he in a like situation.

5. COPY OF PATIENT'S RECORD TO ANOTHER PHYSICIAN

The interest of the patient is paramount in the practice of medicine, and everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient. When a colleague who is presently treating a patient requests records from another physician who has formerly treated the patient, that former physician should promptly make his records available to the attending physician.

No set rule can be laid down to cover the manner in which the records are to be transmitted to the attending physician. Under some conditions a personal inspection of the records might suffice; under others an oral report of what is contained in the records would be of help; or in other circumstances a summary of the records might be made. In extreme cases, a physician might lend his complete record to the attending physician. The manner of making the report—or the information contained therein—available to the succeeding physician is immaterial and will depend on the circumstances of each case. Certainly, however, the attending physician should not demand or expect more information from the former physician than is necessary to give the patient adequate care in the present illness.

It is assumed, of course, that proper authorization for the use of these records has been granted by the patient.

6. REFUSAL TO FORWARD RECORD TO CURRENT PHYSICIAN UNETHICAL

It is unethical for a physician, who formerly treated a patient, to refuse for any reason to make his records of that patient promptly available on request to another physician presently treating the patient.

7. RETENTION OF RECORDS AFTER RETIREMENT

In addition to legal requirements, there may be good reason why a physician would wish to preserve his records for some time. In many instances the patient must rely upon his physician and his physician's records in order to establish the fact that he did receive medical care and treatment or that he has had the services of a qualified doctor of medicine. Without the physician's records the physician who rendered the care would be unable to assist his patient. Thus, in the best interest of the patient, the physician should not indiscriminately dispose of his records but should give consideration to the type of practice he has and to the possible needs of his patients.

8. DISPOSAL OF RECORDS AFTER RETIREMENT

From an ethical point of view a physician is under no obligation to turn his records over to his patients. In the best interest of the patient,

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however, when a physician contemplates moving from a community or retiring from practice, he might notify the patients on his active list of the fact that he intends to leave and encourage the patient to seek the services of some other doctor of medicine. The physician could also suggest that, with the consent of the patient, arrangements can be made to permit a succeeding physician, designated within reasonable time by the patient, to review these records. In this way the patient's best interests may be served.

9. SALE OR PURCHASE OF PHYSICIAN'S RECORDS

A physician, retiring from practice, may not ethically sell his patients' records to another physician. His records have been developed during the physician-patient relationship. To *sell* records would tend to make patient subject to barter to the highest bidder. For the patient's benefit, however, but only with his consent, these records may be transferred to a physician of his choice. A reasonable charge for secretarial or duplicating service connected with such transfer is not improper.

Further, according to Section 9 of the Principles of Medical Ethics, a physician may not reveal the confidences entrusted in him in the course of medical attendance. The physician's records summarizing these confidences are cloaked with this same protection. To transfer a patient's records without his consent would violate this confidence.

A physician may not ethically *purchase* such records from a retiring physician or from the estate of a deceased physician.

10. COMPUTERS—CONFIDENTIALITY

The utmost effort and care must be taken to protect the confidentiality of all medical records. This ethical principle applies to computerized medical records as it applies to any other medical records.

11. RECORDS ON TERMINATION OF PARTNERSHIP

When two or more physicians, who are partners in the practice of medicine, terminate the partnership relationship, any question regarding possession of patients' clinical records should be determined on the basis of what is best for the patients. In case of disagreement, the proper committee of the local medical society should assist in resolving the problem.

When a physician-employee terminates his relationship with an individual physician, a group of physicians or a clinic, the accepted principle is that the employer is entitled to possession of clinical records of all the patients. However, should the physician-employee have need to review these records in the best interests of a patient under his care, their contents should be available to him, with the consent of the patient.

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SECTION 10

THE HONORED ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

1. PHYSICIANS AS CITIZENS

Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of health laws and regulations.

2. PUBLIC HEALTH

Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of cases of communicable disease under his care, in accordance with the laws, rules, and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk of his own health.

3. THE RELATIONSHIP OF THE PHYSICIAN TO MEDIA OF PUBLIC INFORMATION

Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not always easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. On the other hand, it may often happen that the representatives of popular news media are the first to perceive the adaptability of medical material for presentation to the public. In such a situation the physician may be asked to release to the public some information, exhibit, drawing or photograph. Refusal to release this material may be considered a refusal to perform a public service, yet compliance may bring the charge of self-seeking or solicitation.

An ethical physician may provide appropriate information regarding important medical and public health matters which have been discussed during open medical meetings or in technical papers which have been published and he may reveal information regarding a patient's physical condition if the patient gives his permission, but he should seek the guidance of appropriate officials and designated spokesmen of component or constituent medical societies. Spokesmen should

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be empowered to give prompt and authoritative replies and a list should be issued which identifies them and discloses the manner in which they may be reached. These provisions are made with full knowledge that the primary responsibility of the physician is the welfare of his patient but proper observation of these ethical provisions by the physician concerned should protect him from any charge of self-aggrandizement.

Scientific articles written concerning hospitals, clinics or laboratories which portray clinical facts and technics and which display appropriate illustrations may well have the commendable effect of inspiring public confidence in the procedure described. Articles should be prepared authoritatively and should utilize information supplied by the physician or physicians in charge with the sanction of appropriate associates.

When any sort of medical information is released to the public, the promise of radical cures or the boasting of cures, or of extraordinary skill or success is unethical.

4. ADVERTISING AND THE DAILY PRESS

The Principles of Ethics of the AMA define clearly the methods which are objectionable for physicians to use to bring themselves into the public notice in their endeavor to gain a livelihood. They state clearly the methods by which a man may rise by honorable endeavor to the fame of a well-earned reputation, and suggest the different methods by which a man may gain unsavory notoriety. The standards of the medical profession have always demanded that physicians shall not exploit their ability or achievements to the laity. The medical profession condemns such advertising as quackery. The refraining from or the employment of advertising is the clearly defined difference between a reputable physician and a quack—the physician, one who quietly, through his professional work and attainments seeks by daily honorable dealing to spread the truth among his patients; the quack, one who endeavors to obtain his livelihood by playing on the credulity of the ignorant and the timid, imposing on the public statements known to be false, stopping at nothing in his effort to enhance his notoriety or fill his pocket.

The public is eager to hear and learn all it can of the most recent advances in the cure of diseases that so far have baffled the efforts of men to cure; it is eager to hear of the brilliant operations by which men have seemingly been saved from certain destruction and brought back to useful existence. It is anxious to learn and put in practice the best methods of public hygiene and preventive medicine. The daily press has correctly considered such subjects as news, as that is what interests its daily readers, but the medical profession has been placed at a disadvantage. The members of the profession who value the kind of reputation which they may bear before the public and from whom the most accurate information could be obtained, have been forced to see the most garbled statements published as medical facts, or have been refused opportunities to have the truth published unless they were willing to put themselves in the false position of self-exploitation. Certain other members of the profession, however, with a very wide-awake com-

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mercial spirit, have quickly seen the means by which they may appear in the press as doing extraordinary things above their fellows, and have eagerly seized on the opportunity, to have their picture, their honors and their doings put in the public press. While this may not be quackery it must be acknowledged to be advertising. It is frequently difficult to decide where one ends and the other begins. Certain newspapers have heralded this stepping over the limits of the strict adherence of the profession to its non-advertising principles as something much to be desired. They seemingly fail to understand and appreciate that if the barriers which the medical profession has held up, and still holds up, are broken down, quackery will become more and more rampant, and although the ease with which the press will obtain the sensations it desires will increase, the accuracy and the truth and the value of the news which they so eagerly seek will soon be ruined.

To all questions there are two sides and we must realize that if the AMA endeavors to arouse in the public an interest in medical matters and increase its knowledge of public health and hygiene with this increased knowledge will come a demand for more knowledge concerning the various diseases which may be acquired by any individual. The daily press has a right to publish that which is of interest to its readers, hence it has a right to a knowledge of medical matters that shall be accurate and given by honorable men. On the other hand there is every reason why the medical profession shall keep up its barriers against the self advertising of individuals for selfish purposes and no adequate reason why these barriers should be let down.

The Judicial Council therefore recommends:

That each county society should constitute a publicity committee whose duties shall be to give to the daily press accurate information on all medical matters of interest to the public, that this shall be freely given without the mentioning of names or from whence the information comes, and that this committee shall act in an advisory capacity to all physicians of its society in questions relating to publications other than in the medical press.

5. MEDICAL PUBLIC RELATIONS

In the ever-expanding field of medical public relations, no single phase has developed more than that which leads to the publication in national lay magazines and newspapers of stories of research or surgery. Such articles, where authoritatively prepared, usually tend to add to public confidence in the procedure described. The members of the Judicial Council believe that public confidence would be greatly enhanced, if a footnote printed with the article set forth the information that the article as written had the approval of the county or state, or both, medical societies.

6. PHYSICIANS WRITING HEALTH COLUMNS

It is not improper for physicians, not in active private practice, to write health columns for lay readers.

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It is generally inadvisable for physicians in active practice to write for the lay public on medical matters. It is preferable for physicians to act as advisors to writers who commonly serve the several lay publications carrying such articles who are skilled in their ability to translate medical information to lay groups for which they are writing.

7. RELEASE OF MEDICAL INFORMATION TO THE PRESS

Public figures are in a different position, in regard to publicity, than the ordinary citizen. One of the penalties of being in the public eye is the automatic surrender of a portion, at least, of one's right of privacy.

A patient or responsible friend or relative may authorize a doctor to disclose certain health information to the press. Under these conditions, the release of information by the physician does not violate any ethical principle. However, a doctor may release only authorized information or that which is public knowledge.

The use of the expression "medical authorities" is frequently used to preserve anonymity so that no individual doctor can be accused of having an ulterior motive in making a statement for the press. It is better to have a "medical authority" or a doctor act as spokesman so that the information given will be medically accurate.

8. PUBLICATION OF MEDICAL STUDIES OF PUBLIC FIGURES AFTER THEIR DEATH

Most scientific-medical articles, case studies, case reports and clinico-pathological reports are based on actual medical experiences with patients. Medicine does not find it necessary to identify these patients. While one need not condemn those who, after the death of public figures, discuss the medical condition of those people while they were alive, respect for the dignity of man, respect for the deceased, and respect for the medical profession strongly suggest that only some clear and meaningful benefit would justify such discussion.

9. USE OF PHYSICIAN'S NAME IN CONNECTION WITH CIVIC ENTERPRISES

The use of a physician's name in connection with a civic project should not, in itself, be considered contrary to the Principles of Medical Ethics.

10. DISCLOSURE OF INFORMATION TO INSURANCE COMPANY REPRESENTATIVE

History, diagnosis, prognosis, etc., acquired during the physician-patient relationship may be disclosed to an insurance company representative if patient has consented to the disclosure. As recognized in Section 10 of the Principles a physician's responsibilities to his patient are not limited to the actual practice of medicine. They also include the performance of some services ancillary to the practice of medicine. These services might include certification that patient was under the physician's care and comment on the diagnosis and therapy in the particular case.

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11. DISCUSSION OF MEDICAL FACTS WITH PATIENT'S LAWYER

Patient's history, diagnosis, treatment and prognosis may be discussed with patient's lawyer with consent of the patient. The Principles of Medical Ethics recognize in Section 10 that the physician has obligations to society as a whole in addition to his obligations to his patient as an individual. In many instances, the peculiar knowledge and attainments of the physician are indispensable to patients or others in the administration of business and government and in the usual conduct of certain daily affairs. When this knowledge, acquired during the course of the physician-patient relationship, is necessary to enable the patient to obtain his just due the physician should make it available for patient's benefit under proper conditions. Discussion with or report to the patient's attorney may be proper and necessary in order for patient to perfect a claim. The attending physician may ethically discuss patient's history, etc. with the attorney providing, of course, patient has consented to the discussion.

12. PHYSICIAN-PATIENT-PRESS RELATIONS

When a physician is asked by the press to discuss his patient's medical condition, disease or illness he must remember that his obligation is to his patient.

The physician reports to the patient. However, a patient by virtue of his position may have an obligation to others. If so, he must know and discharge that obligation (to the electorate or to the stockholders or to others to whom he is responsible). The physician should insure the medical accuracy of any authorized report.

The physician may not discuss patient's health condition with the press or the public without patient's consent or in the event of his incapacity, the family's consent.

13. RELATIONSHIP WITH COMMUNICATION MEDIA

A. Each medical society should appoint a communications committee, or designate a responsible individual or individuals, whose duty shall be to provide the communications media with accurate information on all medical matters of interest to the public. This information should be given freely. The communications committee may also serve in an advisory capacity to all communications media and to all physicians of its society in questions involving relationship with the media. To assist the media in obtaining information, medical societies may furnish the media with a list of names of physicians from whom authoritative information may be obtained, or a designated individual may serve as liaison between the media and the profession and furnish names of physicians to provide authoritative information when required.

These spokesmen may be quoted by name and title. This should not be considered by their colleagues as seeking publicity, since it is done in the best interest of the public and the profession. They may ethically provide appropriate information regarding medical and public health matters which have been discussed in technical papers or during medical meetings.

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The officers, committee chairmen, and designated spokesmen of medical societies should be available at all times to bonafide representatives of the communication media in order that authentic information may be obtained as soon as possible.

B. Because certain news is a part of the public record, or is a matter of concern to civil authorities, it is readily available for publication. Physicians should cooperate with the press to insure that medical news of this sort is available more promptly and more accurately than would be possible without their assistance.

News in this category, known as news in the public domain, includes: births, deaths, accidents, and police cases.

The following information in the public domain can be made available without the patient's consent:

(a) Personal information: patient's name, address, age, sex, race, marital status, employer, occupation, name of parents in case of births, name of next-of-kin in case of deaths.

(b) Nature of accident:

Only general information regarding injuries will be released. This consists of the name of the injured portion of the body such as back injury, etc. It may be stated that there are internal injuries.

If the patient is unconscious when brought to the hospital, a statement to that effect may be made.

Statements regarding the circumstances surrounding shootings, knifings and poisonings are properly police matters and questions whether they were accident or otherwise should be referred to the appropriate authorities.

A statement may be made to the effect that the patient was injured by a knife or other sharp instrument, but no statement may be made as to whether or not it was assault, accident, or self-inflicted.

A statement may be made that the patient received burns and the member of the body affected may be indicated.

No statement may be made that there was a suicide or attempted suicide.

No statement may be made to the effect that intoxication or drug addiction was involved.

No statement may be made that moral turpitude was involved.

(c) Diagnosis and prognosis:

Inasmuch as a diagnosis may be made only by a physician and may depend upon X-ray and laboratory studies, no statement regarding diagnosis should be made except by or on behalf of the attending physician. For the same reason prognosis will be given only by the attending physician or at his direction.

(d) Patient's condition:

A statement may be made as to the general condition of the patient using the following classifications: minor injuries or similar general diagnosis, good, fair, serious, critical.

C. When information concerning a specific patient is requested, the physician must obtain the consent of the patient or his authorized

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representative before releasing such knowledge. The patient's decision is final under the law. A physician may, within the limits of good taste, encourage the patient or his family to state the cause of illness, or the cause of death, when this information is requested by a bonafide representative of the press. Where a person of public interest is involved, and the release of information has been authorized, the physician may arrange for regular bulletins concerning the person. The ethical physician will use restraint and good judgment regarding the use of his name in connection with such published reports.

D. Publications of photographs of physicians, who appear before recognized medical organizations, either in the official program of the scientific meeting or before the public press in connection with such meeting, is permissible. The use of photographs in the press when physicians are elected to office or when physicians are quoted by name on matters of general interest, not related to the care of a specific patient, is likewise permissible. Photographs of physicians in connection with civic or social affairs, not related to medical news or the care of patients, may be published unless the frequency of such photographs bespeaks self-exploitation. This applies also to magazine articles. Physicians should clear such publicity, whenever possible, with their county society.

E. The promise of radical cures or boasting of extraordinary skill or success is considered unethical by the medical profession because it is contrary to the best interest of the public.

F. For purposes of clarity, the following principles should guide physicians who appear on TV or radio programs or who are interviewed in other media of public information, such as newspapers and magazines:

(a) Doctors of medicine are expected to refrain from sponsoring products directly or by implication.

(b) When introduced as a doctor on TV or radio programs, or quoted in an article as a physician in newspapers and magazines, such individual cannot escape the implication of representing the medical profession and his conduct should be in keeping with the high standards of the profession.

(c) Sound judgment, good common sense and adherence to the Principles of Medical Ethics are expected of any physician when appearing on TV or radio programs, or in other media of public information, such as newspapers and magazines, in whatsoever capacity.

G. Members of medical society speakers bureaus, because of the very nature of their assignments, may be interviewed or quoted by the communications media. This is not considered unethical conduct.

The members of these committees must be most circumspect and uphold the ideals of the medical profession.

H. At all times the doctor of medicine is expected to comply with the Principles of Medical Ethics. Section 10 of the Principles of Medical Ethics deals with relationships between physicians and the communications media. It says: "The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of im-

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proving both the health and the well-being of the individual and the community." The Judicial Council construes Section 10 as encouraging physicians to work with the communications media as an integral and important part of the principle of upholding the responsibility of the physician to society as a whole.

It shall be the responsibility of each county society to see that these Principles are not violated.

I. Doctors of medicine are ethically and legally required to protect the personal privacy and other legal rights of patients. The doctor-patient relationship and its confidential nature must be maintained. With these considerations in mind, the physician may assist the representatives of these media in every way possible.

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AMERICAN MEDICAL ASSOCIATION CONSTITUTION AND BYLAWS

Chapter XI, Section 11
DUTIES OF JUDICIAL COUNCIL

(1) The judicial power of the Association shall be vested in the Judicial Council, whose decision shall be final.

(2) The Council shall have original jurisdiction in (a) all questions involving Membership as provided in Division One, Chapter I, Section 1, of the Bylaws; (b) all controversies arising under this Constitution and Bylaws and under the Principles of Medical Ethics to which the American Medical Association is a party; and (c) controversies between two or more state associations or their members and between a state association and a component society or societies of another state association or associations or their members.

(3) The Council shall have appellate jurisdiction in questions of law and procedure but not of fact in all cases which arise between a state association and one or more of its component societies, between component societies of the same state association, between a member or members and the component society to which said member or members belong or between members of different component societies of the same state association. Notice of appeal shall be filed with the Judicial Council within thirty (30) days of the date of the decision by the state association and the appeal shall be perfected within sixty (60) days thereof; provided, however, that the Judicial Council, for what it considers good and sufficient cause, may grant an additional thirty (30) days for perfecting the appeal.

(4) The Council shall have jurisdiction on all questions of medical ethics and the interpretation of the Constitution, Bylaws and rules of the Association.

(5) The Council at its discretion may investigate general professional conditions and all matters pertaining to the relations of physicians to one another or to the public, and may make such recommendations to the House of Delegates or the state associations as it deems necessary.

(6) The Council shall have authority to request the President to appoint investigating juries to which it may refer complaints or evidences of unethical conduct which in its judgment are of greater than local concern. Such investigating juries, if probable cause for action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against the accused before the Judicial Council in the name and on behalf of the American Medical Association. The Council may acquit, admonish, suspend or expel the accused.

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RULES OF THE JUDICIAL COUNCIL AMERICAN MEDICAL ASSOCIATION

RULE I. ADMINISTRATION

A. *Meetings.* The Judicial Council will meet during the Annual and Clinical Convention of the American Medical Association. Other meetings of the Council may be called, on reasonable notice, by the Chairman of the Council; or they shall be called, on reasonable notice, by the Executive Vice President of the American Medical Association on the written request of at least three members of the Council.

B. *Chairman.* The Judicial Council shall elect from among its members a chairman and vice-chairman each year at the meeting of the Council held during the Annual Convention of the Association. Each shall retain the right to vote on all matters.

C. *Quorum.* Three members of the Judicial Council shall constitute a quorum but a majority vote of the entire Council shall be required to adopt any action.

RULE II. APPLICATION FOR MEMBERSHIP

A. *Regular, Service and Associate Membership.* Applications for membership in the American Medical Association will be considered by the Judicial Council at any meeting upon presentation of the applications by the Executive Vice President of the Association.

B. *Affiliate Membership.* Applications for affiliate membership submitted by (1) physicians who are members of the national medical societies of foreign countries, (2) American physicians located in foreign countries or possessions of the United States, and engaged in medical missionary educational or philanthropic labors, (3) dentists who hold the degree of D.D.S. or D.M.D., who are members of the American Dental Association and their state and local dental societies, (4) pharmacists who are active members of the American Pharmaceutical Association, (5) teachers of medicine or of the sciences allied to medicine who are citizens of the United States and are not eligible to membership, or (6) scientists in sciences allied to medicine and others who have attained distinction in their fields of endeavor who are not otherwise eligible to membership, will be considered at any meeting of the Judicial Council on presentation of the applications by the chief executive officer of the Association. The Council will consider and approve only those applications which are accompanied by a statement of a responsible and qualified individual attesting to the above set forth requirements.

C. *Refusal of Approval.* An applicant for membership in the American Medical Association whose application has not been approved by the Judicial Council will be promptly notified of such fact, and will be given twenty days within which to request reconsideration of his application in accord with the provisions of Rule III.

RULE III. RECONSIDERATION OF APPLICATIONS FOR MEMBERSHIP

A request for reconsideration of a refusal to approve an application for

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membership should be initiated by a written statement setting forth the reasons for reconsideration.

RULE IV. PHYSICIANS DENIED MEMBERSHIP IN COMPONENT OR CONSTITUENT ASSOCIATIONS

Pursuant to Chapter XI, Section 11 (D) (7) of the Bylaws, any physician whose application for membership in a component and/or constituent association has allegedly been denied unfairly because of color, creed, race, religion, or ethnic origin, may appeal to the Judicial Council. The Council shall determine the facts in the case and report the findings to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure or, in the event of repeated violations, recommend to the House of Delegates that the state association involved be declared to be no longer a constituent member of the American Medical Association.

Proceedings for such determination shall be initiated by a written statement. Such statement shall: (1) identify the parties to the case, (2) show that the appellant has exhausted remedies made available by the constitution and bylaws of the component society and the state association, and (3) include a concise factual resume of the case in sufficient detail to enable the Council to ascertain the facts. The appellant should also furnish such other information as may be requested by or helpful to the Council in determining the facts.

RULE V. ORIGINAL CONTROVERSIES

Original proceedings before the Judicial Council shall be initiated by a written statement. Such statement shall include information (1) identifying the parties to the controversy, including membership affiliations, if applicable, and (2) explaining the nature of the controversy, setting forth the provisions of the Constitution, Bylaws, Rules or Principles of Medical Ethics concerned.

RULE VI. APPEALS

Appellate proceedings before the Judicial Council shall be initiated by a written statement of appeal. Such statement shall include information (1) identifying the parties to the case and indicating membership affiliations when appropriate, (2) showing that the appellant has exhausted remedies made available by the constitution and bylaws of the component society and the state association and (3) describing the error of law or procedure which is believed to have occurred during the proceedings. The statement shall also include a concise, factual résumé of the case. Appellant shall submit with the statement, the charges, complaints, findings, opinions and decisions previously entered in the case.

RULE VII. INTERPRETATION OF THE CONSTITUTION, BYLAWS, RULES AND PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION

A. *Requests for Interpretation.* Requests for interpretation of the Constitution, Bylaws, Rules or Principles of Medical Ethics of the Association shall be in writing and shall describe the matter to be interpreted in sufficient detail to enable the members of the Judicial Council to valuate the request in all its aspects.

B. *Interpretations Initiated by the Council.* The Judicial Council, on its own motion, may render an opinion concerning the interpretation or applica-

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tion of the Constitution, Bylaws, Rules or Principles of Medical Ethics of the Association and may, on its own motion, consider and decide the constitutionality and validity of all rules and regulations adopted by Councils and Committees of the Association pursuant to the Bylaws of the Association.

C. *Discretionary Power.* The Judicial Council may, in its discretion, refuse to consider requests for interpretation of the Principles of Medical Ethics which in the opinion of the Council should be resolved by a component society or a state association. Requests for interpretation of the Principles of Medical Ethics which are not of national interest and relate to the observance of local customs and ideals may be readdressed to the component society or constituent association primarily responsible for knowledge of the requirements of such local customs and recognized ideals.

RULE VIII. JURISDICTION

The Judicial Council may, on its own motion or on the motion of any party, determine the question of jurisdiction at any stage of the proceedings.

RULE IX. ADDITIONAL STATEMENTS AND RECORD

After a statement has been submitted to the Judicial Council with the intention of initating an action, all other parties in interest shall have the right to submit a statement on their behalf. Such statements shall be filed within thirty days after the filing of the initiating statement unless additional time is granted by the Council.

The Judicial Council may thereafter require the parties to submit such transcripts of testimony, records, written statements supporting their contentions or other material as the Council may deem necessary.

RULE X. HEARINGS

A. *Notice of Hearings.* The Council, may, in its discretion, determine whether a hearing is necessary or advisable. The Council will designate the time and place for all hearings, giving reasonable notice thereof to all parties.

B. *Attendance.* The attendance at hearings may be limited to the members of the Judicial Council, the staff, witnesses, if any, the parties and counsel, who may speak in their behalf. Should any party to the controversy fail to appear, the Council may, in its discretion, continue, dismiss or decide the matter.

C. *Evidence and Argument.* The Judicial Council will not be bound by technical rules of evidence usually employed in legal proceedings but may accept any evidence it deems appropriate and pertinent.

In any appeal case the review, if any, of the evidence will be limited to the evidence presented in the proceedings before the component society and constituent association or appropriate committee, board, or group thereof; provided, however, that in the event the Council is of the opinion such evidence is inadequate to determine the question of law or procedure presented, the Council, on its own motion or on the suggestion of any party, may require the production of additional evidence before the Council or refer the matter to the appropriate body for additional evidence.

In matters other than appeal cases, the Judicial Council will grant the parties the right to present evidence to the extent the Council believes appropriate to the particular matter in controversy.

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In all hearings, the Council, within reasonable limitations, will allow oral argument.

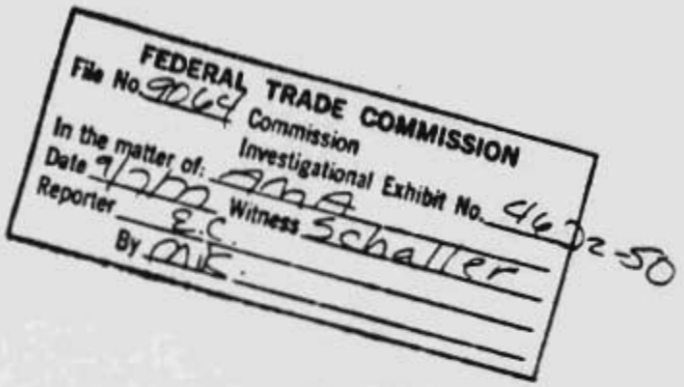
D. *Record.* In hearings of original controversies, appeals and in other proceedings a transcript may be made at the discretion of the Council.

RULE XI. OPINIONS

All opinions or decisions of the Judicial Council shall be in writing. Copies of the opinion or decision and the dissent, if any, will be filed as a part of the record and furnished to all the parties involved.

RULE XII. FILING AND COPIES

Eight copies of all documents shall be submitted to the Secretary of the Judicial Council. One copy of each document shall be submitted at the same time to each of the other parties to the controversy.



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RULES OF PROCEDURE OF THE JUDICIAL COUNCIL AMERICAN MEDICAL ASSOCIATION IN ORIGINAL JURISDICTION CASES

PREAMBLE

At the Annual Convention of the House of Delegates of the American Medical Association, held in June, 1962, Chapter IV of the AMA Bylaws, relating to disciplinary action, was amended. The Bylaws now provide that the Association may take disciplinary action with respect to a physician's AMA membership (1) when a state medical association, to which a member belongs, requests the AMA to take such action or (2) when, at the request of the American Medical Association, a state association to which the member belongs consents to such action.

Chapter XI, Section 11 (A) (6) of the Bylaws provides that the Judicial Council may request the President of the Association to appoint investigating juries to which the Council may refer complaints or evidences of unethical conduct which, in its judgment, are of greater than local concern.

The following Rules of Procedure, respecting notice of charges and the conduct of hearings before the Judicial Council, are based upon these sections of the Bylaws.

INVESTIGATING JURY

At the request of the Judicial Council the President has appointed an investigating jury. Complaints or evidences of unethical conduct of greater than local concern, will be submitted to this jury by the Council.

INSTITUTION OF PROCEEDINGS

If after investigation a probable cause for action is shown, the investigating jury shall submit a statement of charges to the President. The President shall submit to the Judicial Council the statement of charges presented to him by the investigating jury for prosecution in the name and on behalf of the American Medical Association.

STATEMENT OF CHARGES

The statement of charges shall allege in writing an infraction of the AMA's Constitution or Bylaws, or a violation of the Principles of Medical Ethics of the AMA. Exhibits may be attached.

NOTICE

A copy of the statement of charges shall be sent to the respondent physician by personal delivery or by registered or certified mail.

ANSWER

The respondent physician shall have thirty (30) days after personal delivery or mailing of the notice of statement of charges to file a written answer. If the respondent physician fails to file a written answer, the allegations shall be considered to be admitted.

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By MK.

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PROCEEDINGS

The Chairman of the Judicial Council shall designate one or more members of the Council to conduct a hearing on the statement of charges. This member or these members shall be known as the Hearing Officer.

Hearings shall be held at such reasonable time and place, designated by the Hearing Officer, as may be consistent with the nature of the proceedings and the convenience of the parties. The parties shall receive not less than fifteen (15) days notice of the hearing.

The General Counsel of the American Medical Association or his designee shall prosecute the charges against the respondent physician.

Attendance at hearings may be limited to the members of the Judicial Council, the staff, witnesses, if any, the parties and counsel who may speak in their behalf.

The respondent physician or his counsel may cross-examine witnesses and enter objection to the material offered in evidence. The respondent shall also have the right to call witnesses and enter evidence in his behalf.

The Hearing Officer or his counsel may question the parties and their witnesses.

The Hearing Officer shall not be bound by technical rules of evidence usually employed in legal proceedings but may accept any evidence he deems appropriate and pertinent.

Should any party to the controversy fail to appear at the hearing, the Hearing Officer may, in his discretion, continue, dismiss or proceed with the hearing.

FINDINGS AND CONCLUSIONS

At the conclusion of the hearing, the Hearing Officer shall render a report in writing containing findings and conclusions and recommendations, if any. This report, together with a transcript of the proceedings, shall be submitted to the Judicial Council. A copy of the report shall be mailed to all parties of record.

WRITTEN OBJECTIONS

Any party to the proceedings may submit written objections to the report to the Judicial Council. These objections must be submitted within twenty-one (21) days after the report has been submitted by the Hearing Officer to the Judicial Council.

ORAL ARGUMENT

In addition to written objections, any party may request an opportunity to present oral arguments on its objections to the report of the Hearing Officer before the Judicial Council. This request must be made within twenty-one (21) days after the report has been submitted to the Judicial Council. The granting of oral arguments shall be discretionary with the Judicial Council. If granted, the parties shall be notified by the Judicial Council of the place and date for such oral argument; all parties shall be given an opportunity to be heard and the time allotted to argument may be limited by the Judicial Council with due regard to the magnitude and complexities of the issues involved.

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If any party fails to appear, the Judicial Council may continue or proceed with the oral argument.

FINAL DECISION

The Judicial Council, including the member or members who serve as the Hearing Officer, shall render a final decision. A copy of that decision shall be mailed or otherwise served upon all parties.

DISCIPLINARY ACTION

The Judicial Council shall have the authority to acquit, admonish or censure the accused physician or suspend or expel him from AMA membership as the facts may justify. This action shall be in accordance with the authority vested in the Council by Chapter IV Section (1) (B) and Chapter XI Section (11) (A) (6) of the Bylaws.

TRANSCRIPT

A written transcript shall be made of the proceedings and of the oral argument before the Judicial Council.

If any party to the controversy requests a copy of the transcript, it shall be made available to him at his expense.

FILING OF COPIES

Three (3) copies of all pleadings and exhibits shall be submitted to AMA Headquarters to the Chairman of the Judicial Council. One copy of each document shall be submitted at the same time to each of the other parties to the controversy.

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Reporter C.C.
By D.K.

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The Oath of Hippocrates

I swear by Apollo, the physician, and Aesculapius and health and all-heal and all the Gods and Goddesses that, according to my ability and judgment, I will keep this oath and stipulation:

TO RECKON him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none others.

I WILL FOLLOW that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; furthermore, I will not give to a woman an instrument to produce abortion.

WITH PURITY AND WITH HOLINESS I will pass my life and practice my art. I will not cut a person who is suffering from a stone, but will leave this to be done by practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption; and further from the seduction of females or males, bond or free.

WHATEVER, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad I will not divulge, as reckoning that all such should be kept secret.

WHILE I CONTINUE to keep this oath unviolated may it be granted to me to enjoy life and the practice of the art, respected by all men at all times but should I trespass and violate this oath, may the reverse be my lot.

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By D.F.

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Declaration of Geneva

Adopted by the General Assembly of the World Medical Association at Geneva, Switzerland, September, 1948

AT THE TIME OF BEING ADMITTED AS MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE myself to consecrate my life to the service of humanity.

I WILL GIVE to my teachers the respect and gratitude which is their due.

I WILL PRACTICE my profession with conscience and dignity.

THE HEALTH OF MY PATIENT will be my first consideration.

I WILL RESPECT the secrets which are confided in me.

I WILL MAINTAIN by all means in my power, the honor and the noble traditions of the medical profession.

MY COLLEAGUES will be my brothers.

I WILL NOT PERMIT considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.

I WILL MAINTAIN the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I MAKE THESE PROMISES solemnly, freely, and upon my honor.

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Declaration of Helsinki

I. Basic Principles

1. Clinical research must conform to the moral and scientific principles that justify medical research and should be based on laboratory and animal experiments or other scientifically established facts.

2. Clinical research should be conducted only by scientifically qualified persons and under the supervision of a qualified medical man.

3. Clinical research cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

4. Every clinical research project should be preceded by careful assessment of inherent risks in comparison to foreseeable benefits to the subject or to others.

5. Special caution should be exercised by the doctor in performing clinical research in which the personality of the subject is liable to be altered by drugs or experimental procedure.

II. Clinical Research Combined with Professional Care

1. In the treatment of the sick person, the doctor must be free to use a new therapeutic measure, if in his judgment it offers hope of saving life, reestablishing health, or alleviating suffering.

If at all possible, consistent with patient psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation. In case of legal incapacity, consent should also be procured from the legal guardian; in case of physical incapacity the permission of the legal guardian replaces that of the patient.

2. The doctor can combine clinical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that clinical research is justified by its therapeutic value for the patient.

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III. Non therapeutic
Clinical Research

1. In the purely scientific application of clinical research carried out on a human being, it is the duty of the doctor to remain the protector of the life and health of that person on whom clinical research is being carried out.

2. The nature, the purpose and the risk of clinical research must be explained to the subject by the doctor.

3a. Clinical research on a human being cannot be undertaken without his free consent after he has been informed; if he is legally incompetent, the consent of the legal guardian should be procured.

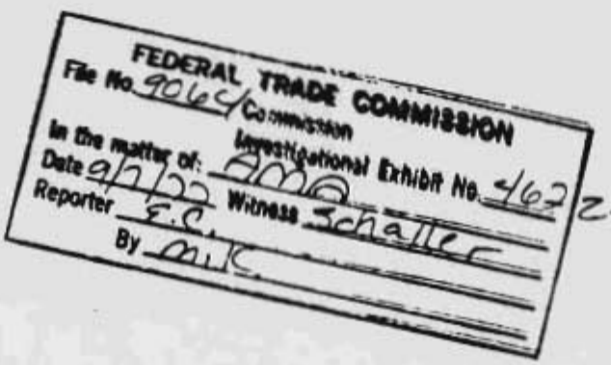
3b. The subject of clinical research should be in such a mental, physical and legal state as to be able to exercise fully his power of choice.

3c. Consent should, as a rule, be obtained in writing. However, the responsibility for clinical research always remains with the research worker; it never falls on the subject even after consent is obtained.

4a. The investigator must respect the right of each individual to safeguard his personal integrity, especially if the subject is in a dependent relationship to the investigator.

4b. At any time during the course of clinical research the subject or his guardian should be free to withdraw permission for research to be continued.

The investigator or the investigating team should discontinue the research if in his or their judgment, it may, if continued, be harmful to the individual.



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CAVEAT

This is the first comprehensive revision of *Opinions and Reports of the Judicial Council* since it was originally compiled in 1958. The Judicial Council decided to prepare this comprehensive revision in the fall of 1975. Subsequently, the Judicial Council suspended the distribution of the previous edition of *Opinions and Reports* and, after extensive discussion and several revisions, produced this edition for publication.

In the previous editions of *Opinions and Reports*, the subject matter was separated into eleven parts, consisting of the *Preamble* and each of the ten sections of the *Principles of Medical Ethics*. The subjects presented, however, did not always closely correspond with the particular *Principles* under which they were listed. Also, the subjects often embraced more than one section of the *Principles of Medical Ethics*, even though listed under only one section. Therefore, the format of *Opinions and Reports* has been changed so that it will now follow an outline based on subject matter.

The *Principles of Medical Ethics* are an expression of the AMA House of Delegates. *Opinions and Reports of the Judicial Council* remains a basic compilation of interpretations, opinions, and statements of the AMA Judicial Council which may be expanded, contracted, or modified from time to time to meet changing conditions of medical practice.

As originally compiled and republished in subsequent editions of *Opinions and Reports*, a number of long-standing statements of the American Medical Association were incorporated without editing because of their historical significance. Some statements were included even though they might be construed to be inconsistent with similar statements of a later date which were also presented.

In the present edition of *Opinions and Reports*, some new items are included, while others have been withdrawn. Editorial changes have been made to clarify and improve the language and to eliminate statements which might be construed to be inconsistent. Some items have been withdrawn because they did not adequately reflect current conditions of medical practice or legal requirements. Other items not included dealt with outmoded matters of medical etiquette which embraced admonitions that have long been unnecessary and were historical anachronisms for a current publication.

Since extensive changes have been made in style, format, and content, the Judicial Council encourages comments which can be considered in the preparation of future editions of *Opinions and Reports of the Judicial Council*.

JUDICIAL COUNCIL

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HISTORY

The earliest written code of ethical principles for medical practice was conceived by the Babylonians around 2500 B.C. That document, the Code of Hammurabi, was indeed a *code* of conduct, setting forth in considerable detail for that era of history the nature of conduct demanded of the physician. Today that code would be subject to criticism because it went into too much detail. It may be doubted that it could have continued as a practical document through the centuries because, as medical science and cultural patterns became more complex, it would have required one skilled in jurisprudence to codify and interpret the myriad situations covered by it.

The Oath of Hippocrates, a brief statement of principles, has come down through history as a living statement of ideals to be cherished by the physician. This Oath was conceived some time during the period of Grecian greatness, probably in the fifth century B.C. It protected rights of the patient and appealed to the finer and finer instincts of the physician without imposing sanctions or penalties on him. Other civilizations subsequently developed written principles, but the Oath of Hippocrates (Christianized in the tenth or eleventh century to eliminate reference to pagan gods) has remained in Western civilization as an expression of ideal conduct for the physician.

The most significant contribution to ethical history subsequent to Hippocrates was made by Thomas Percival, a physician, philosopher, and writer, of Manchester, England. In 1803, he published his *Code of Medical Ethics*. His personality, his interest in sociological matters, his close association with the Manchester Infirmary, led to the preparation of a "scheme of professional conduct relative to hospitals and other charities," from which he drafted the code which bears his name.

After the first real meeting of the American Medical Association in Philadelphia in 1847, the two principal items of business were the establishment of a code of ethics and the creation of minimum requirements for medical education and training. Although the Medical Society of the State of New York and the Medico-Chirurgical Society of Baltimore had formal written codes of medical ethics prior to this time, it is clear from the records and the preface to AMA's first adopted Code of Ethics that it was based on Percival's Code.

In general, the language and concepts of the original Code adopted by the Association in 1847 remained the same throughout the years. There were revisions, of course, which reflected the temper of the times and the eternal effort to express basic concepts with clarity. Major revisions did occur in 1903, 1912, and 1947. In 1957, the language of the chapter dealing with compensation of physicians, contract practice, conditions of medical service, free choice of physician, and removal of medical services was redrafted.

In November, 1955, an attempt was made to distinguish medical ethics from rules of etiquette. A draft of a two-part code sets out to accomplish this was submitted to the House of Delegates at that time but was not accepted. This proposal was, in effect, a segregation of then existing statements, found in the *Principles*, into two categories. Little or no change was made in the language of the forty-eight sections of the *Principles*.

Subsequently, in June, 1956, a seemingly radical proposal was submitted to the House of Delegates for consideration. This proposal, a short version of the *Principles*, was discussed at the following session of the House in December, 1956, after having had wide publication and broad consideration among members of the medical profession. It was then laid over for final consideration at the June, 1957 meeting of the House of Delegates, at which meeting the short version was adopted.

The format of the *Principles* adopted in June, 1957 is a change from the format of the *Principles* promulgated by Percival in 1803 and accepted by the Association in 1847. Ten short sections, preceded by a preamble, "succinctly express the fundamental concepts embodied in the present [1955] Principles," according to the report of the Council on Constitution and Bylaws. That Council assured the House of Delegates in its June, 1957 report that "every basic principle has been preserved; on the other hand, as much as possible of the prolixity and ambiguity which in the past obstructed ready explanation, practical codification and particular selection of basic concepts has been eliminated."

PRINCIPLES OF MEDICAL ETHICS

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with society.

SECTION 1

The principle objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2

Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3

A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5

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

SECTION 6

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7

In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8

A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiences he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10

The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

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I. INTRODUCTION

1.00. TERMINOLOGY

Historically, the term "ethical" has been used in opinions and reports of the Judicial Council and in resolutions adopted by the House of Delegates to refer to matters involving (1) moral principles or practices, (2) customs and usages of the medical profession, and (3) matters of policy not necessarily involving issues of morality in the practice of medicine. The term "unethical" has been used to refer to conduct which fails to conform to these professional standards, customs and usages, or policies, as interpreted by the American Medical Association.

Unethical conduct involving moral principles, values and duties calls for disciplinary action such as censure, suspension, or expulsion from medical society membership.

Failure to conform to the customs and usages of the medical profession may call for disciplinary action depending upon the particular circumstances involved, local attitudes, and how the conduct in question may reflect upon the dignity of and respect for the medical profession.

In matters strictly of a policy nature, a physician who disagrees with the position of the American Medical Association is entitled to freedom and protection of his point of view.

1.01. THE RELATION OF LAW AND ETHICS

The following statements are intended to clarify the interrelationship between law and ethics.

Ethical standards of professional conduct often exceed but are never less than those required by law.

Violations of governmental laws may subject the physician to civil or criminal liability. Expulsion from membership is the maximum penalty that may be imposed by a medical society upon a physician who violates ethical standards involving a breach of moral duty or principle. However, medical societies have a civic and professional obligation to report to the appropriate governmental body or state board of medical examiners credible evidence that may come to their attention involving the alleged criminal conduct of any physician relating to the practice of medicine.

Although a physician charged with alleged illegal conduct may be acquitted or exonerated in civil or criminal proceedings, this does not discharge a medical society from its obligation to initiate a disciplinary proceeding against a member with reference to the same conduct where there is credible evidence tending to establish unethical conduct.

Ethical pronouncements of the Judicial Council and the House of Delegates should not be so interpreted, construed or applied as to encourage conduct which violates a valid law.

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II. HOSPITAL RELATIONS

2.00. ADMISSION FEE

Charging a separate and distinct fee for the incidental, administrative, non-medical service the physician performs in securing the admission of a patient to a hospital is not in keeping with the traditions of the American Medical Association and is to be disapproved as unethical.

2.01. ASSESSMENTS

Neither the hospital management nor the medical staff has the privilege or the right to make compulsory assessments of members of the medical staff for building funds or to demand an audit of staff members' personal financial records as a requisite for staff appointment.

Compulsory assessments, that is, assessments which if not paid would automatically cause physicians to lose staff membership, are not in the best traditions of ethical practice. It is not proper to condition medical staff membership on compulsory assessments for any purpose.

2.02. BILLING FOR HOUSESTAFF SERVICES

When a physician assumes responsibility for the services rendered to a patient by a resident or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction, and supervision.

2.15. FEE SPLITTING AND HOSPITALS

The suggestion has been made by some hospitals that physicians who utilize the hospital facilities should pay to the hospital a percentage of the fees which they receive from their patients who're being cared for in the hospital.

The suggested proposal is clearly a case of splitting or sharing professional fees with a lay organization which has already levied its regular bill for the services which it legitimately rendered.

2.30. HOSPITAL OWNERSHIP BY PHYSICIAN

(1) It is not in itself unethical for a physician to own a for-profit hospital or interest therein. The use the physician makes of this ownership or interest may, however, be definitely unethical. For example, for a physician to send a patient to such a hospital or to prolong a patient's stay in the hospital for his financial benefit would be unethical.

(2) When a physician has an interest in or owns a for-profit hospital to

which he sends his patients, he has an affirmative ethical obligation to disclose this fact to his patient.

(3) Under no circumstances may the physician place his own financial interest above the welfare of his patients. The prime objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration.

(4) When in the course of the physician-patient relationship a conflict develops between the physician's financial investments and the physician's allegiance to his patient, the conflict must be resolved to the patient's benefit.

(5) When questions arise regarding the use that a physician makes of his ownership or his interest in a hospital for-profit, the local medical society has the obligation to ascertain all the facts and, based on an analysis of the facts, to provide guidance to its membership.

2.70. SURGICAL ASSISTANT'S FEE

Each physician engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered.

No physician should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received.

When services are provided by more than one physician, each physician should submit his own bill to the patient and be compensated separately if possible.

It is ethically permissible in certain circumstances, however, for a surgeon to engage other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance, provided the nature of the financial arrangement is made known to the patient. This principle applies whether or not the assisting physician is the referring physician.

III. INTERPROFESSIONAL RELATIONS

3.50. NONSCIENTIFIC PRACTITIONERS AND PHYSICIANS

Section 3 of the Principles of Medical Ethics provides that a physician should not use unscientific methods of treatment nor should he voluntarily associate professionally with anyone who does. It is wrong to engage in or to aid and abet in treatment which has no scientific basis and is dangerous, is calculated to deceive the patient by giving him false hope, or which may cause the patient to delay in seeking proper care until his condition becomes irreversible.

A physician is deemed to be associating "professionally" when he serves as a consultant or shares responsibility jointly in treating a patient. The mere acceptance of a patient sent to a physician by another person does not create a "professional" relationship with that person. As provided in Section 5 of the Principles of Medical Ethics, a physician is free to accept or decline to serve anyone who seeks his services, regardless of who has recommended the individual to him.

Physicians should also be mindful of state laws which prohibit a physician from aiding and abetting an unlicensed person in the practice of medicine, aiding or abetting a person with a limited license in providing services beyond the scope of his license, or undertaking the concomitant medical treatment of patients under the foregoing circumstances.

3.51. OPTOMETRY

It is not unethical for an ophthalmologist to employ an optometrist as an ancillary personnel to assist him provided the optometrist is identified to patients as an optometrist.

A physician may send his patient to a qualified and ethical optometrist solely for optometric service. The physician would be ethically remiss, of course, if before doing so he did not insure that there was an absence of any medical reason for his patient's complaint, and he would be equally remiss if he sent a patient without having made a medical evaluation of the patient's condition.

Physicians may teach in recognized schools of optometry for the purpose of improving the quality of optometric education. The scope of this teaching may embrace subjects within the legitimate scope of optometry which are designed to prepare students to engage in optometry within the limits prescribed by law.

3.60. REFERRAL OF PATIENTS

A physician may refer a patient for diagnostic or therapeutic services to another physician, a limited practitioner, or any other provider of health care services permitted by law to furnish such services.

whenever he believes that this may benefit the patient. As in the case of referrals to physician-specialists, referrals to limited practitioners should be based on their individual competence and ability to perform the services needed by the patient. A physician should not so refer a patient unless he is confident that the services provided on referral will be performed competently and in accordance with accepted scientific standards and legal requirements.

3.70. SPECIALISTS

A physician may choose to limit his practice to a specialty or to certain specialized services. He may also choose to provide services as a consultant to other physicians, or to patients sent to him by other [illegible], or to patients at a hospital with which he has a contractual arrangement. He may, as well, choose to accept or decline patients sent to him by licensed limited practitioners or by laymen.

The specialist or other physician in charge of the case, if any, should keep the patient or his lawful representative informed about the diagnosis and treatment of the patient's ailment. Where the specialist provides diagnostic services to a patient recommended to him by a licensed limited practitioner or by a layman and the results indicate the possible need for surgical or drug treatment, the specialist has a professional responsibility to so inform the patient. A physician-patient relationship exists under these circumstances between the specialist and the person receiving diagnostic services. Although a physician may choose to limit his practice to certain diagnostic services, he is still subject to the provision in Section 5 of the Principles of Medical Ethics that he may not neglect a patient under his care.

3.71. TEACHING

Physicians are free to engage in any teaching permitted by law for which they are qualified.

IV. OFFICE PRACTICES

4.00. APPOINTMENT CHARGES

Charging for a missed appointment or for one not cancelled 24 hours in advance need not, in itself, be considered unethical if the patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration of the patient and his circumstances.

4.02. CLINICS

The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee, or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

4.03. COLLECTION AGENCIES

The physician's ethical responsibilities in referring a delinquent account to a collection agency should include the following. He should first give due consideration to the patient's ability to pay the fee which is due. Secondly, he should not utilize the services of a collection agency whose tactics and methods of collection might be unfair or abusive. The physician may not "sell" his delinquent accounts to a collection agency and may not enter into any arrangement under which the physician would lose complete control of the delinquent account or the method of its collection.

4.04. CONTINGENT PHYSICIAN FEES

If a physician's fee for medical service is contingent on the successful outcome of a claim, there is the ever-present danger that the physician may become less of a healer and more of an advocate. Accordingly, a physician's fee for medical services should be based on the value of the service provided by the physician to the patient and not on the uncertain outcome of a contingency that does not in any way relate to the value of the medical service.

4.05. CONTRACTUAL RELATIONSHIPS

The contractual relationships that physicians assume when they enter prepaid group practice plans are varied.

Income arrangements may include hourly wages for physicians working part time, annual salaries for those working full time, and

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share of group income for physicians who are partners in groups that are somewhat autonomous and contract with plans to provide the required medical care. Arrangements also usually include a range of fringe benefits, such as paid vacations, insurance and pension plans.

Physicians may work directly for plans or may be employed by the medical group or the hospital that has contracted with the plan to provide services. The AMA recognizes that under proper legal authority such plans may be established and that a physician may be employed by, or otherwise serve, a medical care plan without violating the Principles of Medical Ethics. It believes that in the operation of such plans physicians should not be subjected to lay interference on professional matters and that their primary responsibility should be to the patients they serve.

4.[illegible]. ENTERTAINMENT EXPENSES

Expenditures made by physicians for the entertainment of other physicians are not per se unethical. There are circumstances in which a physician may appropriately entertain other physicians. The propriety of such matters must be determined on a case-by-case basis.

4.16. FEES

The charging of an excessive fee is unethical and is contrary to Section 7 of the Principles. The physician's fee should be commensurate with the services rendered and the patient's ability to pay.

4.30. INSURANCE FORM COMPLETION CHARGE

The attending physician should complete without charge the appropriate "simplified" Health Insurance Council forms and similar insurance claim forms as a part of his service to the patient to enable the patient to receive his benefits.

A charge for more complex forms may be made in conformity with local custom. This suggestion is advisory. In all cases, the local medical society can be looked to for an authoritative opinion.

4.31. INTEREST CHARGES AND SERVICE CHARGES

It is not [illegible] the best interest of the public or the profession to charge interest on an unpaid bill or note, or to charge a penalty on fees for professional services not paid within a prescribed period of time, or to charge a patient a flat collection fee if it becomes necessary to refer the account to an agency for collection.

It is not improper, however, for a physician to add a service charge, called by the physician "late charge" or "service charge" or "billing charge," on accounts not paid within a reasonable time. The patient must be notified in advance of the existence of this practice.

4.40. LABORATORY SERVICES

(1) A physician would be guilty of deception if he misrepresented or aided in the misrepresentation of laboratory services performed and supervised by a non-physician as the physician's professional services. Such situations could involve a laboratory owned by a physician who directs and manages its financial and business affairs with no professional medical services being provided, laboratory work being performed by technicians and directly supervised by a medical technologist with no participation by the physician, or the physician's name being used in connection with the laboratory so as to create the appearance that it is owned, operated, and supervised solely by a physician when this is not so.

(2) If a laboratory is owned, operated, and supervised by a non-physician in accordance with state law and performs tests exclusively for physicians who receive the results and make their own medical interpretations, the following considerations would be applicable.

The physician's ethical responsibility is to provide his patients with high quality services. This includes services which he performs personally and those which he delegates to others. A physician should not utilize the services of any laboratory, irrespective of whether it is operated by a physician or non-physician, unless he has the utmost confidence in the quality of its services. He must always assume personal responsibility for the best interests of his patients. Medical judgment based upon interior laboratory work is likewise inferior. Medical considerations, not cost, must be paramount when the physician chooses a laboratory. The physician who disregards quality as the primary criterion or who chooses a laboratory solely because it provides him with low cost laboratory services on which he charges the patient a profit, is derelict in not acting in the best interests of his patient. However, if reliable quality laboratory services are available at lower cost, the patient should have the benefit of the savings. As a professional man, the physician is entitled to fair compensation for his services. He is not engaged in a commercial enterprise and he should not make a markup, commission, or profit on the services rendered by others. This does not prohibit a physician's acquisition or processing charge, if any, and the patient should be notified of any such charge.

4.41. LIEN LAWS

It is not improper for a physician to use a physician's lien law as a means of assuring payment of his fee, provided his fee is fixed in amount and not contingent on the amount of settlement of the patient's claim against a third party.

4.61. PROFESSIONAL CORPORATIONS

If the laws of the state provide that physicians may organize professional service corporations for the practice of medicine, it is ethically permissible for physicians to form such corporations.

The ethical principles for the medical practice conducted under the form of a professional service corporation are exactly the same as for the individual physician. The professional service corporation and each physician member of the professional service corporation should observe the Principles of Medical Ethics.

4.62. RECORDS ON TERMINATION OF PARTNERSHIP

When two or more physicians, who are partners in the practice of medicine, terminate the partnership relationship, any question regarding possession of patients' clinical records should be determined on the basis of what is best for the patients.

When a physician-employee terminates his relationship with an individual physician, a group of physicians, or a clinic, any question regarding possession of patients' clinical records should be determined on the basis of what is best for the patients, consistent with any contractual arrangements that may have been made. In any event, should the physician-employee have need to review these records in the best interest of a patient under his care, their contents should be available to him, with the consent of the patient.

In case of disagreement, the proper committee of the local medical society may be able to assist in resolving the problem.

4.63. RESTRICTIVE COVENANTS

There is no ethical prescription against suggesting or entering into a reasonable agreement not to practice within a certain area for a certain time, if it is knowingly made, understood, and consistent with local law. Whether it is advisable as being in the best interest of the public depends on all of the surrounding facts.

Ethically such agreements are not forbidden.

4.70. SALE OR PURCHASE OF PHYSICIAN'S RECORDS

A physician, retiring from practice, may not ethically sell his patients' records to another physician. His records have been developed during the physician-patient relationship. To *sell* records would tend to make the patient subject to barter to the highest bidder. For the patient's benefit, however, but only with his consent, these records may be transferred to a physician of his choice. A reasonable charge for secretarial or duplicating service connected with such transfer is not improper.

Further, according to Section 9 of the Principles of Medical Ethics, a physician may not reveal the confidences entrusted in him in the course of medical attendance. The physician's records summarizing these confidences are cloaked with this same protection. To transfer a patient's records without his consent would violate this confidence.

A physician may not ethically *purchase* such records from a retiring physician or from the estate of a deceased physician.

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PATIENT RELATIONS AND MEDICAL RESPONSIBILITIES

5.00. ABORTION

The Principles of Medical Ethics of AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law.

5.01. ARTIFICIAL INSEMINATION: HUMAN

The ethical issues in the procedure of human artificial insemination are, of course, the same as in any other medical or surgical procedure. The nature of the procedure, however, requires emphasis of: (1) the importance of the *concern* the physician must have for his patient, her spouse, and the child which may result from the procedure; (2) the need for *consent* arrived at intellectually rather than emotionally; (3) the *competence* of the physician who assumes this unique responsibility; and (4) the need for preservation of *confidentiality* by the physician and his staff.

Even as the physician shows concern for the woman and her desire for motherhood, he must ensure that emotions do not adversely affect those judgments which must be sound and reasoned. The consent of both the woman seeking the procedure and her husband must be secured. This consent must be voluntary and informed.

Physicians without special knowledge and competence in the field should refrain from engaging in the procedure. It must be remembered by the physician and explained by him to the prospective parents that any child conceived and born of an artificial insemination is possessed of and entitled to all the rights of a child conceived naturally.

The utmost medical secrecy by the attending physician and his entire staff is essential in all aspects of the procedure. All medical records regarding the procedure must be securely protected from invasion.

5.02. CLINICAL INVESTIGATION

The following guidelines are intended to aid physicians in fulfilling their ethical responsibilities when they engage in the clinical investigation of new drugs and procedures.

(1) A physician may participate in clinical investigation only to the extent that his activities are a part of a systematic program competently designed, under accepted standards of scientific research, to produce data which is scientifically valid and significant.

(2) In conducting clinical investigation, the investigator should demonstrate the same concern and caution for the welfare, safety, and comfort of the person involved as is required of a physician who is furnishing medical care to a patient independent of any clinical investigation.

(3) In clinical investigation *primarily for treatment*—

A. The physician must recognize that the physician-patient relationship exists and that he is expected to exercise his professional judgment and skill in the best interest of the patient.

B. Voluntary written consent must be obtained from the patient, or from his legally authorized representative if the patient lacks the capacity to consent, following: (a) disclosure that the physician intends to use an investigational drug or experimental procedure, (b) a reasonable explanation of the nature of the drug or procedure to be used, risks to be expected, and possible therapeutic benefits, (c) an offer to answer any inquiries concerning the drug or procedure, and (d) a disclosure of alternative drugs or procedures that may be available.

i. In exceptional circumstances and to the extent that disclosure of information concerning the nature of the drug or experimental procedure or risks would be expected to materially affect the health of the patient and would be detrimental to his best interests, such information may be withheld from the patient. In such circumstances, such information shall be disclosed to a responsible relative or friend of the patient where possible.

ii. Ordinarily, consent should be in writing, except where the physician deems it necessary to rely upon consent in other than written form because of the physical or emotional state of the patient.

iii. Where emergency treatment is necessary, the patient is incapable of giving consent, and no one is available who has authority to act on his behalf, consent is assumed.

(4) In clinical investigation *primarily for the accumulation of scientific knowledge*—

A. Adequate safeguards must be provided for the welfare, safety and comfort of the subject.

B. Consent, in writing, should be obtained from the subject, or from his legally authorized representative if the subject lacks the capacity to consent, following: (a) a disclosure of the fact that an investigational drug or procedure is to be used, (b) a reasonable explanation of the nature of the procedure to be used and risks to be expected, and (c) an offer to answer any inquiries concerning the drug or procedure.

C. Minors or mentally incompetent persons may be used as subjects only if:

i. The nature of the investigation is such that mentally competent adults would not be suitable subjects.

ii. Consent, in writing, is given by a legally authorized representative of the subject under circumstances in which an informed and prudent adult would reasonably be expected to volunteer himself or his child as a subject.

D. No person may be used as a subject against his will.

5.03. CONFIDENTIALITY: ATTORNEY-PHYSICIAN RELATION

The patient's history, diagnosis, treatment, and prognosis may be discussed with the patient's lawyer with consent of the patient or his lawful representative. The physician has obligations to society as a whole in addition to his obligations to his patient as an individual. In many instances, the peculiar knowledge and attainments of the physician are indispensable to patients or others in the administration of business and government and in the usual conduct of certain daily affairs. When this knowledge, acquired during the course of the physician-patient relationship, is necessary to enable the patient to obtain his just due the physician should make it available for the patient's benefit under proper conditions. Discussion with or report to the patient's attorney may be proper and necessary in order for the patient to perfect a claim. The attending physician may ethically discuss such matters with the attorney providing, of course, that the patient has consented to the discussion.

It is not improper, in and of itself, for a physician to testify in court or before a workmen's compensation board or the like in any personal injury or related case.

5.04. CONFIDENTIALITY: COMPUTERS

The utmost effort and care must be taken to protect the confidentiality of all medical records. This ethical principle applies to computerized medical records as it applies to any other medical records.

5.05. CONFIDENTIALITY: DRUG DISPENSING AND VENEREAL DISEASE

Although it is not to be generally encouraged, there are circumstances in which physicians may dispense drugs. At the same time, the obligation of the physician to protect the patient's confidences is one of the most serious obligations imposed on him. Accordingly, the physician is not precluded from dispensing appropriate medication, such as ampicillin-presented, to his patient who has been diagnosed as having a venereal disease, such as gonorrhea, since forcing a patient to have such a drug "dispensed in the presence of the pharmacist" could very well destroy the confidential nature of that particular physician-patient relationship.

5.06. CONFIDENTIALITY: INSURANCE COMPANY REPRESENTATIVE

History, diagnosis, prognosis, and the like acquired during the physician-patient relationship may be disclosed to an insurance company representative only if the patient or his lawful representative has consented to the disclosure. A physician's responsibilities to his patient are not limited to the actual practice of medicine. They also include the performance of some services ancillary to the practice of medicine. These services might include certification that the patient was under the physician's care and comment on the diagnosis and therapy in the particular case.

5.07. CONSULTATION

When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

5.15. DEFINITION OF DEATH

Various medical procedures have resulted in a hue and cry for a statutory definition of death. The Judicial Council is of the opinion that this is neither desirable or necessary for physicians or patients, as it may result in confusion instead of clarification as advances in scientific capabilities occur. The physician is always ultimately responsible for the diagnosis he makes. Accordingly, death should be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria.

5.17. EUTHANASIA AND TERMINAL ILLNESS

In some discussions of the right of the patient to refuse medical care in terminal illness, there is a lack of clarity because those discussions fail to relate to terminal illness. A patient well adjusted to kidney dialysis lives with "a physical disability from which he will not recover." A mentally retarded infant suffers from "mental disability from which he will not recover." A diabetic is irreversibly ill. There is also semantical confusion on the use of the terms "euthanasia" and

"death with dignity," as well as a lack of understanding or agreement about their different connotations.

The Judicial Council does not recommend endorsement of any particular form to express an individual's wishes which relate prospectively to his final illness, but also recognizes that individuals have the right to express such wishes.

Physicians may, and indeed should, be encouraged to discuss death and terminal illness with patients. Physicians may, and indeed should, respect expressions of patient's wishes regarding medical care during terminal illness but may, and indeed should, feel free to question those wishes with the patient's competent legal representative or by appropriate judicial proceedings when the circumstances of a particular situation seem to require it.

The Judicial Council, therefore, recommends the following statement as a guideline for physicians:

> The intentional termination of the life of one human being by another—mercy killing—is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.
>
> The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family.

5.18. EXPERIMENTATION: HUMAN

In the Judicial Council's Guidelines on Clinical Investigation, the Nuremberg Code, and the Principles of Medical Ethics themselves, there are adequate guidelines on human experimentation. Peer review committees also protect against abuses in this area.

Even so, such matters are so basic to professional responsibility and respect for humanity that the Judicial Council recommends adherence to and reaffirmation of the following standards:

(1) In clinical investigation primarily for the accumulation of scientific knowledge, written consent must be obtained from the subject or from his legally authorized representative if the subject lacks the capacity to consent, following:

(a) a disclosure of the fact that an investigational drug or procedure is to be used;

(b) a reasonable explanation of the nature of the procedure to be used and the risks to be expected; and

(c) an offer to answer any inquiries concerning the drug or procedure. Consent should be informed and voluntary.

(2) In clinical investigation primarily for the accumulation of scientific knowledge, minors or mentally incompetent persons may be used only if:

(a) the nature of the investigation is such that mentally competent adults would not be suitable subjects;

(b) written consent is given by a legally authorized representative of the subject under circumstances in which a prudent and informed adult would reasonably be expected to volunteer himself or his child as a subject; and

(c) no person may be used as a subject against his will.

(3) Special precautions should be taken to protect the rights of subjects whenever human experimentation involves the use of those as subjects who are so situated that their ability to consent knowingly and voluntarily is impaired.

(4) It is the duty of each physician engaged in human experimentation to ensure that the rights of human subjects are protected.

(5) It is the goal of the American Medical Association—working with other appropriate groups—to establish and maintain uniformity of standards, guidelines, and procedures for medical experimentation throughout the world.

5.50. NEGLECT OF PATIENT

A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once he has undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives, or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

5.51. ORGAN TRANSPLANTATION GUIDELINES

The following statement is offered to guidance of physicians as they seek to maintain the highest level of ethical conduct in the transplantation of human organs.

(1) In all professional relationships between a physician and his patient, the physician's primary concern must be the health of his patient. He owes the patient his primary allegiance. This concern and allegiance must be preserved in all medical procedures, including those which involve the transplantation of an organ from one person to another where both donor and recipient are patients. Care must, therefore, be taken to protect the rights of both the donor and the recipient, and no physician may assume a responsibility in organ transplantation unless the rights of both donor and recipient are equally protected.

(2) A prospective organ transplant offers no justification for a relaxation of the usual standard of medical care. The physician should provide his patient, who may be a prospective organ donor, with that care usually given others being treated for a similar injury or disease.

(3) When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. Death shall be determined by the clinical judgment of the physician. In making this determination, the ethical physician will use all available, currently accepted scientific tests.

(4) Full discussion of the proposed procedure with the donor and the recipient or their responsible relatives or representatives is mandatory. The physician should be objective in discussing the procedure, in disclosing known risks and possible hazards, and in advising of the alternative procedures available. The physician should not encourage expectations beyond those which the circumstances justify. The physician's interest in advancing scientific knowledge must always be secondary to his primary concern for the patient.

(5) Transplant procedures of body organs should be undertaken (a) only by physicians who possess special medical knowledge and technical competence developed through special training, study, and laboratory experience and practice, and (b) in medical institutions with facilities adequate to protect the health and well-being of the parties to the procedure.

(6) Transplantation of body organs should be undertaken only after careful evaluation of the availability and effectiveness of other possible therapy.

5.60. PROFESSIONAL COURTESY

The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy.

1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.

2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing benefits for medical or surgical care, a physician who renders such services may accept the insurance benefits without violating the traditional practice of physicians caring for the medical needs of colleagues and their dependents without charge.

3. In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.

4. Professional courtesy should always be extended without qualification to the physician in financial hardship and members of his immediate family who are dependent upon him.

5. These guidelines are advisory only.

5.61. RECORDS OF PHYSICIANS: AVAILABILITY OF INFORMATION TO OTHER PHYSICIANS

The interest of the patient is paramount in the practice of medicine, and everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient. When a colleague who is presently treating a patient requests records from another physician who has formerly treated the patient, that former physician should promptly make his records available to the attending physician.

No set rule can be laid down to cover the manner in which the records are to be transmitted to the attending physician. Under some conditions, a personal inspection of the records might suffice; under others, an oral report of what is contained in the records would be of help; or in other circumstances, a summary of the records might be made. In extreme cases, a physician might lend his complete record to the attending physician. The manner of making the report—or the information contained therein—available to the succeeding physician is immaterial and will depend on the circumstances of each case. Certainly, however, the attending physician should not demand or expect more information from the former physician than is necessary to give the patient adequate care in the present illness.

It is assumed, of course, that proper authorization for the use of these records has been granted by the patient.

It is unethical for a physician, who formerly treated a patient, to refuse for any reason to make his records of that patient promptly available on request to another physician presently treating the patient.

5.62. RECORDS OF PHYSICIANS: INFORMATION AND PATIENTS

Medical notes made by a physician in private practice are for his own use in treating a patient and belong to him. With the patient's consent, the record may be examined by an attorney, another physician employed by the patient, or other party, but the patient has no legal right to its possession or ownership. The record is physically the personal property of the physician, although the patient (or his legal representative) has certain legal rights to the information contained in the record about the patient's diagnosis and treatment.

The record is a confidential document involving the physician-patient relationship and should not be communicated to a third party without the patient's prior written consent, unless it is required by law or is necessary to protect the welfare of the individual or the community.

Medical reports should not be withheld because of an unpaid bill for medical services. Simplified, routine forms can be prepared without charge, but a charge for more complex, complicated reports may be made in conformity with local custom.

5.[illegible] RECORDS OF PHYSICIANS ON RETIREMENT

In addition to legal requirements, there may be good reason why a physician would wish to preserve his records for some time. In many instances, the patient must rely on his physician and his physician's records to establish the fact that he did receive medical care and treatment or that he has had the services of a qualified physician. Without the physician's records, the physician who rendered the care would be unable to assist his patient. Thus, in the best interest of the patient, the physician should not indiscriminately dispose of his records but should give consideration to the type of practice he has and to the possible needs of his patients.

A physician is under no obligation to turn his records over to his patients. In the best interests of the patients, however, when a physician contemplates moving from a community or retiring from practice, he should notify the patients on his active list that he intends to leave and he should encourage the patients to seek the services of some other physician. The physician could also suggest that, with the consent of the patient, arrangements can be made to permit a succeeding physician, designated within reasonable time by the patient, to review or copy these records. In this way the patient's best interests may be served.

5.70. SUBSTITUTION OF SURGEON WITHOUT PATIENT'S KNOWLEDGE OR CONSENT

The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. To have another physician operate on one's patient without the patient's consent and without his knowledge of the substitution is a fraud and deceit and a violation of a basic ethical concept. The patient as a human being is entitled to choose his own physician and he should be permitted to exercise his right to accept the substitution.

The surgeon's obligation to the patient requires him to perform the surgical operation (1) within the scope of authority granted him by the consent to the operation; (2) in accordance with the terms of the contractual relationship; (3) with complete disclosure of all facts relevant to the need and the performance of the operation; and (4) to utilize his best skill in performing the operation.

It should be noted that it is the operating surgeon to whom the patient grants his consent to perform the operation. The patient is entitled to the services of the particular surgeon with whom he contracts. The surgeon, in accepting the patient, obligates himself to utilize his personal talents in the performance of the operation to the extent required by the agreement creating the physician-patient relationship. He cannot properly delegate to another the duties which he is required to perform personally.

Under the normal and customary arrangement with private patients, and with reference to the usual form of consent to operation, the surgeon is obligated to perform the operation himself, and he may use the services of assisting residents or other assisting surgeons to the extent that the operation reasonably requires the employment of such assistance. If a resident or other physician is to perform the operation under the guidance of the surgeon, it is necessary to make a full disclosure of this fact to the patient, and this should be evidenced by an appropriate statement contained in the consent.

If the surgeon employed merely assists the resident or other physician in performing the operation, it is the resident or other physician who becomes the operating surgeon. If the patient is not informed as to the identity of the operating surgeon, the situation is "ghost surgery."

An operating surgeon is construed to be a performing surgeon. As such, his duties and responsibilities go beyond mere direction, supervision, guidance, or minor participation.

The physician is not employed merely to supervise the operation. He is employed to perform the operation. He can properly utilize the services of an assistant to assist him in the performance of the operation, but he is not performing the operation where his active participation consists merely of guidance or standby responsibilities in the case of an emergency.

5.71. UNNECESSARY SERVICES

It is unethical for a physician to provide or prescribe unnecessary services or unnecessary ancillary facilities.

PUBLIC RESPONSIBILITIES

ADVERTISING AND SOLICITATION

This statement reaffirms the long-standing policy of the Judicial Council on advertising and solicitation by physicians. The Principles of Medical Ethics are intended to discourage abusive practices that exploit patients and the public and interfere with freedom in making an informed choice of physicians and free competition among physicians.

Advertising.—The Principles do not proscribe advertising; they proscribe the solicitation of patients. Advertising means the action of making information or intention known to the public. The public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and other useful information that will enable people to make a more informed choice of physician.

The physician may furnish this information through the accepted local media for advertising or communication, which are open to all physicians on like conditions. Office signs, professional cards, dignified announcements, telephone directory listings, and reputable directories are examples of acceptable media for making information available to the public.

A physician may give biographical and other relevant data for listing in a reputable directory. A directory is not reputable if its contents are false, misleading, or deceptive or if it is promoted through fraud or misrepresentation. If the physician, at his option, chooses to supply fee information, the published data may include his charge for a standard office visit or his fee or range of fees for specific types of services, provided disclosure is made of the variable and other pertinent factors affecting the amount of the fee specified. The published data may include other relevant facts about the physician, but false, misleading, or deceptive statements or claims should be avoided.

Local, state, or specialty medical associations, as autonomous organizations, may have ethical restrictions on advertising, solicitation of patients, or other professional conduct of physicians that exceed the Principles of Medical Ethics. Furthermore, specific legal restrictions on advertising or solicitation of patients exist in the medical licensure laws of at least 33 states. Other states provide regulation through [illegible] authority to impose penalties for unprofessional conduct.

Solicitation.—The word "solicitation" in the Principles means the attempt to obtain patients by persuasion or influence, using statements or claims that (1) are false or misleading, (2) are intended or likely to create unjustified or unrealistic expectations of favorable results, (3) are self-laudatory and imply that the physician has skills superior to other physicians engaged in his field or specialty of practice, or (4) contain incorrect or incomplete facts, or representations or implications that are likely to cause the average person to misunderstand or be deceived.

Competition.—Some competitive practices accepted in ordinary commercial and industrial enterprises—where profit-making is the primary objective—are inappropriate among physicians. Commercial enterprises, for example, are free to solicit business by paying commissions. They have no duty to lower prices to the poor. Commercial enterprises are generally free to engage in advertising "puffery," to be boldly self-laudatory in making claims of superiority, and to emphasize favorable features without disclosing unfavorable information.

Physicians, by contrast, have an ethical duty to subordinate financial reward to social responsibility. A physician should not engage in practices for pecuniary gain that interfere with his medical judgment and skill or cause a deterioration of the quality of medical care. Ability to pay should be considered in reducing fees, and excessive fees are unethical.

Physicians should not pay commissions or rebates or give kickbacks for the referral of patients. Likewise, they should not make extravagant claims or proclaim extraordinary skills. Such practices, however common they may be in the commercial world, are unethical in the practice of medicine because they are injurious to the public.

Freedom of choice of physician and free competition among physicians are prerequisites of optimal medical care. The Principles of Medical Ethics are intended to curtail abusive practices that impinge on these freedoms and exploit patients and the public.

6.01. ADVERTISING, SOLICITATION, AND HMOS

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

The foregoing qualification is intended to discourage deceptive advertising which would lead prospective members (or subscribers) to believe that the services of a named physician who has a reputation for outstanding skill would be routinely available to all members (or subscribers) having need for his kind of services if in fact this is not so. However, the publication by name of the roster of physicians who provide services to members, the type of practice in which each is

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ceased, biographical and other relevant information as outlined in 6.07 above is not a deceptive practice.

6.08. CIVIL RIGHTS AND PROFESSIONAL RESPONSIBILITY

The American Medical Association is in favor of equality of opportunity in medical society activities, medical education and training, employment, and all other aspects of medical professional endeavors regardless of race, color, religion, creed, ethnic affiliation, national origin, or sex.

The American Medical Association is unalterably opposed to the denial of membership privileges and responsibilities in county medical societies and state medical associations to any duly licensed physician because of race, color, religion, creed, ethnic affiliation, national origin, or sex.

The American Medical Association calls upon all state medical associations, all component societies, and all individual members of the American Medical Association to exert every effort to end any instance in which such equal rights, privileges, or responsibilities are denied.

6.09. COMMUNICATIONS MEDIA: PRESS RELATIONS

When a physician is asked by the press to discuss his patient's medical condition, disease, or illness he must remember that his obligation is to his patient.

The physician reports to the patient. However, a patient by virtue of his position may have an obligation to others. If so, he must know and discharge that obligation (to the electorate or to the stockholders or to others to whom he is responsible). The physician should insure the medical accuracy of any authorized report.

The physician may not discuss the patient's health condition with the press or the public without the patient's consent or, in the event of his incapacity, the family's consent.

Public figures are in a different position, in regard to publicity, than the ordinary citizen. One of the penalties of being in the public eye is the automatic surrender of a portion, at least, of one's right of privacy.

A patient or his family representative may authorize a physician to disclose certain health information to the press. Under these conditions, the release of information by the physician does not violate any ethical principle. However, a physician may release only authorized information or that which is public knowledge.

The use of the expression "medical authorities" is frequently used to preserve anonymity so that no individual physician can be accused of having an ulterior motive in making a statement for the press. It is better

to have a "medical authority" or a physician act as spokesman so that the information given will be medically accurate.

6.10. COMMUNICATIONS MEDIA: PUBLIC FIGURES

Most scientific-medical articles, case studies, case reports, and clinico-pathological reports are based on actual medical experiences with patients. Medicine does not find it necessary to identify these patients. While one need not condemn those who, after the death of public figures, discuss the medical condition of those people while they were alive, respect for the dignity of man, respect for the deceased, and respect for the medical profession strongly suggest that only some clear and meaningful benefit would justify such discussion.

6.12. COMMUNICATIONS MEDIA: STANDARDS OF PROFESSIONAL RESPONSIBILITY

A. Each medical society should consider appointing a communications committee, or designating a responsible individual or individuals, whose duty would be to provide the communications media with accurate information on all medical matters of interest to the public. This information should be given freely. The communications committee may also serve in an advisory capacity to all communications media and to all physicians of its society in questions involving relationships with the media. To assist the media in obtaining information, medical societies may furnish the media with a list of names of physicians from whom authoritative information may be obtained, or a designated individual may serve as liaison between the media and the profession and furnish names of physicians to provide authoritative information when required.

These spokesmen may be quoted by name and title. This should not be considered by their colleagues as solicitation, since it is done in the best interest of the public and the profession. They may ethically provide appropriate information regarding medical and public health matters which have been discussed in technical papers or during medical meetings.

The officers, committee chairmen, and designated spokesmen of medical societies should be available at all times to bona fide representatives of the communications media in order that authentic information may be obtained as soon as possible.

B. Because certain news is a part of the public record or is a matter of concern to civil authorities, it is readily available for public dissemination. Physicians should cooperate with the press to insure that medical news of this sort is available more promptly and more accurately than would be possible without their assistance.

News in this category, known as news in the public domain, includes births, deaths, accidents, and police cases.

The following information in the public domain can be made available without the patient's consent:

(a) Personal information: patient's name, address, age, sex, race, marital status, employer, occupation, name of parents in case of births, name of next-of-kin in case of deaths.

(b) Nature of accident:

Only general information regarding injuries will be released. This consists of the name of the injured portion of the body, such as back injury and the like. It may be stated that there are internal injuries.

If the patient is unconscious when brought to the hospital, a statement to that effect may be made.

Statements regarding the circumstances surrounding shootings, knifings, and poisonings are properly police matters, and questions whether they were accidental or otherwise should be referred to the appropriate authorities.

A statement may be made to the effect that the patient was injured by a knife or other sharp instrument, but no statement may be made as to whether or not it was assault, accident, or self-inflicted.

A statement may be made that the patient received burns and the member of the body affected may be indicated.

No statement may be made that there was a suicide or attempted suicide.

No statement may be made to the effect that intoxication or drug addiction was involved.

No statement may be made that moral turpitude was involved.

(c) Diagnosis and prognosis:

Inasmuch as a diagnosis may be made only by a physician and may depend upon X-ray and laboratory studies, no statement regarding diagnosis should be made except by or on behalf of the attending physician. For the same reason, prognosis will be given only by the attending physician or at his direction.

(d) Patient's condition:

A statement may be made as to the general condition of the patient using the following classifications: minor injuries or similar general diagnosis, good, fair, serious, critical.

C. When information concerning a specific patient is requested, the physician must obtain the consent of the patient or his authorized representative before releasing such knowledge. The patient's decision is final under the law. A physician may, within the limits of good taste, encourage the patient or his family to state the cause of illness, or the cause of death, when this information is requested by a bona fide representative of the press. Where a person of public interest is involved and the release of information has been authorized, the physician may arrange for regular bulletins concerning the person. The ethical physician will use restraint and good judgment regarding the use of his name in connection with such published reports.

D. Publication of photographs of physicians, who appear before recognized medical organizations, either in the official program of the scientific meeting or before the public press in connection with such meeting, is permissible. The use of photographs in the press when physicians are elected to office or when physicians are quoted by name on matters of general interest, not related to the care of a specific patient, is likewise permissible. Photographs of physicians in connection with civic or social affairs, not related to medical news or the care of patients, may be published unless the frequency of such photographs bespeaks self-exploitation. This applies also to magazine articles. Physicians may wish to clear such publicity, whenever possible, with their county society.

E. The promise of radical cures or boasting of extraordinary skill or success is considered unethical by the medical profession because it is contrary to the best interest of the public.

F. For purposes of clarity, the following principles should guide physicians who appear on TV or radio programs or who are interviewed in other media of public information, such as newspapers and magazines:

(a) Physicians are expected to refrain from sponsoring products directly or by implication.

(b) When introduced as a physician on TV or radio programs or quoted in an article as a physician in newspapers and magazines, such individual cannot escape the implication of representing the medical profession and his conduct should be in keeping with the high standards of the profession.

(c) Sound judgment and good common sense are expected of any physician when appearing on TV or radio programs or in other media of public information, such as newspapers or magazines, in whatsoever capacity.

G. Members of medical society speakers bureaus, because of the very nature of their assignments, may be interviewed or quoted by the communications media. This is not considered unethical conduct.

The members of these committees must uphold the ideals of the medical profession.

H. The Judicial Council construes Section 10 of the Principles of Medical Ethics as encouraging physicians to work with the communications media as an important part of the process of upholding the responsibility of the physician to society at large.

I. Physicians are ethically and legally required to protect the con-

sonal privacy and other legal rights of patients. The physician-patient relationship and its confidential nature must be maintained. With these considerations in mind, the physician may assist the representatives of these media in every way possible.

6.16. DISCIPLINE AND MEDICINE

A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

The Judicial Council cannot pass judgment in advance on a situation that may later come before it on appeal. The Judicial Council cannot be an attorney for a society or a member thereof and later judge in the same factual situation. The component medical society has the initial obligation of determining whether or not the action described constitutes an infringement of the Principles of Medical Ethics. Questions asking for a review of a proposed course of action or an evaluation of an existing factual situation should be presented to the appropriate official of the physician's component society.

6.17. DRUGS AND DEVICES: PRESCRIBING

It is unethical for a physician to be influenced in the prescribing of drugs or devices by his direct or indirect financial interest in a pharmaceutical firm or other supplier. It is immaterial whether the firm manufactures or repackages the products involved.

It is unethical for a physician to own stock or have a direct or indirect financial interest in a firm that uses its relationship with physician-stockholders as a means of inducing or influencing them to prescribe the firm's products. Practicing physicians should divest themselves of any financial interest in firms that use this type of sales promotion. Reputable firms rely on quality and efficacy to sell their products under competitive circumstances, not on appeal to physicians with financial involvements which might influence them in their prescribing.

On the other hand, it cannot be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patients.

The physician is permitted to exercise his own best judgment when

caring for his patients. It is known that there will be situations when it is necessary or desirable for a physician to dispense or supply what he has prescribed. The Principles permit this to be done. A physician in the exercise of sound discretion may dispense "in the best interest of his patient"; he may not dispense solely for his convenience or for the purpose of supplementing his income, especially if the drug needs of patients can be adequately met by local pharmacies.

Physicians who enter into agreements with pharmacists in the dispensing of prescriptions in code are guilty of unethical practices and should be disciplined by their local society. It is also unethical for physicians to use prescription blanks with the name of a pharmacy printed thereon. A patient is entitled to a copy of his or her prescription for glasses, drugs, or appliances and he has the privilege of having the prescription filled wherever he wishes.

The principle of free choice applies as well to the choice of a pharmacy. Accordingly, the Council looks with disfavor upon the use of direct telephone lines between a physician and a pharmacist on the theory that a patient is entitled to a written prescription which he can take to the pharmacist of his choice.

6.18. DUE PROCESS

The basic principles of a fair and objective hearing should always be accorded to the physician whose professional conduct is being reviewed. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut the evidence, and the opportunity to present a defense. These principles apply when the hearing body is a medical society tribunal or a hospital committee composed of physicians.

These principles of fair play apply in all disciplinary hearings and in any other type of hearing in which the physician may be deprived of valuable property rights. Whenever physicians sit in judgment on physicians and whenever that judgment affects a physician's reputation, professional status, or livelihood, these principles of fair play must be observed.

All physicians are urged to observe diligently these fundamental safeguards of due process whenever they are called upon to serve on a committee which will pass judgment on physicians. Medical societies and hospital medical staffs are urged to review the constitutions and bylaws of the society or hospital medical staff to make sure that these instruments provide for such procedural safeguards.

6.20. FEE SPLITTING AND REBATES

By the term secret splitting of fees is meant the sharing by two or more men in a fee which has been given by the patient supposedly to the

reimbursement for the service of one man alone. By secrecy is meant that the division of the fee is done without the knowledge of the patient or some representative of the family. It includes those cases in which the term assistant is used as a subterfuge to obtain a part of the fee which otherwise could not be rightfully claimed. It includes the giving or receiving of a commission, which constitutes fee-splitting and is unethical.

It is ethically permissible in certain circumstances, however, for a surgeon to engage other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance, provided the nature of the financial arrangement is made known to the patient. This principle applies whether or not the assisting physician is the referring doctor.

A physician may only receive from his patient payment for rendered medical services. Hence it should be apparent that no rebate of any kind, in any form or from any source, can be accepted. This applies not to rebates coming from agents or owners of optical companies. They are, in every case, absolutely unethical.

A physician may not accept a gift such as a radio, a compact refrigerator, or the like from a manufacturer or a distributor of drugs, remedies, appliances, or services for prescribing these products for his patients. This amounts to rebating. It is ethically improper because it could influence the physician to prescribe the donor's product. If a product or service is prescribed for its effectiveness, it would be preferable that it be discounted so that the patient, rather than the physician, benefits.

6.23. FEE SPLITTING: BILLING

In many cases insurance companies insist on a joint or combined bill, but the bill is being paid in most instances by two checks. This is not considered unethical, and all insurance plans which do not pay the individual physician in this manner should be urged to do so.

When two or more physicians actually and in person render services to one patient, they should render separate bills. There are cases, however, in which the patient may make a specific request to one of the physicians attending him that one bill be rendered for the entire services. Should this occur, it is considered to be ethical if the physician from whom the bill is requested renders an itemized bill setting forth the services rendered by each physician and the fees charged. The amount of the fees charged should be paid directly to the individual physicians who rendered the services in question.

6.24. FEE SPLITTING: CLINICS AND LABORATORIES

Several proposals looking to the organization of groups of physicians in cooperative projects have been submitted to the Judicial Council. In most instances these have been in the nature of stock selling and stock holding schemes whereby physicians interested would realize on investments in proportion to the amount of work referred by them to the "clinic" or laboratory operated under the particular scheme. After examination of these proposals, nearly all of them appear to be open to the criticism that they are, or may be suspected of being, essentially fee-splitting projects.

Concerns known as "cooperative diagnostic laboratories" have been organized in which practicing physicians participate as "members." Information indicates that organization is effected in such a manner that control will lie in the hands of the promoters and directors of these schemes and that practicing physicians are then expected to refer work to the laboratories operated by the concern. As a consideration for such referrals, the physician members receive from the laboratories compensation varying with the amount of work referred. Schemes of this kind are unethical and directly opposed to the interest of scientific medicine.

On the other hand, it is not unethical in itself for a physician to accept part-time employment with another physician or in a clinic.

Also, in exceptional cases, when it is not possible for the laboratory bill to be sent directly to the patient, the referring physician's bill to the patient should indicate the charges for laboratory services, including the name of the physician director of the laboratory, as well as the charges for his own professional services.

6.24. FEE SPLITTING: GROUP PRACTICE

The division of income among members of a group, practicing jointly or in partnership, may be determined by the members of the group and may be based on the value of the professional medical services performed by the member and his other services and contributions to the group.

6.25. FEE SPLITTING: PURCHASE OF MEDICAL PRACTICE ON PERCENTAGE BASIS

The purchase of a medical practice on a percentage basis is contrary to and in violation of the Principles. A physician may pay anything he wants to for the practice as long as a set price is established, but it is unethical for a physician to pay a percentage of the income of the practice that he has purchased as payment for it. The use of a percentage of fees or an indefinite sum as the purchase price for a medical practice results in dividing fees paid for professional service with a third party—a stranger to the physician-patient relationship. Once a price has been established, it may be paid according to the mutual agreement of the parties. Payment of such an established price

predicated on a percentage of the income of the purchaser is not contrary to the Principles. It is axiomatic that a physician must bill a patient for professional services that he renders to the patient. He must not divide that fee with another. Such practice violates the physician-patient relationship and may be regarded as a commission for having referred the patient.

6.26. FEE SPLITTING: RENTALS

An arrangement by virtue of which a physician leases office space for a percentage of gross income is not acceptable; it is violative of ethical principles. The practice indirectly results in fee splitting and tends to exploit the practice of medicine. If the size of a physician's practice increases and imposes additional demands on the facilities of the building, these facts may be considered when the time comes to renegotiate the rental value of the leased premises, and a new fixed rental, taking these items into account, might be agreed upon.

The rental of space by a physician or group of physicians as a pharmacy should be a fixed one. Were the rental to be based on the amount of business, it might well be argued, and indeed be the case, that fee splitting existed. In addition, the temptation would be ever present for the physician-owner to encourage patients to take their prescriptions to that pharmacy. The evils inherent in such practice are too obvious to be mentioned.

6.28. FREE CHOICE

Free choice of physicians is the right of every individual. The individual may select and change at will the physicians who serve him, or he may choose a medical care plan such as that provided by a closed panel or group practice, or he may choose to obtain medical care by becoming a subscriber of a health maintenance or service organization. The freedom of the individual to select his preferred system of medical care and free competition among physicians and alternative systems of medical care are prerequisites of ethical practice and optimal medical care.

6.40. LOCAL MEDICAL SOCIETIES: RESPONSIBILITIES

The county society is autonomous. Local or state medical associations, as autonomous organizations, may have ethical restrictions on professional conduct of physicians that exceed the Principles of Medical Ethics of the American Medical Association. Ethical standards of professional conduct may also exceed but are never less than those required by law. Such autonomy imposes responsibilities. If medical societies fail to accept and discharge their obligations in matters of ethics, others will assume these obligations by default.

6.51. NURSING HOME OR OPTICAL DISPENSING SHOP OWNERSHIP BY PHYSICIANS

It is proper for a physician to own or have a financial interest in a nursing home or similar facility providing the patient has free choice of physician and facility.

It is proper, too, for a physician to own an optical dispensing shop, provided there is no exploitation of the patient.

6.60. PATENT FOR SURGICAL OR DIAGNOSTIC INSTRUMENT

It is not unethical for a physician to patent a surgical or diagnostic instrument he has discovered or developed. The laws governing patents are based on the sound doctrine that one is entitled to protect his discovery.

6.61. PEER REVIEW

Medical society ethics committees, hospital credentials and utilization committees, and other forms of peer review have been long established by organized medicine to scrutinize physicians' professional conduct. At least to some extent, each of these types of peer review can be said to impinge upon the absolute professional freedom of physicians. They are, nonetheless, recognized and accepted. They are necessary. They balance the physician's right to exercise his medical judgment freely with his obligation to do so wisely and temperately. Responsive, responsible peer review does not cause a physician to violate Section 6 of the Principles of Medical Ethics.

6.70. SECRET REMEDIES

It is unethical for a physician to prescribe, dispense, administer, or promote the use of any drug whose content or effect are unknown to him or to refuse to inform the patient (or his legal representative) about the identity and purpose of any drug which he has prescribed, dispensed, or administered to the patient.

VII. APPENDIX

The Judicial Council, a standing Council of the AMA, consists of five active members of the AMA elected by the House of Delegates on nomination of the President for terms of five years. The duties of the Judicial Council, as defined in Section 4 of Chapter XIII of the AMA Bylaws, are set forth in the Appendix. The Council's Rules of Procedure are also set forth here.

AMERICAN MEDICAL ASSOCIATION CONSTITUTION AND BYLAWS

Chapter XIII, Section 4
JUDICIAL COUNCIL

(a) Charge: The functions of the Judicial Council shall be:

(1) To serve as the judicial authority of the Association. The decisions of the Judicial Council shall be final.

(2) To have original jurisdiction in: (a) all questions involving membership as provided in Division One, Chapter I, Section 1, of the Bylaws; (b) all controversies arising under this Constitution and Bylaws and under the Principles of Medical Ethics to which the American Medical Association is a party; (c) controversies between two or more state associations or their members and between a state association and a component society or societies of another state association or associations or their members; (d) the establishment of principles and interpretation of medical ethics, and (e) the interpretation of the Constitution, Bylaws and rules of the Association.

(3) To have appellate jurisdiction in questions of law and procedure but not of fact in all cases which arise between a state association and one or more of its component societies, between component societies of the same state association, between a member or members and the component society to which said member or members belong or between members of different component societies of the same state association. Notice of appeal shall be filed with the Judicial Council within thirty (30) days of the date of the decision by the state association and the appeal shall be perfected within sixty (60) days thereof; provided however that the Judicial Council, for what it considers good and sufficient cause, may grant an additional thirty (30) days for perfecting the appeal.

(4) To receive appeals filed by applicants who allege that they, because of color, creed, race, religion, ethnic origin, national origin, or sex, have been unfairly denied membership in a component and/or constituent association, to determine the facts in the case, and to report the findings to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure, or, in the event of repeated violations, recommend to the House of Delegates that the state association involved be declared to be no longer a constituent member of the American Medical Association.

(5) To investigate general ethical conditions and all matters pertaining to the relations of physicians to one another or to the public, and make recommendations to the House of Delegates or the state associations.

(6) To request the President to appoint investigating juries to which it may refer complaints or evidences of unethical conduct which in its judgment are of greater than local concern. Such investigating juries, if probable cause for action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against the accused before the Judicial Council in the name and on behalf of the American Medical Association. The Council may acquit, admonish, suspend or expel the accused.

(7) To approve applications and nominate candidates for affiliate membership as otherwise provided for in these Bylaws.

(b) Membership: The Judicial Council shall consist of five Active Members. The members of the Council shall be elected by the House of Delegates on nomination by the President.

(c) Term of Service: Members of the Judicial Council shall be elected by the House of Delegates for terms of five years, so arranged that at each Annual convention the term of one member expires.

(d) Tenure: Members of the Judicial Council shall serve for no more than two terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless he has served three or more years.

(e) Vacancies: Any vacancy occurring on the Judicial Council shall be filled at the next meeting of the House of Delegates. The new member shall be elected by the House of Delegates, on nomination by the President, for the remainder of the unexpired term.

RULES OF THE JUDICIAL COUNCIL AMERICAN MEDICAL ASSOCIATION

RULE I. ADMINISTRATION

A *Meetings*. The Judicial Council will meet during the Annual and Clinical Convention of the American Medical Association. Other meetings of the Council may be called, on reasonable notice, by the Chairman of the Council; or they shall be called, on reasonable notice, by the Executive Vice President of the American Medical Association on the written request of at least three members of the Council.

B *Chairman and Vice-Chairman*. The Judicial Council shall elect from among its members a chairman and vice-chairman every two years at the meeting of the Council held during the Annual Convention of the Association. Each shall retain the right to vote on all matters. No member of the Council shall serve more than two consecutive years as chairman or two consecutive years as vice-chairman.

C *Quorum*. Three members of the Judicial Council shall constitute a quorum but a majority vote of the entire Council shall be required to adopt any action.

RULE II. APPLICATION FOR MEMBERSHIP

A *Regular, Service and Associate Membership*. Applications for membership in the American Medical Association will be considered by the Judicial Council at any meeting upon presentation of the applications by the Executive Vice President of the Association.

B *Affiliate Membership*. Applications for affiliate membership submitted by (1) physicians who are members of the national medical societies of foreign countries, (2) American physicians located in foreign countries or possessions of the United States and engaged in medical missionary educational or philanthropic labors, (3) dentists who hold the degree of D.D.S. or D.M.D., who are members of the American Dental Association and their state and local dental societies, (4) pharmacists who are active members of the American Pharmaceutical Association, (5) teachers of medicine or of the sciences allied to medicine who are citizens of the United States and are not eligible to membership, or (6) scientists in sciences allied to medicine and others who have attained distinction in their fields of endeavor who are not otherwise eligible to membership, will be considered at any meeting of the Judicial Council on presentation of the applications by the chief executive officer of the Association. The Council will consider and approve only those applications which are accompanied by a statement of a responsible and qualified individual attesting to the requirements set forth above.

C *Refusal of Approval*. An applicant for membership in the American Medical Association whose application has not been approved by the Judicial Council will be promptly notified of such fact and will be given twenty days within which to request reconsideration of his application in accord with the provisions of Rule III.

RULE III. RECONSIDERATION OF APPLICATIONS FOR MEMBERSHIP

A request for reconsideration of a refusal to approve an application for membership should be initiated by a written statement setting forth the reasons for reconsideration.

RULE IV. PHYSICIANS DENIED MEMBERSHIP IN COMPONENT OR CONSTITUENT ASSOCIATIONS

Pursuant to Chapter XIII, Section 4 (a) (4) of the Bylaws, any physician whose application for membership in a component and/or constituent association has allegedly been denied unfairly because of color, creed, race, religion, ethnic origin, national origin, or sex may appeal to the Judicial Council. The Council shall determine the facts in the case and report the findings to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure or, in the event of repeated violations, recommend to the House of Delegates that the state association involved be declared to be no longer a constituent member of the American Medical Association.

Proceedings for such determination shall be initiated by a written statement. Such statement shall: (1) identify the parties to the case, (2) show that the appellant has exhausted remedies made available by the constitution and bylaws of the component society and the state association, and (3) include a concise factual resume of the case in sufficient detail to enable the Council to ascertain the facts. The appellant should also furnish such other information as may be requested by or helpful to the Council in determining the facts.

RULE V. ORIGINAL CONTROVERSIES

Original proceedings before the Judicial Council shall be initiated by a written statement. Such statement shall include information (1) identifying the parties to the controversy, including membership affiliations, if applicable, and (2) explaining the nature of the controversy, setting forth the provisions of the Constitution, Bylaws, Rules, or Principles of Medical Ethics concerned.

RULE VI. APPEALS

Appellate proceedings before the Judicial Council shall be perfected by a written statement of appeal. Such statement shall include information (1) identifying the parties to the case and indicating membership affiliations when appropriate, (2) showing that the appellant has exhausted remedies made available by the constitution and bylaws of the component society and the state

association, and (3) describing the error of law or procedure which is believed to have occurred during the proceedings. The statement shall also include a concise factual resume of the case. Appellant shall submit with the statement, charges, complaints, findings, opinions, and decisions previously entered in the case.

RULE VII. INTERPRETATION OF THE CONSTITUTION, BYLAWS, RULES AND PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION

A. *Requests for Interpretation.* Requests for interpretation of the Constitution, Bylaws, Rules or Principles of Medical Ethics of the Association shall be in writing and shall describe the matter to be interpreted in sufficient detail to enable the members of the Judicial Council to evaluate the request in all its aspects.

B. *Interpretations Initiated by the Council.* The Judicial Council, on its own motion, may render an opinion concerning the interpretation or application of the Constitution, Bylaws, Rules or Principles of Medical Ethics of the Association and may, on its own motion, consider and decide the constitutionality and validity of all rules and regulations adopted by Councils and Committees of the Association pursuant to the Bylaws of the Association.

C. *Discretionary Power.* The Judicial Council may, in its discretion, refuse to consider requests for interpretation of the Principles of Medical Ethics which in the opinion of the Council should be resolved by a component society or a state association. Requests for interpretation of the Principles of Medical Ethics which are not of national interest and relate to the observance of local customs and ideals may be readdressed to the component society or constituent association primarily responsible for knowledge of the requirements of such local customs and recognized ideals.

RULE VIII. JURISDICTION

The Judicial Council may, on its own motion or on the motion of any party, determine the question of jurisdiction at any stage of the proceedings.

RULE IX. ADDITIONAL STATEMENTS AND RECORD

After a statement has been submitted to the Judicial Council with the intention of initiating action, all other parties in interest shall have the right to submit a statement on their behalf. Such statements shall be filed within thirty days after the date of the initiating statement unless additional time is granted by the Council.

The Judicial Council may thereafter require the parties to submit such transcripts of testimony, reports, written statements supporting their contentions, or other material as the Council may deem necessary.

RULE X. HEARINGS

A. *Notice of Hearings.* The Council may in its discretion determine whether a hearing is necessary or advisable. The Council will designate the time and place for all hearings, giving reasonable notice thereof to all parties.

B. *Attendance.* The attendance at hearings may be limited to the members of the Judicial Council, the staff, witnesses, if any, the parties, and counsel, who may speak in their behalf. Should any party to the controversy fail to appear, the Council may in its discretion continue, dismiss, or decide the matter.

C. *Evidence and Argument.* The Judicial Council will not be bound by technical rules of evidence usually employed in legal proceedings but may accept any evidence it deems appropriate and pertinent.

In any appeal case the review, if any, of the evidence will be limited to the evidence presented in the proceedings before the component society and constituent association or appropriate committee, board, or group thereof, provided, however, that in the event the Council is of the opinion such evidence is inadequate to determine the question of law or procedure presented, the Council, on its own motion or on the suggestion of any party, may require the production of additional evidence before the Council or refer the matter to the appropriate body for additional evidence.

In matters other than appeal cases, the Judicial Council will grant the parties the right to present evidence to the extent the Council believes appropriate to the particular matter in controversy.

In all hearings, the Council, within reasonable limitations, will allow oral argument.

D. *Record.* In hearings of original controversies, appeals, and in other proceedings, a transcript may be made at the discretion of the Council.

RULE XI. OPINIONS

All opinions or decisions of the Judicial Council shall be in writing. Copies of the opinion or decision and the dissent, if any, will be filed as a part of the record and furnished to all the parties involved.

RULE XII. FILING AND COPIES

Eight (8) copies of all documents shall be submitted to the Secretary of the Judicial Council. One copy of each document shall be submitted at the same time to each of the other parties to the controversy.

RULES OF THE JUDICIAL COUNCIL IN ORIGINAL JURISDICTION CASES

PREAMBLE

At the Annual Convention of the House of Delegates of the American Medical Association, held in June, 1962, Chapter IV of the AMA Bylaws, relating to disciplinary action, was amended. The Bylaws now provide that the Association may take disciplinary action with respect to a physician's AMA membership (1) when a state medical association to which a member belongs requests the AMA to take such action or (2) when, at the request of the American Medical Association, a state association to which the member belongs consents to such action.

Chapter XIII, Section 4 of the Bylaws provides that the Judicial Council may request the President of the Association to appoint investigating juries to which the Council may refer complaints or evidences of unethical conduct which, in its judgment, are of greater than 'local' concern.

The following Rules of Procedure, respecting notice of charges and the conduct of hearings before the Judicial Council, are based upon these sections of the Bylaws.

INVESTIGATING JURY

At the request of the Judicial Council the President has appointed an investigating jury. Complaints or evidence of unethical conduct of greater than local concern will be submitted to this jury by the Council.

INSTITUTION OF PROCEEDINGS

If after investigation a probable cause for action is shown, the investigating jury shall submit a statement of charges to the President. The President shall submit to the Judicial Council the statement of charges presented to him by the investigating jury for prosecution in the name and on behalf of the American Medical Association.

STATEMENT OF CHARGES

The statement of charges shall allege in writing an infraction of the AMA's Constitution or Bylaws or a violation of the Principles of Medical Ethics of the AMA. Exhibits may be attached.

NOTICE

A copy of the statement of charges shall be sent to the respondent physician by personal delivery or by registered or certified mail.

ANSWER

The respondent physician shall have thirty (30) days after personal delivery or mailing of the notice of statement of charges to file a written answer. If the respondent physician fails to file a written answer, the allegations shall be considered to be admitted.

PROCEEDINGS

The Chairman of the Judicial Council shall designate one or more members of the Council to conduct a hearing on the statement of charges. This member or these members shall be known as the Hearing Officer.

Hearings shall be held at such reasonable time and place, designated by the Hearing Officer, as may be consistent with the nature of the proceedings and the convenience of the parties. The parties shall receive not less than fifteen (15) days notice of the hearing.

The General Counsel of the American Medical Association or his designee shall prosecute the charges against the respondent physician.

Attendance at hearings may be limited to the members of the Judicial Council, the staff, witnesses, if any, the parties and counsel who may speak on their behalf.

The respondent physician or his counsel may cross-examine witnesses and enter objection to the material offered in evidence. The respondent shall also have the right to call witnesses and enter evidence in his behalf.

The Hearing Officer or his counsel may question the parties and their witnesses.

The Hearing Officer shall not be bound by technical rules of evidence usually employed in legal proceedings but may accept any evidence he deems appropriate and pertinent.

Should any party to the controversy fail to appear at the hearing, the Hearing Officer may, in his discretion, continue, dismiss or proceed with the hearing.

FINDINGS AND CONCLUSIONS

At the conclusion of the hearing, the Hearing Officer shall render a report in writing containing findings and conclusions and recommendations, if any. This report, together with a transcript of the proceedings, shall be submitted to the Judicial Council. A copy of the report shall be mailed to all parties of record.

WRITTEN OBJECTIONS

Any party to the proceedings may submit written objections to the report to the Judicial Council. These objections must be submitted within twenty-one (21) days after the report has been submitted by the Hearing Officer to the Judicial Council.

ORAL ARGUMENT

In addition to written objections, any party may request an opportunity to present oral arguments on its objections to the report of the Hearing Officer before the Judicial Council. This request must be made within twenty-one (21) days after the report has been submitted to the Judicial Council. The granting of oral arguments shall be discretionary with the Judicial Council. If granted, the parties shall be notified by the Judicial Council of the place and date for such oral argument; all parties shall be given an opportunity to be heard and the time allotted to argument may be limited by the Judicial Council with due regard to the magnitude and complexities of the issues involved.

If any party fails to appear, the Judicial Council may continue or proceed with the oral argument.

FINAL DECISION

The Judicial Council, including the member or members who serve as the Hearing Officer, shall render a final decision. A copy of that decision shall be mailed or otherwise served upon all parties.

DISCIPLINARY ACTION

The Judicial Council shall have the authority to acquit, admonish, or censure the accused physician or suspend or expel him from AMA membership as the facts may justify. This action shall be in accordance with the authority vested in the Council by Chapter IV, Section (1) (3) and Chapter XIII, Section (4) (a) (6) of the Bylaws.

TRANSCRIPT

A written transcript shall be made of the proceedings and of the oral argument before the Judicial Council.

If any party to the controversy requests a copy of the transcript, it shall be made available to him at his expense.

FILING OF COPIES

Three (3) copies of all pleadings and exhibits shall be submitted to AMA Headquarters to the Chairman of the Judicial Council. One copy of each document shall be submitted at the same time to each of the other parties to the controversy.

THE OATH OF HIPPOCRATES

I swear by Apollo, the physician, and Aesculapius and health and all-heal and all the Gods and Goddesses that, according to my ability and judgement, I will keep this oath and stipulation:

TO RECKON him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none others.

I WILL FOLLOW that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; furthermore, I will not give to a woman an instrument to produce abortion.

WITH PURITY AND WITH HOLINESS I will pass my life and practice my art. I will not cut a person who is suffering from a stone, but will leave this to be done by practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption; and further from the seduction of females or males, bond or free.

WHATEVER, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad I will not divulge, as reckoning that all such should be kept secret.

WHILE I CONTINUE to keep this oath unviolated may it be granted to me to enjoy life and the practice of the art, respected by all men at all times but should I trespass and violate this oath, may the reverse be my lot.

DECLARATION OF GENEVA

Adopted by the General Assembly of the World Medical Association at Geneva, Switzerland, September, 1948

AT THE TIME OF BEING ADMITTED AS MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE myself to consecrate my life to the service of humanity.

I WILL GIVE to my teachers the respect and gratitude which is their due.

I WILL PRACTICE my profession with conscience and dignity.

THE HEALTH OF MY PATIENT will be my first consideration.

I WILL RESPECT the secrets which are confided in me.

I WILL MAINTAIN by all means in my power, the honor and the noble traditions of the medical profession.

MY COLLEAGUES will be my brothers.

I WILL NOT PERMIT considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.

I WILL MAINTAIN the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I MAKE THESE PROMISES solemnly, freely, and upon my honor.

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Ex. # 17, p1.

CX 540A

JUDICIAL COUNCIL

AMERICAN MEDICAL ASSOCIATION

MINUTES OF MEETING, SEPTEMBER 26, 1964

CHICAGO, ILLINOIS

The Judicial Council of the American Medical Association held a regular meeting on September 26, 1964, in the Drake Hotel, Chicago, Illinois. The meeting was called to order at 9:00 a.m. on September 26 by James H. Berge, M.D., Chairman. Present, in addition to the Chairman, were E. G. Shelley, M.D., Walter H. Judd, M.D., Charles C. Smeltzer, M.D., members; William J. McAuliffe, jr., Secretary; Robert B. Throckmorton, General Counsel; Betty Jane Anderson and Stanton S. West, attorneys, Department of Medical Ethics; A. M. Edwards, Field Service Representative; and Rosemary Calcaterra, Recorder.

FEDERAL TRADE COMMISSION
File No. 9024 Commission Investigational Exhibit No. 540A
In the matter of: AMA
Date 10-13-77 Witness
Reporter F.B.
By

8 1 0 2 2 1 2 4

CX 540B

II. MINUTES OF MEETINGS OF JUNE 20 AND 22, 1964 AND MEETING OF JUNE 25, 1964. In connection with the appeal of [redacted], M.D., the Council agreed to eliminate the finding that "Doctor [redacted] was not offered the privilege of presenting witnesses in his behalf before the Board of Censors." The minutes of the meetings of June 20 and 22 were approved as amended.

The minutes of the meeting of June 25, 1964, were approved.

III. COMPLAINT AGAINST MICHAEL E. DEBAKEY, M.D. OF TEXAS CONCERNING ARTICLE IN LOOK. By letter dated June 20, 1964, Milford O. Rouse, M.D., Dallas, Texas, requested the Judicial Council to review an article entitled "Rebuilding the Human Body" which appeared in the June 30, 1964, issue of Look Magazine. This article described new medical and surgical techniques with transplants and artificial organs. It featured Michael E. DeBakey, M.D., head of the Department of Surgery of Baylor University. Doctor Rouse contended that: "The title of the article, or ostensible subject, was concerning advances in surgery, but the amount of picture material, the nature of the picture material, and the content about the one physician was far beyond what ordinarily would be expected."

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 540 B
In the matter of: AMA
Date 10/13/77 Witness —
Reporter T.P.
By Lin

CX 540 C p.3.

This article had not been reviewed or approved by either the Texas Medical Association or the AMA. Doctor Rouse suggested that the Judicial Council consider taking original jurisdiction in this matter against Doctor DeBakey.

It was brought to the attention of the Council that the May, 1964, issue of Today's Health carried a story which also extolled the virtues of Doctor DeBakey. This particular article was planted in Today's Health by Reader's Digest. The article also appeared in the May, 1964, issue of Reader's Digest. Neither of these articles were cleared by the Texas Medical Association.

Another somewhat similar article describing new medical techniques used in closing an artery appeared in the August 14, 1964, issue of Life. This article featured Charles Dotter, M.D. of the University of Oregon Medical School.

The Council received a letter dated September 21, 1964, from C. Lincoln Williston, Executive Secretary, Texas Medical Association, stating that the Executive Board of the Texas Medical Association requested the Council to initiate a thorough study of articles lauding physicians.

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 540C
In the matter of: AMA
Date 10/3/72 Witness
Reporter T.P.
By CM

CX 540D

The Executive Board also requested the Judicial Council to "initiate appropriate actions or recommendations which might be indicated."

The Council discussed the problems which result when a medical school publicizes the activities of individual physician-faculty members.

The Secretary reported that he had discussed this problem with Walter S. Wiggins, M.D., Director of the Department of Medical Education. Doctor Wiggins indicated that the Council on Medical Education would be willing to meet with the Judicial Council to consider this matter.

The Secretary also reported that Mr. Jim Reed, Director of the Communications Division, would assist the Council in its deliberations in this problem.

The Council adopted the following motion:

> "The Judicial Council shall: (A) make a thorough study of articles lauding physicians which have been published in magazines directed to the lay public, and (B) initiate appropriate actions or recommendations which might be indicated."

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 540D
In the matter of AMA
Date 10/13/77 Witness
Reporter F.P.
By LM

FEDERAL TRADE COMMISSION
File No. 9064 Commission Investigational Exhibit No. 538B
In the matter of: AMA
Date 10/13/77 Witness
Reporter T. P.
By

Ex. # 18

CX538A

JUDICIAL COUNCIL

AMERICAN MEDICAL ASSOCIATION

MINUTES OF MEETINGS, JUNE 18-19, 1965

NEW YORK CITY

The Judicial Council of the American Medical Association held a regular meeting on June 18-19, 1965, in the Americana Hotel, New York City. Present were James H. Berge, M.D., Chairman; E. G. Shelley, M.D., Charles C. Smeltzer, M.D., Robertson Ward, M.D., and Walter H. Judd, M.D., members; William J. McAuliffe, jr., Secretary; Miss Betty Jane Anderson, Staff Attorney, Department of Medical Ethics; Robert Mayo Tenery, M.D., Consultant to the Department of Medical Ethics; Mr. Doyl Taylor, Director, Department of Investigation; Mr. A. M. Edwards, Field Service Representative; and Rosemary Calcaterra, Recorder.

I. CALL TO ORDER - REMARKS OF CHAIRMAN. The meeting was called to order at 4:00 p.m. on June 18, 1965, by James H. Berge, M.D., Chairman.

II. APPROVAL OF MINUTES OF MAY 22, 1965. The minutes, as submitted, were amended so as to add the word "fully" between the words "not" and "consistent" in the third line on the second page.

On motion duly made, seconded and carried, the minutes of the meeting of May 22, 1965, were approved as amended.

8 1 2 1 7 0 5 2 7 9

CX 538B

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 538B
In the matter of: AMA
Date 10/13/77 Witness
Reporter T.C.
By

IV. CONSIDERATION OF POSTPAYMENT PLANS FOR PAYMENT OF MEDICAL SERVICES. The Council met with the Council on Medical Service to discuss this subject. Larry Mack, Executive Vice President of Medi-Card, Inc., and Joseph Zimring, M.D., Chairman of the Committee on Questions of Ethics of the Medical Society of the State of New York, appeared before the joint meeting.

Mr. Mack explained the operation of Medi-Card. Doctor Zimring advised the Councils that his Society felt it would be unethical for physicians to use credit cards for the post-payment of medical care.

Following this meeting, the Judicial Council agreed upon the following statement:

CX 538 BC

p3

PROGRAMS FOR FINANCING MEDICAL CARE

In 1934 the House of Delegates declared that "One of the strongest holds of the profession on public approbation and support has been the age old professional ideal of medical service to all, whether able to pay or not. That ideal is basic in our ethics."

The medical profession cannot dictate to patients how they shall finance their medical bills. The medical profession must oppose any prepayment or postpayment program that might result in advertising or solicitation of patients by physicians, profit to the physician for other than professional services, exploitation of the patient, or unnecessary increase in the cost of medical care.

Any proposed program for financing medical care, or parts of medical care, should be judged by the above criteria.

The Council agreed that the opinion would be inserted following opinion 31 on page 28 of Opinions and Reports provided it is approved by the Council on Medical Service.

FEDERAL TRADE COMMISSION
File No. 4064 Commission
Investigational Exhibit No. 538C
In the matter of: AMA
Date 10/3/77 Witness
Reporter T.P.
By GM

Ex #19, p. 1.

CX 537A

JUDICIAL COUNCIL

AMERICAN MEDICAL ASSOCIATION

MINUTES OF MEETING, OCTOBER 1, 1965

CHICAGO, ILLINOIS

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 537
In the matter of: AMA
Date 10/13/77 Witness —
Reporter T.P.
By CM

The Judicial Council of the American Medical Association held a regular meeting on October 1, 1965 in the Palmer House, Chicago, Illinois. Present were James H. Berge, M.D., Chairman; E. G. Shelley, M.D., Charles C. Smeltzer, M.D., Robertson Ward, M.D. and Walter H. Judd, M.D., members; H. Doyl Taylor, Acting Secretary; Miss Betty Jane Anderson and Mr. Stanton S. West, Staff Attorneys, Department of Medical Ethics; Mr. A. M. Edwards, Field Service Representative; Rosemary Calcaterra and Elsa Congiu, Recorders.

A. CALL TO ORDER - REMARKS OF CHAIRMAN. The meeting was called to order at 9:00 a.m. on October 1, 1965 by James H. Berge, M.D., Chairman.

B. APPROVAL OF MINUTES OF JUNE 18-19, 1965 AND JUNE 24, 1965. The minutes, as submitted, were amended by changing the word "was" to "is" and the word "all right" to "acceptable" on page 5 under Item VII, line 1.

On motion duly made, seconded and carried, the minutes of the meetings of June 18-19, 1965 and June 24, 1965 were approved as amended.

CX 537B

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 537B
In the matter of: AMA
Date 10/13/77 Witness
Reporter T.P.
By LM

G. STATEMENT ON PROGRAMS FOR FINANCING MEDICAL CARE. The Secretary presented a memorandum dated September 27, 1965 addressed to him from Charles C. Edwards, M.D., Secretary of

CX 5378 C

the Council on Medical Service concerning the proposed joint statement of the Judicial Council and the Council on Medical Service on "Programs for Financing Medical Care."

In his memorandum, Doctor Edwards stated that the members of the Council on Medical Service indicated that they would find the Judicial Council's statement acceptable if the words "by the physician" were inserted in the last paragraph to avoid the connotation that the AMA would judge prepayment or post-payment programs. As revised, the statement would read:

> "In 1934 the House of Delegates declared that 'One of the strongest holds of the profession on public appropriation and support has been the age-old professional ideal of medical service to all, whether able to pay or not. That ideal is basic in our ethics.'
>
> "The medical profession cannot dictate to patients how they shall finance their medical bills. The medical profession must oppose any prepayment or postpayment program that might result in advertising or solicitation of patients by physicians, profit to the physician for other than professional services, exploitation of the patient, or unnecessary increase in the cost of medical care.
>
> "Any proposed program for financing medical care, or parts of medical care, should be judged by the physician in light of the above criteria."

FEDERAL TRADE COMMISSION
File No. ____ Commission
Investigational Exhibit No. ____
In the matter of ____
Date ____ Witness ____
Reporter ____
By ____

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 537C
In the matter of AMA
Date 10/15/54 Witness —
Reporter T.P.
By L.M.

05213

CX 537 D

p.4

It was agreed by members of the Council that this joint statement would be submitted to the House of Delegates in a supplementary report at the Clinical Convention in November, 1965.

FEDERAL TRADE COMMISSION
File No. 9064 Commission Investigational Exhibit No. 537D
In the matter of AMA
Date 10/13/65 Witness
Reporter T. P.
By Gm

8102253214

-05129

JUL 7 1975

Ex # 00, p 1

EX 673 A

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 751-6000 • TWX 910 221 0300

OFFICE OF THE GENERAL COUNSEL
BERNARD D. HIRSH
General Counsel
DEPARTMENT OF MEDICAL ETHICS
EDWIN J. HOLMAN
Director

July 2, 1975

William West, M.D.
Executive Secretary
The New Haven County Medical Association
362 Whitney Avenue
New Haven, Connecticut 06511

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 673A
In the matter of: AMA
Date 6/24/77 Witness
Reporter E.C.
By M.K.

Dear Doctor West:

Your letter of June 23 is at hand. You say that you note in the yellow pages an increasing tendency for physicians to double list under a group name and under the individual's name or to double list by specialty and alphabeltically. You ask for specific guidelines in these areas.

I am enclosing herewith Guidelines for Telephone Directory Listings drafted by AMA's Judicial Council and adopted by the AMA House of Delegates. You are experiencing the same "problems" in your community that other medical societies are experiencing. Physicians are using multiple listing or insisting upon special classifications for one reason or another. The AMA Judicial Council is of the opinion that the county medical society, more than ever before, must assume a strong leadership role and insist that the guidelines be followed for the benefit of the public and the profession. The guidelines permit this. They conclude "the county medical society must ascertain local community needs and through a well thought out program serve those needs. It is incumbent on the county society to implement these guidelines for the local medical community."

If I may be of further assistance, in this connection or in some other way, please do not hesitate to get in touch with me.

Sincerely,

Edwin J. Holman

EJH:saj

1305

3102736215

CX 673 B

TELEPHONE DIRECTORY LISTINGS

for

Physicians and Surgeons

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 673B
In the matter of: AMA
Date 6/14/67 Witness
Reporter R.C.
By M.C.

Guidelines
Prepared by
Judicial Council
American Medical Association

June 1966

1307

CX673C

GUIDELINES
for
TELEPHONE DIRECTORY LISTINGS

Prepared by
Judicial Council
American Medical Association

June 1966

The public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and the like. The physician may ethically furnish this information through the accepted local media of communications which are open to all physicians on like conditions.

To the extent that such information may appear in telephone directories, the Judicial Council is of the opinion that guidelines are desirable to assist the public, to maintain the dignity of the medical profession and to assure uniformity of practice from community to community.

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 673C
In the matter of: AMA
Date 4/4/72 Witness
Reporter E.L.
mlc

CX 673 E

V

The name of a physician should not be listed in a telephone directory of a locality where he does not have an office, residence, or hospital affiliation. An exception to this general guide may be necessary in larger metropolitan areas because of the growth pattern of the community or because telephone directories are subdivided according to geographic areas. Under these conditions a physician's name, to be properly identified for community services, may appear in a directory of a locality in which he does not have an office, residence or hospital affiliation in accordance with specific guidelines established by the local medical society or societies in these areas.

VI

In larger metropolitan areas listings of physicians according to a locality descriptive of their practice areas is not objectionable if the practice is approved by the county medical society and serves the public good. (Exhibit C)

VII

It is permissible to list answering service numbers for the convenience of patients. (Exhibits A2 & B2)

VIII

It is commendable for the county medical society to utilize a display or box advertisement to list its address, office hours, and services for the public, e.g. emergency medical service and assistance in selecting a physician. (Exhibit D)

The county medical society, in the last analysis, must ascertain local community needs and through a well thought-out program serve those needs. It is incumbent on the county medical society to implement these guidelines for the local medical community. With an established program, the county medical society can meet with representatives of the telephone company and develop an acceptable program of public service.

FEDERAL TRADE COMMISSION
File No. 9064 Commission Investigational Exhibit No. 673
In the matter of: AMA
Date 6/14/72 Witness
Reporter E.C.
By mik.

1810

CX 673 D

THE FOLLOWING SUGGESTIONS FOR TELEPHONE LISTINGS HAVE BEEN DRAFTED FOR THE GUIDANCE OF PHYSICIANS AND COUNTY MEDICAL SOCIETIES:

FEDERAL TRADE COMMISSION
File No. 9064
Exhibit No. 673 D
In the matter of AMA
Date 6/4/71
Rep. F.C.
By MLK

I

In telephone directory listings of doctors of medicine it is preferable for the physician's name to be followed by the abbreviation "M.D."

The use of the abbreviation "Dr." preceding the name is misleading. It could refer to a doctor of dentistry, doctor of osteopathy, doctor of philosophy, doctor of divinity, etc. The use of the abbreviation "Phys." may also be confusing for it can refer to doctors of osteopathy. (Exhibits A1, A3, A4, & A5)

II

Physicians' names should be listed alphabetically in the classified section of the telephone directory. It is not objectionable in this alphabetical listing to follow the physician's name with the simple statement "practice limited to_____." (Exhibit B1)

If, in a particular community the county medical society believes it would be helpful to the public to follow the alphabetical listing with a listing of physicians by type of practice, only those specialties and subspecialties recognized by the American Medical Association and the Advisory Board for Medical Specialties should be used. Only those physicians who are Board certified or who limit their practice exclusively to a specialty should list themselves in the designated field.

No physician should be permitted to list himself under more than two such specialties or subspecialties.

Multiple listings and specialty listings by those not certified or who do not limit their practice to the specialty can be a form of self-aggrandizement. They can also confuse the patient who should not be expected to diagnose his own condition and determine the specialist he should consult.

III

The size and face of type in the classified section should be uniform.

IV

Display or box advertisements for individual physicians or groups of physicians or for clinics are not in keeping with the dignity of the medical profession and are not recommended.

Exhibit A

CX 673 F

The following examples illustrate telephone diretory listings in the white pages.

A 1. Business Listings

A 2. Alternate Calling Arrangement

A 3. Business Listing Followed by Residence Listing

A 4. Multiple Office Listings

A 5. Complete White Pages Listing Arrangement

Dabbs Geo 818Curtice 836-3131
Dabney Jas H MD 32622 241-6138
Dagner Ray W 5670VerPl 693-6615
Daigneault Marion A 2053Fairfa ... 475-1893
Dailey Gordon 1101DeWitt 877-5427
Dailey Herbert A 2004 N Cove ... 479-6329
Dake Irene B 1048Calhoun 246-1694
Dalton Frank Mrs 2721Drumnd ... 474-4370
Dalton Kenneth C 550 E Florence 693-4917
Dame Wm 1109Camden 691-5993
Dampier Earl 144 N River 878-3350
Daniel Jos A MD 2934Carlsbad .. 472-2131
If No Ans Call 246-3601
Daniel Phyllis 2705 IshaLayeDr .. 531-2713
Darby Luth Church
AirportHwy&Albon 865-4548
Darling Floyd A MD 3939Monroe .. 479-4433
Res 1020Glenn 536-5074
If No Ans Call 246-3601
Darling Franklin B 4222Walker .. 474-6573
Darling Gayle M 3331Pelham .. 531-4127
Darner C E MD 1838Harwd 241-9512
Res 2947Rosewd 244-8421
Datz Geo W 928Prospct 248-3650
Daugherty Gertrude 1340 W Wdruf 241-5493
Daugherty Gladys 449Dun 246-5586
DAVID H A STUDIOS photogry
2495Collingwd 244-1465
Davis H Eugene 1067Wall 893-3842
Davis H O 4855Monroe 479-1784
Dean Ida B 421 Sumner 242-4285
Deer Shelgon W Jr 1829Wayne .. 385-3469
Dees Henry 561 Normd 241-7785
Delinger Walter 4679 Sabalia .. 882-6114
Dement Wm R 2332Isabel 472-3583
Denmark Wm T MD
1614 S Byrne 882-6618
2140 Scotwd 242-9495
Res 3531 Secor 536-0790
Denner C L 2237Evrgn 536-4257
Denner Clarence 2111Brancaster .. 536-2809
Derdiger Don 1848Georgia 472-8021
Desatner Jas W atty 2018g 241-5171
Res 5317Jackman 475-2227
Desther Louise 2664LetchworthPkwy 472-3265
Deutsch Robt K consltnt
SecurityBg 244-7285
Deutsch W C 5035Benet 479-8714
Deutsch Wm R 3545CamilleDr 382-3944
De Vanna Harold A MD SecorHolen 241-4830
Res 3033Wiltshir 536-7444
Family Teleph 3033Wiltshir .. 536-2337
If No Ans Call 246-3601
DIAMOND SHIPPERS BOX CO
350Morris 243-9246
Dober Corp 129 Summit 242-2319
Dock John F 313 Tyrone 246-0332
DOCTORS AUDTNG SERV
GardnerBg 255-8400
Dotton Bldg Parker&Monroe 246-9814
Duerr Raymond 5740LaVargeDr 382-6980
Durning Jim 1936Brkwd 241-5745
Donahue Fred J 5120Glendale 474-7443
DONALDSON SIGN CO INC
128 13 - 244-4002
Donalson Arthur 1016Turner 536-7856
Donn Jas L 5309Bentbrook 882-6618
Donovan Norman P 4160Bowen ... 474-5308

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 673F
In the matter of: AMA
Date 6/16/77 Witness
Reporter F.C.
By M.F.

1811

CX 673G

The following examples, used in different parts of the country and found to be helpful to the public, are set forth as descriptive of acceptable yellow pages listings

B 1. Description of Practice

B 2. Alternate Calling Arrangement

B 3. Residence Listing Indented Following Office Listing.

B 4. Office Hours

Physicians & Surgeons, M.D.

Anderson Robert C
Practice Limited To Pediatrics
Hours By Appointment Only
347Front 234-1300
If no answer call 226-4400
Baldwin Robt B
Orthopedic Surgery
Telephone Answered Day And Night
MidwayMedArtsBldg 645-7706
Bergen Arnold C
Internal Medicine - By Appointment
236Main 235-5766
Carter Sami G DoctorsBldg 333-2348
If no answer call 339-1411
Cohen Chas J
Skin Diseases.
MedArtsBldg 332-2457
Hall Edwin H 30W59 753-8430
Harold Joseph A MedArtsBldg 333-1477
Heppler L E DoctorsBldg 332-8019
Hick B J
Practice Limited To Surgery
Office Hours Daily Except Wed
Shaker Medical Center
11710Shaker 991-1123
If no answer call 464-1337
Johnston Jerome W
Internal Medicine, Telephone Answered Day & Night.
MedArtsBldg 335-5125
Klingman David H MedArtsBldg .. 338-4335
Larson Richard B
General Practice
DoctorsBldg 333-0811
Loper Harrison H MedArtsBldg .. 339-7695
MacMurray Leo W
Ear, Nose, Throat
MedArtsBldg 333-6451
Putnam Benj A MedArtsBldg .. 332-3307
Residence 7854S 685-2241
Rathbone Leonard W
Psychiatrist
Phys&SurgBldg 335-3322
Rothschild Meyer Z DoctorsBldg .. 338-7697
Sand John K
Plastic And Reconstructive Surgery.
Telephone Answered Day-Night
MedArtsBldg 333-5221
Smith Bernard M e3W95 645-3251
Streich Richard J
Practice Limited To Urology
Office Hours 2-5 Except Wed
35Main 235-7761
Todd G G & Alberts G T
3145HennAv 827-4007
If no answer call 339-1411
West Fredk H 5201BryantAvN 521-6688
If no answer call
Wolter Fredk H 521-8057
Wilson Philip J 3819WBdway 533-2534
Young G W
Surgery.
Main Ofc MarcBkBldg 333-0494
North Ofc 710WBdway 521-4719
Southdale Ofc
SouthdaleMedBldg 333-0494
Zynda Donald L
Columbia Park Clinic
3620Central AvNE 781-3494
If no answer call 339-1411

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 673G
In the matter of: AMA
Date 6/14/77 Witness
Reporter E.C.
By MIC.

Exhibit C

CX673H

The following examples illustrate Locality Listings which follow the main yellow pages heading in some metropolitan areas

Physicians & Surgeons, M.D.

Grouped by Location

Locality Captions

CAMDEN

Rogers David
Infants, Children & Adolescents
BurchBldg 521-3656

COLUMBIA HEIGHTS

Alberts Gary D
Telephone Answered Day And Night
3827CentralAvNE 788-9091
Goode T J 4555UnivAvNE 560-7250
If no answer call 339-1411
Murphy P C 4555UnivAvNE 560-7250
If no answer call 339-1411

CRYSTAL

Johnson Richard L
Practice Limited To Gynecology
Telephone Answered Day & Night
5311-36AvN 529-2445
Olsen O C
Practice Limited To Obstetrics
5617HampshireAvN 527-2788
Smith Bernard M 63W95 645-3251
Residence 78545 665-2241
Thompson James C
Practice Limited To Women's Diseases
5617HampshireAvN 537-2788

EDINA

Adams Chas J
Skin Diseases
SouthdaleMedBldg 927-7793
Bender Leon H SouthdaleMedBldg 920-2761
Gaucher Robert A
SouthdaleMedBldg 927-7345
Morrison E F
General Practice
Day And Night
SouthdaleMedBldg 927-7095
Smith Wm B Jr
Telephone Answered Day And Night
SouthdaleMedBldg 920-1644
Stench Richard J
Practice Limited To Urology
Office Hours 2-5 Except Wed
35WMain 235-7761
Vemer Keith
Diseases Of The Eye
3939A50 920-2731
If no answer call 890-1550

FEDERAL TRADE COMMISSION
File No. 3064 Commission
Investigational Exhibit No. 673H
In the matter of AMA
Date 6/14/77 Witness
Reporter E.C.
By MIK.

1613

Ads that have been used by county medical societies to list their address, office hours and services for the public

CX 673 I

NEED A PHYSICIAN?

CALL DAY OR NIGHT

933-3010

SPONSORED BY

Montgomery County Medical Society, Inc.

A PUBLIC SERVICE TO PERSONS WISHING TO LOCATE A FAMILY PHYSICIAN OR SPECIALIST THIS IS THE ONLY TELEPHONE NUMBER THAT WILL REACH THE DOCTORS SOCIETY'S ANSWERING SERVICE

EMERGENCY MEDICAL SERVICE

Medical Emergency

If You Cannot Locate Your Family Physician

Call 562-0918

Any Hour-Day Or Night

REMAIN NEAR THE PHONE & EMERGENCY MEDICAL SERVICE OPERATOR WILL MAKE EVERY EFFORT TO LOCATE A PHYSICIAN AND HAVE HIM CALL YOU BACK

This Is A Public Service Maintained By The Doctors Of The New Haven Medical Association

Call The MEDICAL BUREAU Of DC

For Physician Information Or Help In Selecting Physicians

CALL 223-2200

Operated For The Convenience Of The Public By

THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

IF YOU NEED A FAMILY DOCTOR OR SPECIALIST WHO IS A MEMBER OF THE AMERICAN MEDICAL ASSOCIATION AND ITS LOCAL BRANCH

Call

DAY OR NIGHT

SAN FRANCISCO MEDICAL SOCIETY

567-6230

WE SUGGEST THAT YOU ARRANGE WHILE YOU ARE WELL FOR A PERSONAL PHYSICIAN WHO WILL CARE FOR YOU AND YOUR FAMILY AT ALL TIMES

250 MASONIC AVE. • SAN FRANCISCO, 94118

TO LOCATE

YOUR DOCTOR (M.D.)

Or To Secure

A Physician (M.D.)—Day or Night

CALL THE

MEDICAL SOCIETY

271-4131

OPERATED IN THE PUBLIC INTEREST BY THE MEDICAL SOCIETY OF MILWAUKEE COUNTY

FEDERAL TRADE COMMISSION

File No. 906-4 Commission PHYSICIANS' SERVICE

Investigational Exhibit No. 673 I

In the matter of AMA

Date 6/11/70 Witness

Reported E

By

191

8 1 7 0 2 3 7 2 2 3

AMERICAN MEDICAL POLITICAL ACTION COMMITTEES

535 North Michigan Avenue, Chicago, Illinois 60611. AREA CODE 312 644-1585

Ex. 21, p.1

November 22 1968

CX1205A

Edwin J. Holman, Esq.
Director
Department of Medical Ethics

Dear Ed:

On November 21, 1968, I attended an Executive Council meeting of the Connecticut Medical Society. In the course of the meeting, a question arose as to a resolution on chiropractors and physicians. Below is a copy of the resolution.

REPORT - JUDICIAL COMMITTEE RE CHIROPRACTORS

At a meeting of the Judicial Committee on November 13,1968, two rulings on the ethics of physician-chiropractor relations were adopted unanimously as follows:

(a) It is unethical for a Doctor of Medicine to refer a patient to a chiropractor.

(b) It is unethical for any Doctor of Medicine who receives a patient referred to him by a chiropractor to consider the referring chiropractor as other than a lay person.

My purpose in sending this to you is that the Council was having a difficult time with section b of the resolution.

It was recommended that words should be put in suggesting that the physician tell the patient that he should not be going to a chiropractor. I think this might have legal implications. I leave this to your expertise.

My point is that Dr. Max Caplan will be at the Clinical meeting and perhaps you can give him some suggestions. I feel you should be aware that you will be asked this. I'd

FEDERAL TRADE COMMISSION
Docket No. 9064 COMMISSION RESPONDENT Exhibit No. 1205A
In the Matter of: A.M.A.
Date 11/21/72 Witness [illegible] Reporter [illegible]

CX 1205 B -)

like to know myself! I'll look for you in Miami to fill you in on what else was said.

It was good to see you recently. Nice to know that some people have stayed on.

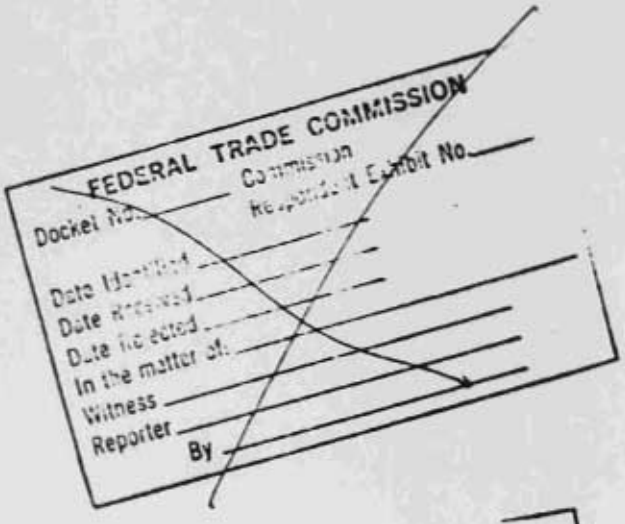
Cordially,

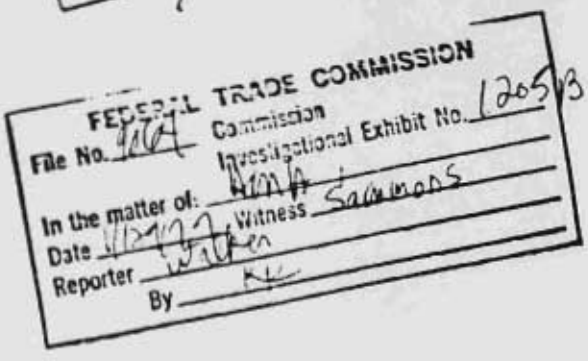
Ed

Edward M. Donelan
Field Representative

EMD:plb

9 1 0 2 1 5 3 9 2 5





Ex. # 22, p. 1
CX1050A

AMERICAN MEDICAL ASSOCIATION

ANNUAL REPORTS

JULY 1, 1972 TO JUNE 30, 1973

Each Division and Department of the AMA was asked to prepare an annual report of its activities from July 1, 1972 to June 30, 1973. These reports contain detailed information regarding the programs and contributions of the Standing Committees of the House as well as the Councils, Committees and Commissions of the Board of Trustees.

The following summary of AMA activities is included in the Delegates Handbook to acquaint the Delegates and Alternate Delegates with the comprehensiveness of the Association's program. No action will be requested of the Delegates other than to accept these reports as information without referral.

Department of Medicine and Religion 2
Office of the General Counsel 2
Center for Health Services Research and Development 6
Division of Scientific Publications 9
Division of Scientific Activities 9
Division of Medical Education 16
Division of Medical Practice 22
Public Affairs Division 32
Communications Division 41
Management Services Division 44
AMA Education and Research Foundation 46

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 1050A
In the matter of: AMA
Date 10-18-77 Witness NOW.E
Reporter TH
By BJ

3100225339226

790 L

CX1050 B

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 1050 B
In the matter of: AMA
Date 10-18-77 Witness NONE
Reporter +H

DEPARTMENT OF MEDICINE AND RELIGION 65

During the year the Board of Trustees discontinued its Committee on Medicine and Religion; however, this action did not indicate reduced interest in the Department and its programs. The Department continues to develop programs that will lead to greater effectiveness in the working relationship between physicians, clergy and chaplains for the benefit of patients and their families. The task is carried on through medical society committees, other medical groups and institutions. The Board has supported the use of consultants to provide staff with special expertise and guidance in future programs. All state committees have maintained their activities.

Four regional workshops were held for state society committee chairmen. These programs provide the chairmen with education, training and an opportunity to share their plans with each other.

The Department provides resource material to state committees that cooperate with seminaries in developing medicine and religion emphases in their courses. The purpose is to help seminarians understand their role in working with physicians in caring for patients. Medical schools are encouraged to include medicine and religion in continuing education programs. Many postgraduate departments of medical schools now offer symposia on medicine and religion.

An increasing number of state societies held interfaith prayer breakfasts at their annual meetings. This trend developed with the first breakfast at AMA's Annual Convention in 1970. The Department works with the National Congressional Committee in planning a seminar for physicians at the time of the Annual National Prayer Breakfast in Washington, D.C.

The Department newsletter continues to be of increasing interest to both physicians and clergy, and its films and exhibits have one of the largest circulations of any at AMA. Staff worked with the American Hospital Association's Committee on Chaplains and the Joint Commission on Accreditation of Hospitals in developing standards for hospital chaplaincy departments.

The Medicine and Religion program during the Annual Convention featured Father Charles Carroll, who spoke on "The Primary Community--State or Family?" John R. Schenken, M.D., gave a special presentation on "The Life of Christ in Art" at the Interfaith Prayer Breakfast.

OFFICE OF THE GENERAL COUNSEL

This report covers the activities of the Office of the General Counsel, the departments under its jurisdiction, and the following Councils and Committees staffed by the Office: Council on Constitution and Bylaws, the Judicial Council, and the National Conference of Representatives of the AMA and ABA.

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The Office continued to function as a source of information on developments in the medicolegal field. Information on such subjects as abortion, blood transfusions, body donations, chiropractic, consent by minors, immunity for peer review committees, malpractice, physician unions, professional corporations, reportable acts and diseases, and many other topics was sent to physicians and organizations on request.

The Office advised the AMA on wage and price control developments. It negotiated the new Group Term Life and Excess Major Medical insurance plans with Provident Life Insurance Company. It maintained liaison with outside counsel in the litigation against AMA regarding Educational Council For Foreign Medical Graduates.

Cease and desist letters were written to many companies and organizations to prevent unauthorized use of the AMA's name or copyrighted materials for promotional purposes.

Council on Constitution and Bylaws: The Council held six meetings during the period and reports were submitted to the House of Delegates at the Annual and Clinical Conventions.

CORPORATE LAW DEPARTMENT

This Department handles all the business law questions of the AMA and AMA-ERF, such as contracts, leases, taxes and insurance. In addition, it advises the membership of general legal developments in the tax area. Among other activities, the Department negotiated contracts with Pennsylvania Medical Society regarding flood relief ERF loans, with two unions covering AMA tradesman employees, with Batelle Labs regarding a long-range planning system for AMA, with Firemans Fund on the Members Disability Insurance program, with Fulfillment Corporation of America regarding mailing AMA subscription publications, with Blue Cross regarding sharing time on AMA computers, and with Gittleman Film Associates, New York, regarding the Today's Health TV pilot. The Department entered AMA as amicus curiae in Williams & Wilkins v. U.S., a case attempting to charge royalties for Xeroxing copyrighted articles in medical journals. It incorporated the National Joint Practice Commission. It successfully petitioned the IRS not to apply retroactively a ruling prohibiting withdrawal of voluntary contributions to Keogh plans. The Department met with the direct mail houses to negotiate a new two-year contract regarding the AMA master physician lists. It met with the legal and tax committees of the Magazine Publishers Association in New York. Legal research memoranda were prepared on such subjects as AMA withdrawal from the World Medical Association, pricing policy of AMA publications, sale of goods at AMA conventions, solicitation of sales of Members Retirement Plan, and tax aspects of a subsidiary "for-profit" corporation.

DEPARTMENT OF INVESTIGATION

The Department continued activities to fight health quackery in general and deal with chiropractic in particular.

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Health Quackery in General: Information was collected and disseminated on all forms of health quackery. Liaison and cooperation with federal, state and local legal and administrative agencies brought action in a number of cases. A few examples of activities include:

1. Liaison was maintained with an ad hoc committee named by the National Institutes of Health to investigate acupuncture. The Department compiled information on legislative actions and opinions issued on acupuncture by state boards of medical examiners and attorneys general. Most opinions held that acupuncture should be performed only by licensed medical practitioners.

2. A do-it-yourself "pap check" kit offered to women in nationwide advertisements was investigated. Action by HEW halted sale of the kits.

3. Information was gathered on claims and promotions by groups headed by laymen who are selling courses in "alpha wave and biofeedback training."

4. Several schemes involving foreign promoters who offered "opportunities" for a fee to American students to receive a medical education and/or obtain a medical "degree" overseas were blocked through cooperation of the Department with the U.S. Postal Inspection Service.

Committee on Quackery: Congress passed an amendment to the Medicare law in October 1972 that added chiropractic services on a limited basis for "manual manipulation of the spine (to correct subluxation demonstrated by x-ray to exist) which he is authorized to perform." The limitation resulted primarily through successful efforts by medicine to obtain reconsideration of amendments that had included a broader provision. Regulations and standards for the new law were announced by HEW in June. While the regulations and standards were being drafted, the Department provided HEW with information and materials pertaining to chiropractic. After announcement of the proposed standards and regulations, the AMA urged reconsideration because a "minimum standard" was set and there was a lack of specificity in the published regulations. The AMA expressed "extreme concern" that the proposed regulations would grant "point-of-entry status" under Medicare to chiropractic services.

The Committee chairman testified in March 1973 before the Advisory Committee on Accreditation and Institutional Eligibility of the U.S. Office of Education, opposing two applications by different chiropractic groups for recognition as the accrediting agency for chiropractic schools. The Office of Education denied both applications, subject to review hearings requested by both chiropractic groups.

The Committee resumed conferences dealing primarily with federal and state legislative problems relating to chiropractic. A poll by mail of state medical societies showed the majority favored resumption of regional conferences rather than national conferences at the time of AMA Conventions. One national conference already scheduled at the 1972 AMA Clinical Convention was well attended.

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A claim published by chiropractors that chiropractic services are required in health maintenance organizations was called to the attention of HEW by the Committee, and an HEW official refuted the claim.

DEPARTMENT OF MEDICAL ETHICS

The Department provides staff support to the Judicial Council. In addition, it works closely with the staffs of state and county medical societies when questions of medical ethics (solicitation of patients, advertising, fee splitting, excessive fees, etc.) or bioethics (clinical investigation, genetic engineering, mercy death/euthanasia, behavior control, test tube babies/ artificial insemination) arise.

The Department also answers inquiries on ethical subjects presented by physicians, the public, governmental departments and the media. It prepared a series of three articles on the Supreme Court opinion on abortion for the "Law and Medicine" section of JAMA. It cooperated with two specialty societies that were drafting supplements to Opinions and Reports of the Judicial Council for their own memberships. A paper on "Group Legal Services to Medical Societies and Their Members" was prepared, and a paper on "The Time Lag Between Advances in Medicine and Law" was presented at the annual meeting of the American Association for the Advancement of Science.

Judicial Council: The Judicial Council held its Fourth National Congress on Medical Ethics in Washington, D.C. The philosophical aspects of ethical issues were emphasized. The Council answered a number of inquiries and completed the 15th annual distribution of Opinions and Reports to all senior medical students. In statements, the Council said that physicians should not withhold signatures on insurance claims forms as a means of collecting unpaid bills and that it is demeaning to the profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises.

LEGAL RESEARCH DEPARTMENT

The Department developed and made available to members and to medical societies a variety of informational and instructional materials. Twenty-four issues of The Citation, the newsletter of the Office of the General Counsel, were published and 52 articles were written or reviewed for the "Law and Medicine" section of JAMA.

Thousands of copies of the 500 items of medicolegal information available from the Office of the General Counsel were distributed. A revised and enlarged edition of the Medicolegal Forms book was published. A third book in the Best of Law and Medicine series was begun.

The Department assisted C. A. Hoffman, M.D., in his work as a member of the HEW Commission on Medical Malpractice, including assistance in the preparation of separate and dissenting statements for publication with the Report of the Commission. It worked with the staff of the Commission in an attempt to improve its studies and prepared a point-by-point analysis and critique of

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the Commission's Report. It provided staff assistance to the planning committee which decided to establish the Medical Liability Commission. The membership of this independent organization is limited to national organizations representing medical care providers.

National Conference of Representatives of AMA and ABA: This Conference covers the activities of the AMA Liaison Committee to the American Bar Association and the ABA Committee to Cooperate with AMA. The Conference met twice. It presented the 1973 National Medicolegal Symposium at Las Vegas, Nev., in March. The Proceedings of this Symposium are being prepared for publication. The site for the 1975 Symposium will again be Las Vegas. The Conference established liaison with the National Conference of Commissioners on Uniform State Laws so that both associations can be kept advised of proposed legislation. In cooperation with the American Hospital Association it assisted in the development of a medicolegal film on hospital safety, titled The Best of Care, produced by Richardson-Merrell.

Ad Hoc Committee on Blood Grouping Tests for Determination of Questions on Disputed Paternity: The Committee, which was appointed to cooperate with the Committee on Paternity of the Section on Family Law of the American Bar Association in the development of a model law, recommended that a compilation of data on blood grouping tests be undertaken by AMA. The compilation is being prepared.

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CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT

The Center for Health Services Research and Development is continuously engaged in conducting and encouraging socioeconomic research on the environment within which medicine is practiced. The Center consists of the Department of Survey Research, the Department of Economic Research, and the Department of Systems Research. The three departments seek to: (1) evaluate experimental health care delivery systems; (2) identify cost-effective models for the financing, organization, and delivery of health services; (3) provide AMA with research reports and data to assist in the formulation of its policies; (4) facilitate participation by medical societies in health services research and development; (5) provide a link between AMA and other sectors of the health services research community; and (6) conduct research on the supply and distribution of health manpower.

Economics of Medical Practice: In June 1973, the Center completed the third year of a research project with the University of Southern California. Early phases concentrated on development of methodologies and collection of data for the comparative evaluation of the economics of alternative forms of medical practice. The two surveys--one of 2,000 group practices and one of 10,000 physicians--completed a data base for purposes of analysis.

Research papers completed or in progress concern factors affecting employment and utilization of allied health personnel; the impact of allied health personnel on productivity of primary medical care; efficient classification of medical practice; effect of the use of allied health personnel on

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the prices of medical services, physicians' incomes and hours worked by physicians; and cost and utilization experiences in prepaid group practice. Preliminary research into the productivity of medical practices was completed. Further effort is underway to extend the study of physician productivity as a means of gaining insight into the relative efficiency of larger scale (group) practices.

Staff is engaged in a joint study with faculty members of the University of Florida. Three projects are progressing: (1) an analysis of physicians' pricing decisions; (2) a study of hours worked by physicians; and (3) non-price rationing by physicians. A paper on pricing was presented at a seminar of the Center for Health Administration Studies, University of Chicago, in May 1973. Another joint study involves Center staff and faculty of the Center for Health Administration Studies at the University of Chicago. This effort focuses on physicians' referral patterns. Data collection has been completed and analysis is underway. A collaborative study with the Rand Corporation analyzes factors affecting the location of physicians in rural and urban areas. This project is funded by HEW.

Public Affairs Research: Staff provided assistance and research support to the AMA representative to the Health Services Industry Committee of the Economic Stabilization Program. Staff assisted in revising AMA's Medicredit proposal and worked on revised cost estimates for that bill. Proposals were submitted to HEW for the development of both a clearinghouse for information on professional standards review organizations and a proposed academy to train PSRO administrators.

Health Manpower Research: The Center is engaged in nine major health research projects. Among these are:

A project on comprehensive health manpower strategy, focusing on the supply and distribution of physicians, was initiated at the request of the HEW Secretary. A report to be published in the summer of 1973 will include research papers on the measurement of the supply of physicians' services, distribution of physicians by both geographic and specialty characteristics and the supply of foreign medical graduates.

A long-term study of physicians' specialty and practice-site decisions will make full use of AMA's current and historical data on physicians' locational, professional, and practice characteristics. The analysis will focus on changes in physician characteristics over time, permitting the identification of determinants of trends in a variety of aspects of medical practice. Results of this analysis will provide sound statistics for the formulation of future public policy.

Research Clearinghouse: At the 1971 Clinical Convention the House of Delegates directed the Center to establish and maintain a central clearinghouse for information on research, development, and demonstration projects being conducted by medical societies. Examples of the types of projects that are included in the clearinghouse are: HMO planning and development programs; Experimental Medical Care Review Organization projects; research projects on such issues as medical education, quality of care, health care costs, and health manpower. Some benefits already resulting are:

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1. Societies studying similar problems or issues have been identified and brought together to share information.

2. An annual report of the research and development activities of organized medicine is prepared and disseminated to all participants in the clearinghouse and to selected private medical organizations.

3. Organized medicine is provided with the latest research findings for policy making and legislative efforts.

To ascertain what research and development activity was being conducted and planned by medical societies, the Center surveyed executive officers of state, county and specialty medical societies. Responses indicate that continuation of this activity is desired.

Data Requests: Each year the Center responds to numerous requests for information, usually in the form of data from the AMA Physician Masterfile. These requests are carefully screened. The integrity of the AMA data base and protection of the individual physician are paramount considerations. In supplying data, the Center collaborated with the National Medical Association on a project to identify all black physicians in the U.S.; worked with Columbia University researchers who are doing a major study of physicians' attitudes on various aspects of the health delivery system; assisted the National Center for Health Statistics in selecting a sample for the National Ambulatory Medical Care Survey; worked with the National Health Service Corps in developing procedures for determining areas which have a shortage of physicians.

Updating the AMA Data Base: The Center conducted the triennial census of the entire physician population to obtain information for the "current activity, specialty and employer" sections of the AMA Physician Masterfile; maintained quality control and review of the weekly update procedures for assuring that information on the AMA Physician Masterfile is current; conducted the AMA-Rand Survey of 1965 Medical School Graduates, a major survey of all 1965 graduates of American medical schools to obtain information on the location choice of young physicians; conducted the American Medical News readership survey and prepared a market analysis of the survey; analyzed the Weiskotten Survey of 1960 Medical Graduates of American Medical Schools; conducted the second AMA Membership Opinion Survey under the direction of the AMA Committee on Membership Opinion Polls; conducted a survey of U.S. jails to collect data on the health facilities and services available; conducted the eighth Periodic Survey of Physicians to collect information on practice characteristics of physicians, including hours worked, volume of patient visits, income, expenses, fees, employment of allied health personnel; designed a fourth survey of group practice that will become the initial data for the newly designed permanent data file on group practice; conducted a survey to collect information on frequency of prescribing certain types of drugs, physicians' opinions of certain information sources, and other data related to prescribing patterns of physicians.

AMA National Advisory Committee on Physician Data: This committee was established to assist the Center in maintaining and improving the AMA data base. The committee includes representatives from major organizations concerned with physician data, including government agencies, the academic community, and various medical associations and other health related organizations.

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Publications: The Center published the following volumes: Distribution of Physicians in the U.S., 1971; 1973 Reference Data on Socioeconomic Issues of Health; 1973 Reference Data on the Profile of Medical Practice; Towards a Comprehensive Health Manpower Strategy; 1973 Opinion Survey of the AMA Membership; Medical Care in U.S. Jails--A 1972 AMA Survey. Numerous articles and reports also were published.

DIVISION OF SCIENTIFIC PUBLICATIONS

The Division continued its efforts to make The Journal of the American Medcal Association and the 10 AMA specialty journals eminent periodicals in the medical field, both in content and style.

Two supplements to JAMA were published. For the first time continuing education courses appeared in supplementary form (August 13, 1972) rather than in the body of The Journal. The Primer on the Rheumatic Diseases, a supplement to The Journal of April 30, 1973, was acclaimed as a valuable contribution to the literature.

Special numbers of JAMA published were: Olympic Issue, August 28, 1972; Clinical Convention Number, October 16, 1972; Education Number, November 20, 1972; Book Number, April 2, 1973; Annual Convention Number, April 16, 1973.

In June 1973 the Board of Trustees announced that Robert H. Moser, M.D., will assume the editorship of JAMA and become director of the Division of Scientific Publications on October 1, 1973. Hugh H. Hussey, M.D., will become editor emeritus and will continue in full-time employment.

SPECIALTY JOURNALS

Eight of the ten specialty journals (Archives of Dermatology and Archives of Internal Medicine excepted) now have covers which are uniform in style. The objective is to establish the appearance of a family of journals. Different colors are assigned to specific journals.

DIVISION OF SCIENTIFIC ACTIVITIES

The Division of Scientific Activities comprises seven departments and the Division Office. It is responsible for staffing four councils and ten committees of the Association.

The Division Office provided staff services for the following: The Advisory Committee on Medical Science, the Advisory Committee on Cancer, the Committee on Hypertension, the Committee on Maternal and Child Care, the Committee on Transfusion and Transplantation, and the Committee on Human Sexuality.

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Advisory Committee on Medical Science: This Committee considered the problems of AMA scientific journals and proposed organizational and operational changes to improve scientific communication in AMA media.

Advisory Committee on Cancer: This Committee closely followed the activities of the National Cancer Institute which was established under the National Cancer Act of 1971. The Committee advised the Board of Trustees on tumor registries and supported the development of a new book on cancer based on a series of articles published in JAMA under the heading "Current Concepts in Cancer Therapy." The book is being prepared for publication.

Committee on Hypertension: A report to the Board of Trustees, subsequently endorsed by the House of Delegates, was initiated to establish policy recommendations to all physicians on the discovery and therapy of hypertension. To facilitate implementation of the policy, the Committee authored for JAMA a scientific article on the office management of hypertension. The Committee maintained close liaison with the national effort against hypertension led by the U.S. Department of Health, Education and Welfare.

Committee on Maternal and Child Care: This Committee advised the Board of Trustees on a variety of matters including abortion, smallpox immunization, and vaccination for rubella. It has participated in an ad hoc committee effort to establish guidelines for the implementation of Report J (C-71) regarding centralized perinatal intensive care. Also participating were the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Physicians, and the National Foundation-March of Dimes.

Committee on Transfusion and Transplantation: This Committee advised the Board on federal activities relating to blood banking and transfusion facilities and services. It initiated a report which, after approval by the House of Delegates, was presented to the federal study panel group engaged in developing a national blood policy. A revised edition of General Principles of Blood Transfusion was published, and the Committee completed its work on a national survey of blood banking activities.

Committee on Human Sexuality: This Committee published a book titled Human Sexuality. The first edition was sold out in a short time and a revised edition was developed for the second printing. The Committee was discharged in June 1973.

DEPARTMENT OF SCIENTIFIC ASSEMBLY

Clinical Convention, Cincinnati, November 26-29, 1972: There were 18 half-day sessions, with three presented simultaneously. Physician registration was 2,214, almost 700 lower than last year, an indication that physicians may prefer a warmer climate for December meetings. Once again, the three postgraduate courses were sold out. The 13 luncheon round-tables also were well attended.

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Annual Convention, New York, June 23-27, 1973: Physician registration was 8,756. There were 66 half-day sessions developed by the 26 Section Councils. A highlight of the program was a Symposium on Acupuncture, featuring a film from the People's Republic of China and a panel of experts. The reduced attendance at some sessions reflected the lower total physician registration as well as the separation of meeting rooms from the Coliseum. Because of strong physician interest in continuing education, as demonstrated by full attendance at postgraduate courses during previous conventions, the number of courses was increased to 15. Approximately 1,100 physicians registered for courses presented by the Council, and five courses were sold out.

The Scientific Awards Dinner was addressed by Edward H. Rynearson, M.D., emeritus, Mayo Graduate School of Medicine. The Scientific Achievement Award was presented to Edith Hinkley Quimby, Sc.D., and the Distinguished Service Award was presented to George Hoyt Whipple, M.D. The Citation of a Layman for Distinguished Service Award was presented to Leslie Townes (Rob) Hope at the opening session of the House of Delegates, instead of at the Awards Dinner, because Mr. Hope had a previous commitment on that date.

Two new Section Councils have been added: Cardiovascular Disease and Plastic and Reconstructive Surgery. One step was removed to facilitate the organization of new Section Councils. It is no longer necessary for the permanent Section Councils to review the final petition submitted by the sponsoring organization of a new Section Council. This will eliminate a second vote and save at least six months' time.

Scientific Exhibits: New York was the site of the first AMA-sponsored self-evaluation area at an Annual Convention. New technology for self-evaluation was demonstrated. Corporate-educational exhibits were incorporated in both the Annual and Clinical Conventions with good attendance shown in these areas. Special exhibits initiated by the Council on patient-management problems were well received.

Medical Motion Pictures and Television: Motion Picture Symposiums on Infertility and on the Treatment of Breast Cancer were the best-attended events on the film programs at the conventions. Staff assisted in selecting films for international and domestic festivals and aided other medical groups in planning motion picture programs. Staff processed 5,500 requests for information about films on specific subjects or for general film information. Almost 22,000 films were distributed by the film library to hospitals, medical schools and medical societies.

DEPARTMENT OF ENVIRONMENTAL, PUBLIC, AND OCCUPATIONAL HEALTH

The Department of Environmental, Public, and Occupational Health continued its combined activities in these related fields and provided staff for the newly named Council on Environmental, Occupational, and Public Health.

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Environmental Health: Liaison was maintained with the Environmental Protection Agency, the Council on Environmental Quality, other governmental agencies and non-governmental associations, and particularly with the Public Health Service Center for Disease Control.

The Tenth Annual Congress on Environmental Health, held in Chicago in April, featured "Energy, the Environment, and Human Health." The papers presented at this meeting will be published in book form by a commercial publisher. The biennial Air Pollution Medical Research Conference was held in Chicago in October 1972.

By action of the Board of Trustees, the Council on Environmental and Public Health was given added responsibilities in the field of occupational medicine and was re-designated the Council on Environmental, Occupational, and Public Health. The Council held the last two of a series of environmental and public health planning regional meetings for representatives from medical societies, state health departments, state environmental protection agencies, and regional and federal governmental agencies. The Council and the Department cooperated with the Union of Medical Societies of Yugoslavia in developing the program for an International Conference on Environmental Health in Primosten, Yugoslavia, in October 1973.

The Department continues to publish a monthly newsletter, Environmental and Public Health News, for distribution to medical societies, physicians and allied health professionals. Physician's Guides to Pollution (air, water, noise and odor) were published.

Occupational Health: The former Council on Occupational Health sponsored its 32nd AMA Congress on Occupational Health in Chicago in September 1972. Two monographs, "Occupational Dermatoses" and "Health Hazards in Farming and Gardening," were published under the direction of the former Council's Committee on Occupational Toxicology. The Council also published revisions of "Guide to the Development of an Industrial Medical Records System" and "Guide to the Significance of Occupational Exposure Limits."

Although the Board of Trustees terminated the Council on Occupational Health and its three committees (Occupational Toxicology, Aerospace Medicine, and Mental Health in Industry) in October 1972, programs in occupational health are continuing under the re-designated Council on Environmental, Occupational, and Public Health. The 33rd AMA Congress on Occupational Health is scheduled for Philadelphia on September 17-18, 1973.

AMA consultants, ad hoc committees, and staff are assisting the National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration in toxicology-standards development, record keeping, and advice on medical services under the Occupational Safety and Health Act.

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DEPARTMENT OF DRUGS

The staff of the Department was reorganized and consolidated following the termination of the Council on Drugs. Staff effort was devoted principally to completing the second edition of AMA Drug Evaluations. Contractural arrangements were made for publication by Publishing Science Group, Inc., Acton, Mass.

Departmental publications in JAMA included three monographs on new drugs, five editorials, and one statement. The nomenclature section published 12 listings of new nonproprietary names and two new editions of the nomenclature print-out.

The Department sponsored a conference attended by representatives of the FDA and 15 major medical organizations to consider alleged overutilization of antibiotics; appropriate follow-up studies are underway. Staff worked closely with the Legislative Department in preparing AMA testimony and responses to proposed FDA rule-making and regulations.

Liaison was maintained with many governmental agencies and medical organizations. Staff answered 5,000 inquiries from physicians and the public, mailed 37,000 reprints and pamphlets, and staffed 11 exhibits at scientific meetings.

Committee on Cutaneous Health and Cosmetics: The Committee met twice. A significant portion of both meetings was devoted to discussions of proposed legislation and regulations dealing with the safety of cosmetic products. The Committee sponsored a Symposium on Environment and the Skin in Cincinnati and a Conference on Hair Growth in Chicago. Committee members and staff gave eight talks to various groups and supplied data for a large number of magazine and newspaper articles. A new public exhibit on acne was constructed. Four scientific articles and two new pamphlets were published.

DEPARTMENT OF FOODS AND NUTRITION

Concerned about potential hazards to health, the Council on Foods and Nutrition published a detailed critique of low carbohydrate ketogenic weight reduction regimens and, in particular, the book Dr. Atkins' Diet Revolution.

The Goldberger Award in Clinical Nutrition was given to Clement Finch, M.D., for his outstanding contributions in the research of hematology, iron metabolism, biophysics and clinical pathology. Fifteen medical students were awarded research fellowships in honor of the Goldberger Award recipient. AMA Lectures in Medical Sciences were given at 84 colleges by 17 lecturers. This program presents AMA on campus to inform the audience of current concepts in the medical sciences and to stimulate careers in the health professions.

The Council's Subcommittee on Total Parenteral Nutrition, which was organized to study and evaluate the safety and composition of the TPN solutions

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and delivery systems, developed recommendations for the nutrient composition of large-volume parenteral solutions that is the basis of FDA regulations. A resource conference was held on the technical and clinical aspects of intravascular catheters and related devices.

The Council, with the AMA Food Industry Liaison Committee, sponsored a resource Conference on the Physicians' Guide to Processed Foods which provided an opportunity for physicians and industry representatives to discuss current concepts in clinical nutrition, processed food, and the responsibilities of both physicians and industry in nutrition. A Symposium on Fats and Carbohydrates in Processed Foods is scheduled for October. The Council evaluated the newer techniques of food processing and published a definitive monograph with recommendations for safe and effective management of processing problems.

Five books based on recent conferences are being published. Audiotape cassettes of a number of Council symposia have been completed, as well as a clinical teaching videotape-film on Absorption and Digestion: Normal and Abnormal. A pilot community nutrition education program at the Daniel Hale Williams Health Center in Chicago has been underway since the first of the year. Plans are being developed for the Western Hemisphere Nutrition Congress IV in Florida next year.

OFFICE OF CURRENT MEDICAL TERMINOLOGY

The Office of Current Medical Terminology, in cooperation with the Division of Medical Practice and consultants from specialty societies, and under the direction of an editorial board, produced the third edition of Current Procedural Terminology. This edition includes approximately 500 new terms and related definitions for "new" procedures, an expanded index, and a new format. CPT utilizes a five-digit coding system and is computer oriented to facilitate a variety of statistical applications, including peer review.

Staff has begun work on the fifth edition of Current Medical Information and Terminology, which will include many new terms and definitions of diseases and conditions. CMIT employs random numbers for coding its entries. The fifth edition will provide code numbers for symptoms, which will allow reporting for therapy in cases where a final diagnosis has not been determined.

DEPARTMENT OF MENTAL HEALTH

Council on Mental Health: The theme of the 19th Annual Conference of State Mental Health Representatives, held in April, was the right to treatment of patients who are involuntarily committed.

As part of its commitment to monitor the comprehensive community mental health centers program, the Council presented a progress report to the Board of Trustees outlining some of the major problems, such as staffing, funding and community participation.

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The Council's statement on physicians with psychiatric disorders was adopted by the House of Delegates at its 1972 Clinical Convention. A revision of the Handbook on Mental Retardation is in progress.

Committee on Alcoholism and Drug Dependence: The Committee advised the FDA in the development of new regulations on the use of methadone. The Committee and the FDA, with the assistance of the government's Special Action Office for Drug Abuse Prevention, issued a series of 24 questions and answers on the methadone regulations, seeking to clarify some of the provisions. This clarification was sent to state and county medical society executives, members of state medical society mental health and drug abuse committees, state medical society journal editors, and directors of methadone treatment programs.

Testimony was given on barbiturate abuse before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare. A Conference on Medical Complications of Drug Abuse, held under AMA sponsorship in December, highlighted non-psychiatric sequelae of drug-taking and the relationship of drug abuse to disease.

Council and Committee representatives and staff took an active part in two international drug abuse research projects--the Japan-United States Cooperative Science Program on Drug Abuse Research and a bilateral exchange on drug abuse initiated at the request of the President of Mexico.

The Department wrote to the deans and heads of several departments of all U.S. medical schools urging that instruction on alcoholism be incorporated in the curriculum. Accompanying the letter was a reprint of the Council and Committee statement "Medical School Education on Abuse of Alcohol and Other Psychotropic Drugs," published in the March 27, 1972, issue of JAMA.

DEPARTMENT OF HEALTH EDUCATION

Major areas of Department activity are health education of the public, school and college health, safety education and administration, medical aspects of sports, physical fitness, automotive safety and voluntary health agencies.

Staff answered nearly 50,000 requests for information from the public and 10,000 inquiries from health professionals. Updated publications include Birth Control, Blood Tests, Allergies and Why Girls Menstruate. Ten issues of Health Education Service for Schools and Colleges (circulation 20,000) and 12 issues of More Life for Your Years (circulation 44,000) were published. A VD Education Kit was prepared for physicians, health educators and civic groups.

Committee on the Medical Aspects of Sports: The 14th National Conference on the Medical Aspects of Sports was held in Cincinnati in November. Committee representatives testified on the use of drugs in athletics before the Senate Subcommittee on Juvenile Delinquency. A Guide for the Medical Evaluation of Candidates for School Sports was revised. Liaison was maintained with 25 national health and safety agencies.

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Committee on Exercise and Physical Fitness: A Symposium on Exercise and the Heart was sponsored in September 1973 in cooperation with the Washington State Medical Association, the Washington State Heart Association and the President's Council on Physical Fitness and Sports. The Committee has completed "Evaluation for Exercise Participation--The Apparently Healthy Individual," a section of its Guide to Prescribing Exercise Programs. A new pamphlet, Physical Fitness, and a statement, "Ethical Considerations Regarding Referral Services for Cardiac Rehabilitation," are being developed.

Joint Committee on Health Problems in Education of the National Education Association-American Medical Association: Resolutions were adopted on improving nutrition education in schools, legal immunity for school personnel reporting battered children, alcohol and health education, the cycle of life and health career education. These statements were distributed to education accrediting agencies, state departments of health, state departments of education, state medical societies and their journals, appropriate federal and state government agencies, PTAs, educational publications and the mass media. The pamphlet Why Health Education and the book Health Education were revised.

AMA-American College Health Association Liaison Committee: This Committee considered problems related to college entrance medical examinations, consumer participation in college health activities and higher education's responsibility for student health. A questionnaire to survey the activities of state medical associations in the area of college health was completed.

A program to upgrade the medical understanding of lay driver examiners has been launched in cooperation with the American Association of Motor Vehicle Administrators. The program has been conducted in three states and plans are underway for 15 more states to participate. Physician's Guide for Determining Driver Limitation has been revised. The theme of the AMA-American School Health Association Session was "Driving Safely--A Critical School Health Problem."

Patient education programs of 11 voluntary health agencies were discussed by agency and AMA representatives at the October 1972 meeting of the former Committee on Continuing Professional Education Programs of Voluntary Health Agencies. In February 1973 the Department sponsored an exploratory meeting on patient education with representatives from medicine, hospitals, universities and insurance companies participating.

DIVISION OF MEDICAL EDUCATION

Five additional medical schools accepted their first classes during the year, bringing the number with students enrolled to 113. First-year enrollment exceeded 13,500, and graduates exceeded 10,000 for the first time. "Essentials" were approved by the House of Delegates for three new allied health occupations, bringing to 24 the number of occupations for which the Council on Medical Education has accreditation responsibility. The field of continuing medical education grew rapidly. Eighty-one additional institutions were accredited, bringing the total to 248. Thirteen state medical societies are

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functioning as accrediting agencies for intra-state programs, under AMA supervision. In graduate medical education, "Essentials" were approved by the House of Delegates for the new specialty of nuclear medicine.

The newly established Coordinating Council on Medical Education and Liaison Committee on Graduate Medical Education held their first meetings. These bodies, with representation from American Medical Association, Association of American Medical Colleges, American Board of Medical Specialties, American Hospital Association, and Council of Medical Specialty Societies, will coordinate and supervise accreditation activities at the medical school, internship and residency levels. Staff services are provided by the Division.

The 69th Annual Congress on Medical Education was held in Chicago in February. It was attended by 1,603 physicians, educators, students, residents, administrators and licensure representatives.

Publications and Reports: The Division published reports that form the major national informational bases. The Medical Education Number of JAMA was the AMA's 72nd annual report on this subject. Directory of Approved Internships and Residencies was the 45th annual report on graduate medical education. Continuing Education Courses for Physicians was the 18th annual listing of such courses and was published for the first time as a supplement to JAMA, permitting broader distribution. Medical Licensure Statistics for 1971 was the 70th annual report on this subject. Allied Medical Education Directory was published in its third edition.

DEPARTMENT OF ALLIED MEDICAL PROFESSIONS AND SERVICES

The House of Delegates adopted "Essentials" for the approval of educational programs for the operating room technician, electroencephalographic technician, electroencephalographic technologist, and a two-year program for the radiation therapy technologist. Revised "Essentials" were approved for the medical technologist and occupational therapist programs. The AMA now cooperates with 27 allied health and medical specialty societies for the approval of educational programs for 24 allied medical occupations.

The Department worked closely with the U.S. Office of Education in preparing revised applications for recognition of the AMA Council on Medical Education and the 27 collaborating organizations to accredit educational programs for the 24 allied medical occupations. A study Committee on Accreditation is investigating ways to reorganize accreditation for allied health occupations. The AMA, Association of Schools of Allied Health Professions, and National Commission on Accrediting are represented.

Four regional workshops were conducted in Chicago, San Francisco, New Orleans, and Hot Springs, Va., to prepare a cadre of personnel to evaluate programs purporting to educate assistants to primary care physicians. The seminars were supported by a grant from the National Institutes of Health. A special publication, Educational Programs for the Physician's Assistant, includes information on the accreditation effort and lists approved programs.

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Requests for Department publications increased. Allied Medical Education Newsletter has a monthly circulation of over 4,600, and 10,000 copies of the 1973 edition of the Allied Medical Education Directory were printed.

More than 2,700 educational programs for allied medical occupations have been approved by the Council on Medical Education. Basic information on these and other allied health education activities is maintained in the Department's National Information Center on Allied Medical Education.

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Reporter TH
By BJ

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Eighty-one institutions and organizations were granted accreditation by the Council on Medical Education, after review by the Advisory Committee on Continuing Medical Education. On June 30, 1973, there were 248 accredited institutions--70 medical schools, 89 hospitals, 55 specialty societies, and 34 others, including medical societies, voluntary health and governmental agencies, etc. The list of "Continuing Education Courses for Physicians" includes 2,441 courses offered by 697 institutions and organizations.

The AMA Physician's Recognition Award, established in 1969, is now in its second three-year cycle. During this time 40,501 physicians qualified for the Award, of whom about 40% were in residency training programs. Revision of the criteria for the Award has given added emphasis to the AMA accreditation program.

Seven state medical societies now require continuing medical education as a condition of membership. They are Arizona, Florida, Massachusetts, New Jersey, North Carolina, Oregon and Pennsylvania. Three states--Kansas, Maryland and New Mexico--have permissive legislation giving their medical licensing agency authority to require continuing medical education as a condition for re-registration of the license to practice. Both New Mexico and Maryland are implementing this provision of their laws.

More than half of the state and territorial medical societies have expressed interest in carrying out accreditation programs as an extension of the national AMA accreditation program. Thirteen state medical associations, an increase of eight over last year, have had their accreditation programs approved by the Council, and state associations are implementing these programs.

A Self-Assessment Resource Center has been established by the Department in cooperation with the Center for Educational Development of the University of Illinois School of Medicine. A Second Biennial Workshop was organized and conducted for representatives of the specialty societies. A large variety of physician self-assessment instruments was developed with the Center for Educational Development and was demonstrated in the workshop, as well as at the AMA Annual Convention. Data were obtained for preparing a second edition of the Directory of Self-Assessment Programs for Physicians. Fourteen national medical specialty societies now have self-assessment programs in operation. A continuation grant from HEW was requested and funded for the work at the Center.

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The Continuing Medical Education Newsletter has a mailing list of about 3,000.

The third National Conference of State Medical Association Respresentatives on Continuing Medical Education was held in Chicago in October, 1972. Plans for an institute on the status and future of continuing medical education in the U.S. are being developed by the staff and a subcommittee of the Advisory Committee on Continuing Medical Education. It will be sponsored by the American Medical Association and the Association of American Medical Colleges.

The Department continues to work with plans for a proposed data system that would utilize a name-imprinted card for automating the recording of continuing medical education activities. A pilot project, utilizing such a card, was carried out at the Annual Convention.

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Date 10-18-77 Witness NONE
Reporter TH
By BJ

DEPARTMENT OF GRADUATE MEDICAL EDUCATION

The Liaison Committee on Graduate Medical Education met three times. It developed proposed bylaws and determined the procedures for annual rotation of officers through each of the sponsoring organizations. It will develop a document for submission to the U.S. Commissioner of Education requesting recognition as the accrediting body for programs in graduate medical education.

A Residency Review Committee for Nuclear Medicine was established, the "Essentials" of a residency program in nuclear medicine were adopted by the House of Delegates, and a guide for program directors is being developed. Residency review committees have been engaged in developing new or revising existing guides for directors of residency programs.

The emphasis placed on family practice by the AMA is being reflected in hospitals, in clinics, and in federal support. The number of institutions developing or expanding family practice programs is increasing as are the number of training opportunities offered. Approved residency programs increased from 103 on September 1, 1971, to 151 one year later, and to 164 as of June 30, 1973. Residents on duty increased from 632 on September 1, 1971, to 1,041 one year later, and to 1,601 as of July 1, 1973. Responses to a survey made by the American Academy of Family Physicians in late July, 1973, received from 152 of the 164 approved programs, indicated that of the 1,601 family practice residents on duty in July, 683 were in the first year of training, 591 in the second, and 327 in the third.

Eligibility of foreign medical graduates for participation in undergraduate and graduate medical education continues to be misunderstood or misconstrued, creating serious difficulties for candidates, institutions, organizations and state and federal governments. A memorandum of May 23, 1973, on the "Policy on Eligibility of Foreign Medical Students and Graduates for Admission to American Medical Education" states clearly the five routes that can be taken by students in or graduates of foreign medical schools. It will help answer some of the questions that arise and will guide program directors

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as well as students and graduates. Problems continue to exist, however. The "fifth pathway" and COTRANS have relieved the situation of a small number of U.S. citizens studying medicine abroad. The diversity of responsibility, however, among governmental and non-governmental agencies, as well as the diversity of institutional and personal aims, will continue to make graduate education in the U.S. difficult for students and graduates of foreign schools.

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Reporter TH
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DEPARTMENT OF UNDERGRADUATE MEDICAL EDUCATION

The rapid expansion in the number of American medical schools, and the rising number of applicants, greatly increased the activity of this Department during the year. Five additional schools opened, for a total of 113 with 13,570 first-year places. As many as 43 additional schools are under consideration.

Through the Liaison Committee on Medical Education, accreditation surveys were made of 33 schools, including five Canadian. In addition, consultation surveys were made of eight prospective new schools. In half of the surveys, the secretary of the team was an AMA staff member.

With nearly 40,000 applicants to American medical schools, more than three for every available place, many applicants sought guidance from the staff, especially in regard to study abroad. Some 4,200 Americans are estimated to be studying abroad. Attention was devoted to aiding the return of these students, especially through the development of "fifth pathway" programs, now in operation at 12 medical schools, including two in Canada.

Revisions were made in the document Functions and Structure of a Modern Medical School. It was approved by the House of Delegates in June 1973.

The Advisory Committee on Undergraduate Medical Education met three times. Studies of the teaching of team management and of ethics in medical school and the development of family medicine programs, were undertaken. Steps towards the final preparation of a document concerning the Functions and Structure of Schools of Basic Science were made. Other projects included a study of the retention of minority students in medical schools and participation in the coordination of longitudinal studies in health professional education.

DEPARTMENT OF INTERNATIONAL MEDICINE

In addition to its AMA responsibilities, the Department continued to provide administrative assistance to the National Council for International Health, the Vietnam Medical School Project and the Volunteer Physicians for Vietnam Program.

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Reporter TH
By RJ

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National Council for International Health: This Council met four times, and its Committees and Subcommittee held 16 meetings. The NCIH sponsored an International Health Conference in Washington, D.C., in April. At this Conference a steering committee was elected to work closely with the NCIH in developing the next conference and to evolve a plan for formation of a general assembly to relate to the NCIH.

Vietnam Medical School Project: The AMA's project to support medical education in South Vietnam, funded by the Agency for International Development, is now in its seventh year. Of the 19 counterpart departments in 15 U.S. medical schools, eight hold active sub-contracts and the remainder provide voluntarily in the form of department chairmen interchanges and in their willingness to train Vietnamese participants in the United States. During this seven-year period, the AMA has been able to provide support to the University of Saigon Faculty of Medicine in the form of 62 long-term personnel (visiting faculty and administrative personnel), 124 short-term faculty, as well as books, supplies and equipment. Thirty-six Vietnamese faculty participants have returned to Vietnam after receiving advanced training in the U.S.; 32 are currently in training in the U.S.; and approximately 30 are enrolled in graduate training programs supported by the Project in Saigon.

A Colloquium on Medical Education, sponsored by the AMA's project for the Faculty of Medicine in Saigon during July of 1972, proved successful in defining the role of the physician in that country and in stimulating cooperation among the ministries of the government as well as consideration of changes in the medical curriculum.

Volunteer Physicians for Vietnam: The contract with the Agency for International Development for the AMA to administer the Volunteer Physicians for Vietnam Program was scheduled for termination at the end of Fiscal Year 1973. All operations related to the program ceased in Vietnam on June 30. This humanitarian program, initiated as Project Vietnam in 1965, became the responsibility of the AMA on July 1, 1966. Since the inception of the program, a total of 774 American physicians have served 1,029 tours in provincial hospitals in South Vietnam. Seventeen percent of these served multiple or extended tours. These American physicians have contributed more than 150 man-years of voluntary service to the civilian population of war-torn South Vietnam. They have served at 33 provincial hospitals and assignment sites in Vietnam.

The Department developed the AMA's first meeting outside the United States. In late February and early March, the first AMA International Health Conference was held in Israel. It was co-sponsored with the Weizmann Institute of Science in cooperation with the Israel Medical Association, the Sackler School of Medicine of the Tel Aviv University, the Hebrew University-Hadassah Medical School, and the Aba Khoushy School of Medicine in Haifa. The scientific portion of the conference included three and a half days of presentations by professors from the Israeli institutions. A second AMA International Health Conference is planned in Australia, March 23-April 7, 1974. This conference will be co-sponsored with the Australian Medical Association in cooperation with the New South Wales Branch of the Australian Medical Association, the Australian Post-Graduate Federation in Medicine and the Post-Graduate Committees of the University of New South Wales and the University of Sydney Medical Schools and the Royal Australian College of General Practitioners.

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The Department hosted an increasing number of foreign physician visitors to the AMA headquarters and the Annual Convention. Among the visiting groups was a delegation of physicians from the People's Republic of China for three weeks in October. The Department increased its liaison with organizations, agencies and individuals involved with international health activities in the U.S. and abroad. Until withdrawal of the AMA from the World Medical Association, the Department staffed the AMA's work for that organization. Through the Doctor-to-Doctor Program, physicians in developing countries were matched with U.S. physicians who indicated their willingness to contribute journals and to establish communications. Assistance to American medical missionaries continued, primarily through distribution of medical journals and textbooks.

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In the matter of AMA
Date 10-18-77 Witness NONE
Reporter TH
By BJ

DIVISION OF MEDICAL PRACTICE

The Division focused on the organization, delivery and financing of health care.

New Projects: The Division completed development of a national health insurance claim form; carried out a series of ten regional conferences to provide training for medical directors and administrators of long-term care facilities; sponsored seven practice management workshops for new physicians and has scheduled 20 additional workshops to be held across the country during the next year in conjunction with state medical societies. The Division is working with the American Bar Association's Commission on Correctional Facilities and Ser ices to establish a national health and medical certification program and develop medical standards to stimulate improvement of medical and health care services in the nation's jails, prisons and juvenile detention facilities. The Division's Project USA has so far assigned 20 physicians as short-term, voluntary replacements for National Health Service Corps physicians on vacation or leave. The Division also developed plans to organize a national commission to conduct certification of the physician's assistant, and has planned an experimental financial management workshop for established physicians.

Publications: New pamphlets were Project USA, Community Health Delivery Programs, Education and Utilization of Allied Health Manpower, Education and Use of Physician's Assistants and Survey of Medical Care in U.S. Jails. New statements published included Priorities for Increasing Availability of Health Services in Rural Areas, prepared jointly by the Councils on Health Manpower and Rural Health; Statement on Health Outreach, Statement on Free Clinics: 1972 and Committee on Health Care of the Poor Progress Report, all developed within the Department of Community Health; and a comprehensive report entitled "National Certification of Physicians' Assistants by Uniform Examinations." A Statement on Home Health Care was also printed. A textbook on practice management is being prepared for publication.

Publications revised and reprinted were Peer Review Manual, Horizons Unlimited, What Do You Know About Your Physicians' Placement Service?, Finding a Place to Practice, Health Care Delivery in Rural Areas, and the Division's booklet listing publications, conferences, councils and committees and topics of current interest.

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In the matter of: AMA
Date 10.18.77 Witness NONE
Reporter TH

Conferences: Conferences sponsored by Division councils included the 26th National Conference on Rural Health, the seventh National Congress on the Socio-Economics of Health Care, a PSRO Conference held in conjunction with the 1972 Clinical Convention and a Conference on Home Health Care preceding the 1973 Annual Convention. The Division participated actively in AMA's National Leadership Conference held in February 1973.

Physicians' Placement Service: The Physicians' Placement Service continued its trend over the past several years of increased registrations, processing a total of 7,608 applications, of which 4,434 were for physicians seeking locations and 3,174 were for practice opportunities, resulting in an increase of 485 registrations over last year. The number of physicians, utilizing the Service rose by 9% and location registrations increased by 3%. The Service maintained contact with 47 organizations that locate physicians outside the United States, and 152 physicians applied to the Service for information on positions abroad. The Service staffed a placement room at the 1972 Clinical and 1973 Annual Conventions and at the April 1973 Annual Meeting of the American College of Physicians.

Practice Management: The Section on Practice Management devotes a large amount of its time to answering inquiries and developing resource information. Liaison is maintained with various associations and firms that provide services on all aspects of practice management. Two major brochures on this subject, The Business Side of Medical Practice and A Planning Guide for Medical Facilities, are being revised. Work is progressing on a program in cooperation with the American Institute of Architects to award cash prizes to student architects who design or plan medical facilities as a part of their academic program, and an experimental project designed to provide physicians with video-cassette players for patient education, practice management, training for medical assistants, scientific programs, and entertainment for children in the reception room is in progress.

Government Medical Services: Activities consist of maintaining Medicare data, handling correspondence concerning government programs and maintaining liaison with the Veterans Administration, Public Health Service, the Medical Services Administration and the Social Security Administration. Additional activities included updating and reprinting the booklet HMOs as Seen by the AMA and providing staff assistance to the Advisory Committee on PSRO Task Force on Rules and Regulations. Staff also assisted the Committee on Government Medical Services.

Computer Systems in Medicine: A program in computer systems in medicine was begun. The program will provide a foundation for continued AMA activity in the computers and medicine area. A newsletter, Computers and Medicine, was initiated to inform physicians of practical applications of computers in medicine. In a brief time the newsletter gained a readership of over 1,300 and is continuing to grow. An exhibit on the use of the computer in medicine was developed and has been shown at many conventions and meetings. Staff spoke at many medical meetings, and developed and presented a computers in medicine program at the 1973 Annual Meeting of the American Academy of Neurology. Staff also assisted in the preparation of the third edition of Current Procedural Terminology, and prepared for the Committee on Computer Systems in Medicine a national medical data base feasibility study.

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Date 10.18.77 Witness NONE
Reporter JH

Committee on Computer Systems in Medicine: The Committee's attention during the past year was divided between meetings on revision of CPT, site visits to medical data processing programs and development of a sound computers in medicine program. The Committee also initiated development of magnetic computer tapes for CPT-3. The Committee provided direction and support for a portion of the seventh National Socio-Economics Congress.

Council on Medical Service: Council reports submitted to the House of Delegates concerned a wide variety of subjects--home health care, health outreach, public involvement in health services review, medical society peer review activities, free clinics, Veterans Administration medical care and the private physician, a health care of the poor progress report, notification of physicians by Medicare carriers of payments made directly to patients, claims practices of Aetna Life and Casualty Company, continuing education in long-term care, PSRO report, guidelines for medical directors in long-term care facilities, certificate of need laws, uniform claim form, Council structure, Medicare and Medicaid, confidentiality of medical information, the American Hospital Association's Quality Assurance Program, and renal dialysis and transplantation under Medicare and Medicaid.

The seventh National Congress on the Socio-Economics of Health Care, sponsored by the Council in April, was addressed to increasing the productivity and efficiency of the physician's office practice.

The Council reduced the membership of each of its six committees. Membership was increased by one with election of an intern-resident member in accord with the House's June 1973 action. Tenure was changed to three three-year terms.

Committee on Aging: The Committee continued its program of continuing education for physicians and allied health professionals in the field of long-term care and sponsored seminars in each of the ten HEW regions on the role of the medical director in the long-term care facility. A meeting was sponsored at the 1973 Annual Convention to expand physicians' concern for both preventive and well-care and rehabilitation and long-term care. The Committee designed guidelines for medical directors in long-term care facilities and is working with the Gerontological Society to develop education activities in mental health care of the elderly and with the American Hospital Association to design better environmental facilities for the aged.

Committee on Community Health Care: The Committee met with representatives from federal agencies, congressional staff and national organizations to formulate recommendations for an AMA position on Community Health Planning renewal legislation. Guidelines on certification of need were developed, and the Committee also monitored health planning agency improvement efforts undertaken by the federal government and private organizations. Recommendations were developed on renewal legislation for Regional Medical Programs and other sections of the Public Health Service Act.

The Committee was responsible for the development of an AMA policy statement on Home Health Care and inclusion of home health care benefits in Medicredit and collaborated with the AMA Committee on Health Care of the Poor in developing position statements on free clinics and health outreach. The Committee helped sponsor a conference on home health care at the Annual Convention

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Reporter TH
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and sponsored several meetings of national organizations concerned with the future of neighborhood health centers. Committee representatives served on boards of national home care organizations, participated in regional and national home care and homemaker conferences and served as consultants on the SAMA-MECO Advisory Committee as well as the SAMA Local Community Health Projects Review Committee.

Committee on Government Medical Services: The Committee met with representatives of the Veterans Administration to complete a detailed report on VA health activities. It met with representatives of the Bureau of Disability Insurance, Social Security Administration, to discuss the disability benefit program and the new Supplementary Security Program. With representatives of the Medical Services Administration, it conducted a review of the impact of PL 92-603 on Medicaid, the results of which were reported at the 1973 Annual Convention. The Committee conducted a continuing review of proposals for health maintenance organizations. It met with staff of HEW's HMO office and with Department of Defense officials. It reviewed the CHAMPUS program and the impact of the shift to a volunteer army and projected base-closings. The Committee met with Indian Health Service officials and began preparation of a report on the IHS and its problems.

Committee on Health Care Financing: Under the Committee's sponsorship, the AMA Work Group on Attending Physician Report Forms developed a computer-adaptable uniform claim form designed to satisfy the needs of most health insurance organizations and agencies, reduce the total cost of claims processing and simplify physician reporting and third-party processing. The Committee is continuing its investigation of problems related to the confidentiality of medical records. Practical solutions are being sought with representatives of the health insurance industry, management of large group employer self-administered programs, and firms serving insurance companies, business and industry in an investigatory capacity. The Committee is continuing its efforts to encourage health insurance for mental illness on the same basis as coverage for any other illness.

Committee on Health Care of the Poor: The Committee held two regional meetings in areas where the Appalachian poor and American Indians reside. The meetings provided poor people and concerned providers an opportunity to express their views directly to the AMA. Another Committee meeting to emphasize AMA's concern with the special problems of the poor was held with government officials representing the Appalachian Regional Commission, Regional Medical Programs, ACTION, Indian Health Service, Migrant Health Service, Community Health Service, Office of Economic Opportunity and Model Cities Program.

The Committee also (1) developed an educational film depicting the lifestyles and health problems of the Appalachian poor, with a similar film on the American Indian in the process of development; (2) initiated a pilot school health program with the Mount Sinai Department of Community Medicine; (3) supervised an AMA contract with HEW to develop a "Guide for Professional Health Provider Participation in Early and Periodic Screening, Diagnosis and Treatment"; and (4) provided assistance to the Student American Medical Association Local Community Health Projects Review Committee.

Committee on Private Practice: The Committee continued its work on the revision of the 1964 Report on Physician-Hospital Relations and directed the

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Date 10-18-77 Witness: NONE
Reporter TH

development of a survey to collect information on the observance of AMA policy in this regard. The Committee reviewed the Quality Assurance Program of the American Hospital Association and a report on this subject was submitted by the Council on Medical Service to the House at the 1973 Annual Convention. The Committee also reviewed AHA's "Patient Bill of Rights" and the TAP (Trustee, Administrator, Physician) Institute of the Joint Commission on Accreditation of Hospitals.

Representatives of the Committee attended a Pilot Conference on Community Hospital Residency Programs and an HEW Conference on Norms of Lengths of Stay in Nursing Homes. The Committee continued liaison with the Federation of American Hospitals, the American Hospital Association and the Joint Commision on Accreditation of Hospitals. The Committee maintained liaison with the Student American Medical Association through a SAMA representative who attended its meetings.

Joint Liaison Committee of American Association of Medical Clinics, American Medical Association, Medical Group Management Association: A large portion of the Committee's activity has been directed to developing better liaison and coordination in research projects projects concerning medical group practice. The Committee developed a new definition of group practice and has been studying the growing trend towards profit-sharing plans and has requested the Judicial Council to reevaluate its statements on pension and profit-sharing plans. The Committee recommended increased emphasis on socio-economic training for young physicians in residency programs and has given attention to seeking more exposure to group practice by both medical and health administration students. The Committee continued to consider pertinent legislative proposals, accreditation programs, media coverage of group practice and peer review programs.

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DEPARTMENT OF COMMUNITY HEALTH

The Department provided staff support for the Board of Trustees' Commission on Emergency Medical Services, the Committee on Community Emergency Services and three Committees of the Council on Medical Service: Committee on Community Health Care, Committee on Health Care of the Poor and Joint Liaison Committee of the American Association of Medical Clinics, American Medical Association and Medical Group Management Association. Staff also assisted the Board's ad hoc Task Force on Hospital Emergency Department Services.

Staff prepared a new publication, Topics: Information on Significant Programs and Issues in Health Care, which provides information on a broad range of AMA activities and concerns, and published a revised edition of Community Health Delivery Programs: Task Force Report. The newsletter Emergency Medicine Today was published throughout the year.

Staff coordinated arrangements for the Conference on Home Health Care preceding the Annual Convention and continued to work closely with the Emergency Medical Services triage program at O'Hare Airport. Training classes in

medical self-help for firemen and other airport personnel were conducted by a member of the Committee on Community Emergency Services. Under an HEW contract, AMA staff and members of the Committee on Health Care of the Poor will develop a "Guide for Professional Health Provider Participation in Early and Periodic Screening, Diagnosis and Treatment" of children under the Medicaid program. Meetings at the national, state and local levels will be held with representatives of a number of medical organizations to develop recommendations and a pilot demonstration project.

Staff also assisted in preparation of a legislative proposal on emergency medical care, testimony for AMA representatives appearing before Congressional committees and critiques of a number of manuscripts for AMA publications.

Commission on Emergency Medical Services: The Commission was reorganized and re-established under new "Rules of Procedure." The Commission now elects its own officers and executive committee. The Commission is revising the booklet "Guide for Program Planning--Emergency Medical Service Technician" and has recommended development of a standard ambulance report form.

More than 4,000 copies of the Commission newsletter, Emergency Medicine Today, are distributed monthly. Future activities of the Commission include review of the Model Ambulance Ordinance, development of a list of essential emergency medical services supplies for the physician's office and automobile, establishment of guidelines for an emergency medical technician career ladder, and development of model legislation to allow emergency medical technician use of IV fluids and defibrillation equipment.

Committee on Community Emergency Services: Major activities were development of an AMA legislative package, work on a model airport disaster plan, a listing of state and county medical society committees on emergency medical services and a study of the communications needs for emergency medical services.

An AMA bill was introduced into the 92nd Congress. Another bill was introduced and passed by the 93rd Congress and is now awaiting action by the President. This bill, while not in total agreement with the AMA-sponsored bill, is an acceptable package and could do much to improve emergency medical services. In recognition of the need from the medical community for a single voice concerning long-range emergency medical services communications needs, the Committee is in the process of developing recommendations on this subject for submission to the Federal Communications Commission.

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In the matter of AMA
Date 10-18-77 Witness NONE
Reporter TH
By BJ

DEPARTMENT OF HOSPITALS AND HEALTH FACILITIES

The Department provided staffing for the Board of Trustees' Committee of AMA Commissioners to the Joint Commission on Accreditation of Hospitals and for two Committees of the Council on Medical Service: Committee on Aging and Committee on Private Practice. The Department also coordinated analyses of proposed standards for inclusion in the JCAH's hospital and long-term care

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facility accreditation programs. Other departmental activities included preparation of an analysis of the American Hospital Association's Quality Assurance Program, development of a questionnaire to measure the degree of observance of AMA policy in hospital-physician relationships, a survey to determine which state medical and hospital societies have formed joint committees to mediate physician-hospital disputes and sponsorship of a series of regional seminars on "The Role of the Medical Director in the Long-Term Care Facility."

Staff helped develop a program for the 1974 Quality of Life Congress and participated with the AHA and the JCAH in developing a proposal to conduct a training program in utilization review for part-time physician consultants in HEW. Liaison was maintained with AHA, JCAH, specialty medical societies, component and constituent associations and a variety of organizations concerned with health care of the aged.

Committee of AMA Commissioners to the Joint Commission on Accreditation of Hospitals: The JCAH Board of Commissioners approved new standards for hospital outpatient departments, hospital-based home care programs and respiratory therapy services; considered drafts of standards for non-hospital health care facilities and adopted a statement that Joint Commission philosophy does not prelude change in the composition of the Board and/or corporate membership, provided such a change would result in the improvement of health and medical care. This statement was approved by the Committee of AMA Commissioners to the JCAH and by the AMA Board of Trustees.

The JCAH conducted accreditation surveys in 2,221 hospitals and 423 free-standing and long-term care facilities during 1972. Of the hospitals surveyed, 1,766 were granted full two-year accreditation, 390 were provisionally accredited for one year and 65 were not accredited. Of the long-term care facilities surveyed, 333 received full accreditation, 46 provisional accreditation and 44 non-accreditation. As of January 1, 1973, there were 5,200 accredited hospitals and 1,800 accredited long-term care facilities. This is a decrease of seven accredited hospitals and an increase of 196 accredited long-term care facilities since January 1972. The decrease in hospitals accredited is predominantly due to mergers during 197[illegible]

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 1050 Z-3
In the matter of: AMA
Date 10-18-77 Witness NONE
Reporter TH
By BS

DEPARTMENT OF HEALTH INSURANCE

A large part of the Department's activity concerned Professional Standards Review Organizations. The Department staffs the AMA Advisory Committee on PSRO and four of the Advisory Committee Task Forces, and has participated in various other meetings on this subject. The Department also publishes a twice-monthly newsletter, PSRO Report, and has completed plans for a series of eight AMA-sponsored regional conferences on PSRO.

A survey of medical society peer review activities was presented to the House of Delegates in November 1972. Two PSRO reports were prepared for the 1973 Annual Convention. Staff surveyed state and county medical societies to determine their experience with Aetna Life and Casualty Company claims-processing practices, and as a result of that survey Aetna is seeking to resolve differences with the profession.

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In cooperation with the AMA Interspecialty Council, a Conference on Guidelines for Use in Peer Review was held in September 1972. A consensus was reached that each national specialty society should be responsible for the development of its own guidelines, with AMA coordinating development of such guidelines.

The Department prepared three separate updates to the Peer Review Manual and continues to serve as AMA's clearinghouse for receipt and dissemination of correspondence and publications concerning peer review. It also is responsible for AMA liaison with foundations for medical care, and provides staffing for AMA representatives serving on the Board of Directors of the American Association of Foundations for Medical Care. The Council on Medical Service's Committee on Health Care Financing, the Joint Conference Committee of AMA-NABSP and the Committee of AMA Representatives on the NABSP Board of Directors are also staffed by the Department.

Joint Conference Committee of American Medical Association and National Association of Blue Shield Plans: The Committee met twice during the past year in an attempt to resolve matters at issue between the Medical Society of the County of Erie and Blue Shield of Western New York, Inc. A third meeting has been planned.

AMA Representatives on NABSP Board of Directors: AMA representatives and participated in discussions concerning NABSP bylaws changes, Federal Employee Program costs, nofault automobile insurance, Current Procedural Terminology, reimbursement of physician's assistants, National Blue Shield Index and continuation of the development of nationwide computer system.

FEDERAL TRADE COMMISSION
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International Exhibit No. 105028
In the matter of AMA
Date 10-18-77 Witness DANE
Reporter TH
By BS

DEPARTMENT OF MILITARY MEDICINE

The Department has been primarily concerned with Department of Defense activities governing health and environment, the three military medical services, the Selective Service System and the National Health Resources Advisory Committee. With dissolution of the Council on National Security by the House of Delegates, the functions of the Council's involvement with medical and health aspects of national security were assigned to staff.

The Department maintains an information service designed to provide guidance and assistance on military medical matters, and also is a clearinghouse for information concerning recruitment and retention of military physicians, military medical legislation, medical reserves, career incentives, utilization, improved professional programs through academic affiliations and military medical facility planning. Staff was instrumental in developing AMA's Project USA and medical care in prisons and jails programs.

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FEDERAL TRADE COMMISSION
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In the matter of AMA
Date 10-18-72 Witness NONE
Reporter TH
By BS

DEPARTMENT OF RURAL HEALTH

Improvement in the health care delivery system for the rural population, community organization for health services and liaison efforts with national organizations interested in improving the quality of rural life continue to be major goals of the Department. The Department staffs the Council on Rural Health and its Advisory Committee.

Manuscripts were prepared on health care in rural areas, rural development and health services, guidelines for medical association committees on rural health and rural health care delivery programs. The Department is preparing a research report on a survey of 1960 medical school graduates regarding factors which influenced their selection of a practice location. Another report is being prepared on a similar survey of 1965 graduates, and the Department is also conducting a review of research in rural health services.

Council on Rural Health: The Council, in cooperation with the Washington State Medical Association, is continuing to provide assistance and direction to a rural health project in a ten-county area in northeastern Washington where health providers and community leaders are working to establish an effective health delivery system. AMA-ERF has provided a third-year $15,000 grant for the project.

Council reports were "Statement on Voluntary Health Planning for Rural America," "Pilot Project in Comprehensive Health Care Delivery in the State of Washington," "Health Services: An Essential Component of Rural Development" and, with the Council on Health Manpower, "Increasing Availability of Health Services in Rural Areas: A Progress Report."

The Council's 26th National Conference on Rural Health, "Rural Health--Innovation to Implementation," held in Dallas in March, had an attendance of 751 from 44 states. Other meetings were the 27th meeting of the Council's Advisory Committee; the Tenth Seminar for Extension Specialists in Health Education and Related Fields; a meeting with state medical association rural health committee chairmen; and a joint meeting with representatives of the American Public Health Association and American Dental Association on the subject of two-way communication on programs of mutual concern. The Council is cooperating with the American Bankers Association to arrange a half-day program on rural community health services for four Regional Community Banker Workshops.

DEPARTMENT OF HEALTH MANPOWER

The Department staffs the Council on Health Manpower and its five Committees on Certification, Registration and Licensure, Emerging Health Manpower, Manpower Utilization, Liaison with Related Health Professions, and the Ad Hoc Advisory Committee on the Physician's Assistant, established to advise the Council and the National Board of Medical Examiners on developing a national certification program for primary care physician's assistants.

File No. 1210-4 Commission
Investigational Exhibit No. 105076
In the matter of: AMA
Date 10/18/77 Witness NONE 31
Reporter TH
By BJ

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Last year the Department assumed expanded responsibility for development and distribution of health careers information, including revision of Horizons Unlimited and Project FIND. Staff assisted the National Health Council in a project to improve manpower distribution and a study of institutional licensure in Illinois, and developed a seminar for the AMA National Leadership Conference.

Department activities on the subject of certification of physician's assistants included a survey of health care functions performed by currently employed physician's assistants, a survey of numbers enrolled and graduated from training programs and, with the Bureau of Health Manpower Operation, developed a list of all known training programs in operation or planned.

Section on Nursing: This Section staffed the Committee on Nursing and its Panel of Consultants, the Inter-agency Liaison Committee of the AMA-ANA-NLN and the National Joint Practice Commission between Medicine and Nursing. Staff participated in a number of meetings with national nursing organizations, provided consulting assistance to nine of these groups and represented the AMA on several others. Staff also handled numerous requests for information on nursing and nursing careers.

Council on Health Manpower: With the Committee on Nursing, the Council sponsored a workshop in January for reorganized medical specialty societies to discuss coordination of activity in surveying manpower needs and developing new physician-support occupations. The Council also made recommendations on AMA involvement in accrediting training programs for surgeon's assistants, corrective therapists, ophthalmic assistants and electroencephalographic assistants.

The Council prepared policy statements or reports on the subjects of physician distribution by medical specialty, describing the role of the primary care physician, status and utilization of health professional in hospitals, temporary licensure for volunteer physicians, physician assistants, institutional licensure in relation to physicians and nurses, emergency medical personnel and increasing the availability of health services in rural areas (with the Council on Rural Health).

Committee on Nursing: The Committee has supported, encouraged and guided the National Joint Practice Commission through its early stages. The NJPC, with financial assistance from the AMA, the American Nurses' Association and the National Commission for the Study of Nursing and Nursing Education, sponsored a meeting of representatives from 41 state medical societies and nursing associations to encourage the establishment of state joint practice committees. A number of states have now created such committees.

The Committee held its first joint meeting with the Council on Health Manpower in January. Reports developed jointly with that Council were "Institutional Licensure in Relation to Physicians and Nurses" and "Status and Utilization of New or Expanding Health Professionals in Hospitals." The Committee also, with the Inter-Agency Liaison Committee, American Nurses' Association and National League for Nursing, co-sponsored a meeting for representatives of national nursing organizations and student nurses.

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Inter-Agency Liaison Committee of the American Medical Association-American Nurses' Association-National League for Nursing: Meetings were held to discuss education, credentialing and utilization of the physician's assistant. Other topics were national health insurance, peer review, accreditation of health education programs, credentialing, licensure in health occupations and the extended role of the nurse.

FEDERAL TRADE COMMISSION
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Commission Investigational Exhibit No. CX1050 2-7
In the matter of: AMA
Date 10.16.77 Witness: NONE
Reporter TH
By BI

PUBLIC AFFAIRS DIVISION

DEPARTMENT OF FIELD SERVICE

The Officers Services Department was merged with the Department of Field Service during 1973. This activity has become an additional priority to the existing emphasis on federal health legislation, political education and AMA membership retention and growth.

Legislative Activities: Each of the 12 field representatives provided close liaison between component and constituent medical societies and the AMA's Legislative Department. The field representatives served as consultants to the states on legislation and became the catalyst for developing field activity on federal health legislation of interest to the profession. Staff mounted a strong effort in opposition to health maintenance organization (contract practice) legislation and helped develop membership education programs on national health insurance for state and county medical societies. An educational program to combat efforts to repeal state anti-substitution statutes and regulations was conducted.

Leadership Consulting Service: A special "hot line" telephone service linking the Department in Chicago with state and county medical societies was installed during 1973. Medical society executives requiring a quick response on a matter of urgency used this special telephone line when they did not know who to contact directly at AMA Headquarters.

Political Education: The field representatives worked closely with state political action committees by providing direct assistance in the development of membership programs, political education workshops and campaign management expertise. Membership in AMPAC set a new record. This political education program was supported by the creation of numerous audio-visual materials and manuals on PAC and campaign organization.

Speakers and Leadership Services: Nineteen speakers and leadership training seminars were conducted in 13 states reaching more than 700 key physician leaders. The AMA Speakers Bureau on National Health Insurance placed key physician speakers before lay and professional audiences.

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AAMSE Regional Meetings: During the year, six American Association of Medical Society Executives regional meetings were held on the subject of management training. Although the meetings were the responsibility of the AAMSE Board, the Department of Field Service provided staff backup for this series of meetings. The subject material was developed and coordinated by the Department in conjunction with outside management experts.

1973 AMA-AMPAC Public Affairs Workshop: The Department planned and conducted the AMA-AMPAC Public Affairs Workshop in Washington, D.C. Conducted in conjunction with the AMPAC Board of Directors, a record 800 participants attended the meeting from all parts of the country.

AMA National Leadership Conference: The first AMA National Leadership Conference was held early in 1973 at the Marriott Hotel, Chicago. A registration of more than 800 far exceeded estimates. The meeting was designed to provide technical skills and information on priority subjects to physicians and staff in leadership positions in constituent, component and specialty medical societies. A post-meeting survey produced an extremely favorable response to this type of program. The multimedia presentation shown at the opening session of the Conference was duplicated for use by medical societies. Titled Three Days in February, the film has been seen by more than 5,000 physicians since the Leadership Conference.

General Service: The Department conducted three invitational surveys of the organizational structure, administrative policies, membership programs and services and community posture of constituent societies. The assistant directors assisted members of the Board of Trustees during visitations to annual state medical meetings, arranged numerous speaking engagements for AMA spokesmen, and promoted use of AMA literature, including the AMA Quick Reference Guide, Sharing a Common Goal, Current National Health Insurance Proposals and the AMA Congressional Directory. The assistant directors continued to attend regular meetings of state governing bodies and annual state meetings. Report of the principal actions at state meetings were distributed to each state association. The Department planned and conducted the New Medical Executives Conference in conjunction with AAMSE. Twenty-nine new medical executives attended the 1973 meeting.

FEDERAL TRADE COMMISSION
File No. 9064 Commission
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In matter of AMA
Date 10-8-77 Witness NONE
Reporter TH
By BJ

LEGISLATIVE DEPARTMENT

The Legislative Department continued its primary assignment of reporting on national legislative activities of medical interest. Three new activities were undertaken this year. The Department began a surveillance of state legislation of medical interest. The second activity concerns the staffing of the Task Force on Rules and Regulations of the AMA's Advisory Committee on PSRO. The third new program is an expansion of services to medical specialty organizations. A legislative attorney has been assigned in the Washington Office with the specific responsibility of monitoring medical legislation and regulations of particular interest to specialty societies. This is expected to enable the specialty societies to more easily keep abreast of events in Washington and to respond to issues of particular significance to them.

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File No. 9064 Commission Investigational Exhibit No. 1050 Z-9
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An ever-increasing volume of health bills were analyzed as introduced in Congress, as modified in Congressional committees, conferences, and floor actions, and as finally enacted into law. The analyses, as well as summaries of lengthy bills, were distributed to appropriate Committees, Councils, Departments of the American Medical Association, and state and specialty medical societies. Comments on these bills were encouraged in order to provide the Council on Legislation with the most complete information upon which to base its recommendations.

Another major activity has been the monitoring of proposed regulations, rules, and final regulations published in the Federal Register. In addition to a distribution to AMA Councils, Committees and staff within the AMA, a substantial distribution is made to state and specialty medical societies. Comments received from these societies are considered in any decision which the Association makes in submitting comments on these proposals and in the position which is taken.

Council on Legislation: The Council met six times. It reviewed legislation of medical interest and made appropriate recommendations to the Board of Trustees. Representatives of the specialty societies and the Student American Medical Association attended and participated in one of the meetings. Legislation studied included the major national health insurance bills; expiring health programs under the Public Health Service Act; health maintenance organizations; health services for migrant workers; research on aging; drug abuse; children's dental health; medical library assistance; family planning; lead-based paint poisoning prevention; catastrophic illness insurance; cosmetic safety; national standards for blood banks and tax incentives for blood donation; creation of a cabinet level Department of Health; training programs for physician's assistants; emergency medical care; veterans' drug and alcoholism treatment programs; Social Security amendments; protection of human subjects in medical experimentation; bill of rights for the mentally retarded; hospital accreditation; and occupational safety and health amendments.

General Services: Publication of Legislative Roundup continued with a weekly distribution of approximately 4,500. New federal regulations and changes, as proposed and as finally promulgated, were disseminated. Proposed regulations included such subjects as cosmetic product safety; cosmetic ingredient labeling; use of mercury in cosmetics; shipment of etiologic agents on passenger-carrying aircraft; registration of blood banks and other firms collecting, manufacturing, preparing or processing blood; conditions of participation of hospitals in Medicare; fairness doctrine as it relates to broadcasting; state program for licensing administrators of nursing homes; medical services in hospitals for persons unable to pay; disclosure of certain Medicare reports and records; proposed special requirements for the use of methadone; modification concerning safety and health records and reporting requirements under the Occupational Safety and Health Act of 1971; legal status of approved labeling for prescription drugs.

Development of Proposed Legislation: Legislative bills prepared by AMA were reviewed for introduction in the 93rd Congress. They included:

--Medicredit, a national health insurance proposal, which provides comprehensive protection against ordinary and

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Reporter JH
By BS

catastrophic expenses of illness for all persons and families, regardless of income levels, through a system of voluntary health insurance. The benefits are comprehensive, including full hospitalization, all physician services, outpatient care, home health services, skilled nursing home services, and specified dental care. The program is financed through the use of tax credits on a sliding scale with the greater financial assistance being provided to low-income individuals and families. The cost of the catastrophic coverage would be paid by the government for all persons.

--Emergency Medical Services. This bill would establish a comprehensive emergency medical service system throughout the country. While direction and financial assistance would be provided at the federal level, the program is focused at the community level. Communities would be assisted in establishing and operating an emergency medical service program as a part of an overall state program.

--Blood Bank Legislation. The AMA bill would amend the antitrust laws to provide that the refusal of nonprofit blood banks and of hospitals and physicians to obtain blood and blood plasma from other blood banks would not be deemed to be acts in restraint of trade.

--Establishment of a U.S. Department of Health. Created within the Executive Department, at the Cabinet level, would be a separate Department of Health which would be headed by a Secretary of Health who would be a doctor of medicine, appointed by the President, with the consent of the Senate. This Department would administer all programs relating to health now under the jurisdiction of HEW.

--Labeling of Containers of Prescription Drugs. The AMA draft bill would amend the Federal Food, Drug, and Cosmetic Act to require that the label of drug containers, as dispensed to the patient, would carry the established or trade name, the quantity and the strength of the drug dispensed, except when otherwise specified by the prescribing physician.

--Social Security Cash Pension Benefits For Physician. This draft legislation would amend the Social Security Act to change the qualifying dates so that physicians would receive equitable treatment under Social Security in order to qualify for cash benefits.

--Free Choice of Physicians and Hospitals for Veterans. This proposal gives to the veteran the choice of receiving his hospitalization either in a VA hospital or a local community hospital.

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--Amendment to the Internal Revenue Code to Permit Individuals to Deduct Expenses for Medical Care. This AMA bill would remove the 3% and 1% limitations on medical and drug deductions and would permit a taxpayer to deduct the full amount of medical expenses and drug expenses.

--Medical Bills Enacted Into Law: Among the new enactments in the 93rd Congress are: PL 93-12, Federal Rules of Evidence Study; PL 93-14, The Solid Waste Disposal Act Extension; PL 93-15, The Clean Air Act Extension; PL 93-28, Economic Stabilization Act Extension; PL 93-29, The Older Americans Comprehensive Services Amendments of 1973; PL 93-45, The Public Health Service Assistance Extension Act of 1973.

AMA Testimony: The AMA testified on emergency medical services; the Clean Air Act and the Solid Waste Disposal Act extensions; the Economic Stabilization Act; Federal Employee Health Benefits Program; human experimentation; federal rules of evidence concerning the physician-patient privilege in federal court actions; national blood policy; cosmetic product experience; the Veterans Health Care Expansion Act; the Health Programs Extension Act; registration of practitioners in narcotic treatment programs; barbiturate abuse; control of methaqualone; prescription drugs used in the treatment of coughs and allergies; Drug Abuse Education Act extension; Emergency Health Personnel Act Amendments; and medical education.

The AMA also presented its views on the following informational subjects: Republican and Democratic Convention Platform Committees concerning health priorities; cost of educating various health professionals; financial asistance for medical education; proposed "Walk A Mile For Your Health Day" observance; project and formula grants under Title V of the Social Security Act to extend maternal and child health and crippled childrens' services; physicians for penal institutions; drug use in amateur athletics; national blood policy; and tax incentives to encourage practice in rural areas.

Pending Legislation: At midyear 1973, about 13,000 bills had been introduced in the 93rd Congress, some 1,000 being of medical interest. Several important measures are awaiting action by either or both Houses. Among them are several national health insurance bills; establishment of an Office of Rural Health Care in HEW; creation of a cabinet level Department of Health; restructuring of the Public Health Service Act; health maintenance organization enabling bills, the Rehabilitation Act of 1973; the Veterans Medical care Act of 1973 which provides expansion of medical care to veterans and improves recruitment of career personnel; the Emergency Medical Services Systems Development Act of 1973; child abuse prevention; continuation of programs for the elimination of lead based paint poisoning; Narcotic Addict Treatment Act of 1973 which provides for registration of practitioners conducting narcotic maintenance programs; and the Medical Devices Safety Act.

AMA OFFICE IN WASHINGTON

The Washington Office continued its operation of collecting, evaluating and reporting information and observations, concerning proposed legislation

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and regulations, as well as supplying a fast and accurate flow of information between the AMA and the federal government and all Washington-based health related organizations and agencies. Day-to-day informational services to national communications media also continued to expand. Much of the Office's activity was related to clarification of PSRO and to proposed HMO and NHI legislation.

A major activity of the Office continues to be the briefing of state and specialty society representatives during their visits to Washington. Some 30 briefings were conducted by Washington staff during the report period. In addition, some 35 speaker requests from medical and non-medical groups were fulfilled.

Department of Congressional Relations: During the period of this report, more than 1,000 bills relating to medical and health care were introduced in Congress. Among the bills of interest to the AMA are:

--National Health Insurance: AMA's "Medicredit" has 181 sponsors, more than all other proposals combined.

--Health Maintenance Organizations: The Department worked closely with members of Congress, relating AMA's position of opposition to any HMO legislation involving large federal involvement in health care delivery.

--Health Appropriations: Extensive efforts were made to assure adequate funding for health programs passed by Congress.

The Department also covered Congressional hearings, assisted AMA witnesses, and obtained Congressional speakers for various groups.

Department of Governmental Relations: The three major areas of activity during the year involved the Economic Stabilization Program, health maintenance organization legislation and Professional Standards Review Organization. In the first few months of 1973 there was a complete change in top personnel at the Department of HEW, followed by a series of reorganizations in both the Department and the White House. These changes necessitated the development of numerous new contacts.

Other activities included arrangements for meetings between AMA representatives and key government officials, including a meeting between the Chairman of the Board and the President of the United States; a close watch on the implementation of Public Law 92-603 (HR 1); Commission on Medical Malpractice; arrangements for visitations by Russian and Chinese medical delegations; and the securing of appointments to permanent positions and advisory committees in the federal agencies.

Department of Communications: Support was provided to all operations of the Washington Office. Broadened day-to-day services were furnished national news media, private health related organizations and agencies, and the federal government. Speeches were produced; radio and television interviews arranged;

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news releases prepared and placed; press room services provided; public relations advice and counsel given; topics researched; background materials assembled; information kits prepared; and statements and testimony written. The Department also continued to provide Washington reporting services to AM News and JAMA.

Washington Library: More than 6,700 inquiries were answered, some 800 of these originated directly or indirectly from members of Congress. Another 540 inquiries came from governmental agencies, 557 from private health related organizations, and 382 from the medical community. Public inquiries numbered 4,239 and were concerned with such issues as health careers, financial assistance for medical education, various diseases, euthanasia and acupuncture. A revised edition of publication listings was produced and more than 450 copies distributed. The working relationship for the exchange of information was continued with more than 50 libraries, publication officers, and the statistical offices of various agencies and organizations.

FEDERAL TRADE COMMISSION
File No. 9064 Commission
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In the matter of: AMA
Date 10-13-77 Witness NONE
Reporter TH
By BJ

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DEPARTMENT OF SPECIALTY SOCIETY SERVICES

The Department coordinates the AMA's activities for specialty societies, medical students, and interns and residents. Staff continued its general liaison program with 26 national specialty groups. Five legislative briefings for specialty group representatives were scheduled during the year in cooperation with the Washington Office staff.

Staff support for the Section Councils continued, and new Section Councils on Plastic and Reconstructive Surgery and Cardiovascular Disease were formed. Convention arrangements for the Association of Section and Service Delegates were also handled. The Department staffed the Task Force on Communications and Education of the AMA Advisory Committee on PSRO.

Interspecialty Council: Four meetings were held and recommendations were made to the Board of Trustees. Primary topics of interest to the Council were specialty representation in the House of Delegates, expiring health legislation, physician distribution, and nursing practice. New societies added to the Council were the American College of Cardiology, American College of Chest Physicians/American Thoracic Society, and the American College of Gastroenterology/American Gastroenterological Association.

Intern and Residents' Business Meetings were held just prior to the Clinical and Annual Conventions, and new officers were elected at the 1972 Clinical. Special programs on topics of interest to physicians-in-training followed each business meeting. Representation within the AMA structure was increased by the House of Delegates' action to add house officers to the Council on Long Range Planning and Development, the Council on Medical Service, and the Council on Medical Education. To better identify house staff interests, the Board of Trustees authorized a special think session in June 1973. Participants included 15 medical leaders and 15 interns and residents. As

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one result of the meeting, the Board authorized the establishment of a Committee on House Staff Affairs, which will advise on issues of concern to interns and residents and which will complement the participation of the Intern and Resident officers.

A membership mailing and four issues of an Intern and Residents' Newsletter were produced and mailed. The membership effort produced 2,400 requests for information. Membership increased from 1,650 in 1972 to 2,300 in mid-1973. A regular membership for medical students was offered for the first time in 1973, and approximately 1,000 students joined the AMA during the first six months of the year. The first Medical Students' Business Meeting was held just prior to the 1973 Annual Convention.

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In the matter of AMA
Date 10-18-77 NONE
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DEPARTMENT OF MEMBERSHIP DEVELOPMENT

The responsibility of the Department is to increase the percentage of AMA dues-paying members proportionate to the physician population. This Department staffs the Board of Trustees' Committee on Membership, the Staff Committee on Membership Growth and Retention, the Staff Committee on Insurance, and the AAMSE Ad Hoc Committee on Membership.

Until May 1973, the Department also staffed the Council on Long Range Planning and Development, and arranging open hearings in Detroit, Cincinnati, and Washington D.C. The purpose of the hearings was to receive comments, constructive criticism and ideas for future planning from the membership.

The AAMSE Ad Hoc Committee on Membership met three times and took action to encourage local society membership programs, bylaw revisions, billing systems, and state and county cash incentives programs.

The Department, in its responsibilities to the Board Committee on Membership, has uncovered and researched many of the roadblocks to membership growth. Several bylaw revisions, approved by the House of Delegates, will aid in improving membership communications, growth and retention. They are:

1. A physician can now become a member of AMA upon certification, prior to the delivery of his dues to AMA.

2. AMA will now have the option of doing its own billing under certain circumstances.

3. A physician who has dropped AMA may now rejoin without the penalty of one year's dues.

4. Dues exemptions in AMA will be consistent with the exemption of each state medical society.

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In the matter of: AMA
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Reporter TH
By BS

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5. State societies have been encouraged to reduce the period of provisional membership."

6. April 30 has been established as the new membership delinquency date.

A cash incentives program was approved for state societies which will pay the state one-half percent above prime interest rate on Certificates of Deposit for early reporting of physicians' dues dollars. In addition, the AMA will pay a county society one-half of a physician's AMA dues if the physician is a new member or a dropout of at least 24 months.

The Department has initiated numerous other membership projects. It provided assistance to 30 local societies, through the Department of Field Service, in establishing regular membership programs. Assistance included counseling, and providing computer printouts and resource materials. Two of these societies have shown a 20% increase in AMA membership. Special membership programs were presented at the 1972 Clinical Convention and the 1973 National Leadership Conference. More than 100,000 copies of the pamphlet Sharing A Common Goal were distributed to physicians. Nine advertisements for insert in the publications of AMA and state and county medical societies were designed. More than 100 computer printouts of physicians' names, addresses, and membership status have been supplied to local medical societies for support of membership identification and program implementation. Twenty-four membership awards were presented to state society presidents at the National Leadership Conference. In 1972, these states exceeded their 1971 total dues-paying memberships in AMA.

The Department published an "Intern and Resident" pamphlet which was sent to all interns and residents in the nation. Responses requesting more information have exceeded 2,400. The Department also designed new publications on medical student membership and benefits of membership. The latter will be sent to 342,000 eligible members late in 1973. A reception was held at the Annual Meeting of the Medical Society of the State of New York, where 16 AMA staff members discussed issues with physicians who chose to attend. A special 1973 supplemental dues statement was sent to 29,997 physicians who are members of state and county societies but not AMA. As a result, 398 physicians rejoined the AMA. (The Department continues to receive responses from this mailing.) Another special mailing was sent to 396 Texas physicians who dropped their AMA membership in 1973. A total of 62 physicians, 16% of those asked to reconsider, have rejoined. The Department has responded, by letter, to more than 3,000 letters received from physicians who expressed an area of concern or criticism about AMA. Non-AMA physicians who registered at the 1973 Annual Convention have received special membership invitations. Of the 25,000 AMA-ERF loan recipients, 12,000 have been identified. A total of 6,900 of these non-members have been contacted with a membership solicitation. The Department arranged for a meeting between the Board Committee on Membership and representatives of HEW, Department of Defense, Public Health Service, and the Surgeons' General of the three military branches.

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By BS

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COMMUNICATIONS DIVISION

In the area of general, non-clinical information the Communications Division serves as an important link between the AMA and physicians, the press and the general public.

The most significant achievement of the year was the publication of Prism, a monthly magazine devoted to exploration and discussion of the socio-economic issues of medicine. Published in a unique format (11x11), with a strong emphasis on graphics, the magazine quickly established itself as a major new voice, with early indications of a predominantly positive response from physicians.

A second major area of activity was a dispute with the National Broadcasting Corporation regarding a documentary entitled What Price Health? which was broadcast on December 19, 1972. Following an exchange of letters and the filing of a protest with the Federal Communications Commission, NBC offered the AMA an opportunity to appear on the Today show to discuss Medicredit and other health care issues. The AMA-NBC dispute generated considerable attention in the press, with considerable support for the AMA position.

NEWS BUREAU

Press Relations: This staff coordinated media coverage of the three-week six-city tour of the United States by physicians from the Peoples Republic of China, a tour co-sponsored by the AMA. As part of its regular duties, Press Relations handled many requests from newspapers, wire services and radio-TV networks and stations for information and assistance on stories about the socioeconomics of medicine. Staff also assists officers and AMA departments by serving as liaison with the press, and it operates press rooms at the Annual and Clinical Conventions and other AMA events.

Science News: This section, which maintains contact with science writers and media representatives, added a new weekly column, "Health Tip from the American Medical Association." It offers basic information on maintenance of good health and has been widely used, particularly by news magazines. Staff distributed some 400 news releases on AMA programs and on newsworthy papers published in JAMA and other Association journals; answered more than 1,200 queries from writers and staffed press rooms at the Conventions. Press arrangements for 14 other meetings also were handled. The section conducted the annual AMA Medical Journalism Awards program, which drew more than 500 entries.

Magazine Relations: This staff alerts editors and writers to story ideas and assists in story development. It handled 93 requests for editorial assistance during the year. A number of stories were prepared specifically for national publications, including the National Observer, Good Housekeeping and Parade. A total of 83 manuscripts were reviewed for medical accuracy and 120 requests for library research were answered. A 20-minute slide presentation

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on rural health was prepared and shown at the national meeting of the Agricultural Editors Assn. and will be given before other interested groups. The section also handled publicity for the Quality of Life Congress, arranging national TV and press coverage, and continued a program of personal contact with editors of consumer magazines.

Speakers Services: Staff assisted AMA officers and members of the Board of Trustees in the research and preparation of 81 speeches on various socio-economic topics. Other writing projects included several newspaper and magazine articles and initial copy for a pamphlet on the AMA's revised Medicredit plan. Staff also wrote summaries of House of Delegates actions at the Clinical and Annual Conventions.

AMA News Features: This service, begun in August 1972, provides in-depth stories on AMA activities as well as the entire medical scene. More than 100 daily newspapers regularly carry the articles in full or in part. Although aimed at medium and smaller dailies, News Features have been picked up by many larger papers as well as news magazines, news services, and professional journals.

AMA Update, aimed at opinion makers such as editorial writers and editors, continued to be quoted frequently by the media. A highlight was a special issue devoted to debunking in detail allegations contained in an NBC television documentary on health care, which was criticized not only by physicians but by lay press editors and TV columnists for [illegible] bias.

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 1050Z-17
In the matter of AMA
Date 10-18-77 Witness NONE
Reporter TH
By BI

AUDIO VISUAL DEPARTMENT

This Department serves both the media and constituent societies. During the past fiscal year it assisted in the creation and production of a pilot television program, Today's Health. The program, designed for commercial syndication, is produced in cooperation with Today's Health magazine.

Other activities: Public service announcements produced for television were broadcast by more than 600 stations, and the "instant radio news service," offering pre-recorded news and health messages, was used by more than 500 major radio stations each week. More than 18 million people saw AMA films during the year; audio cassette highlights were produced for every major AMA meeting and more than 15,000 cassettes were sold; two films dealing with problems in the health care delivery system were completed.

TODAY'S HEALTH

"Your magazine is appreciated by myself, and many others like me, and fills a great need in a day when nearly everybody considers himself an expert on matters of human health." That letter, from an Oklahoma man, was just one of many received during the year by TH. It reflected the magazine's continuing effort to improve the quality of the physical-mental health and consumer-oriented information it presents to the public. Today's Health marked its 50th anniversary with a special issue focusing on the next 50 years in medicine.

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File No. 9064 Commission 1050Z-18
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In the matter of AMA
Date 9/12/73 Witness
Reporter GTH
By

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SPECIAL PROJECTS DEPARTMENT

During the past year, this Department, in cooperation with the Scientific Assembly staff, launched major promotional programs to encourage attendance at the Annual and Clinical Conventions. Special efforts also were made to promote participation in a variety of conferences and seminars.

Today's Health subscription promotion got special attention through installation of a new, more thorough "source information system," a concentrated Christmas-gift subscription campaign and a new subscriber marketing test. In addition to an increasing number of pamphlets, booklets, mailers, books, posters and other materials produced for various AMA departments, Special Projects was involved in preparing promotional and advertising materials for two major projects -- (1) AMA Membership Drive, and (2) VD Educational Kits for physicians and counselors.

DEPARTMENT OF PROFESSIONAL COMMUNICATIONS

This Department is responsible for the AMA Newsletter, American Medical News, JAMA Medical News, the Annual Report published in the Clinical Convention Handbook and Proceedings, the Daily Bulletin and the 535 Reporter. The Department also staffs the Sheen Award Committee and performs various editorial services for the Office of the Executive Vice President.

AMA Newsletter: Bulk shipments of the "Green Sheet" are now sent to 123 state, county and specialty medical societies for distribution to their officers. In Brief, a new monthly publication of short items, is being distributed to medical society editors for reprinting in journals and bulletins.

American Medical News: A readership survey by the Center for Health Services Research and Development during the summer of 1972 revealed that 88.6% of the physicians responding spend some time reading AMNews. Only 9.5% replied that they do not read it. The survey was based on a 5,196 physician random sample with a 53% response rate. Eighty-six percent of office-based MDs said they spend some time reading the paper, and only 2% of the interns who replied said they do not read AMNews.

Emphasis during the year was placed on reporting in depth, and on interpreting, subjects of major interest to the profession. Subjects included health maintenance organizations and professional standards review organizations; efforts to attract more women, blacks, and other minorities to medicine; price controls; physicians in politics, and the controversy between AMA and NBC News over the documentary What Price Health? A new column, "AMA Report," was introduced to inform readers regularly about AMA activities.

JAMA Medical News: This weekly section has continued to stress comprehensive stories on such subjects as transplantation, psychosurgery, old age and the medical uses of transfer factor, as well as coverage of scientific meetings. Emphasis also was placed on feature articles of general physician interest.

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MANAGEMENT SERVICES DIVISION

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File No. 4064 Commission 1050Z-19
Investigational Exhibit No.
In the matter of: AMA
Date 12/18/79 Witness
Reporter TSH
By

BUILDING SERVICES DEPARTMENT

Building alterations were made in the basement and on floors 1, 2, 3, 6 and 8. The Department responded to 3,654 calls for custodial and decorating services, as well as for carpentry, lighting, electrical, plumbing and mechanical repairs. Security measures were enforced to ensure the safety of employees and the building.

CIRCULATION AND RECORDS DEPARTMENT

This Department handles the distribution of all regularly published AMA publications and maintains the physicians' biographical and historical records and the AMA membership records. Requests for information totaled more than 2,600 per day.

Of the 19 regularly published periodicals, eight had increases in average circulation and 11 showed slight decreases. AMNews, with an average circulation of 368,380 per week, led those that showed an increase. The average number of copies of the 19 periodicals distributed per month totaled 3,560,500.

CONVENTION SERVICES DEPARTMENT

The Department made arrangements for the Clinical Convention in Cincinnati and the Annual Convention in New York, with total attendance of 4,788 and 22,122 respectively. In addition 350 separate meetings and social functions were handled at the headquarters hotels during the two Conventions.

During the reporting period, 232 ancillary meetings were set up. Of these, 191 were handled by the Department. In the AMA exhibit program, 269 exhibits were displayed in 123 cities for a total of 2,545 show days. They were viewed by two million persons. Twenty-four exhibit construction projects were completed. Tour programs are being developed and coordinated in conjunction with continuing education for physicians.

GENERAL SALES OFFICE

A number of changes were made in the advertising sales program. These include changes in staff personnel, specialization of sales personnel and realignment of sales territories, creation of a practical incentive program, and development of new reporting and record-keeping methods that will be computerized to provide better internal sales data.

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FEDERAL TRADE COMMISSION
File No. 45 9064 Commission Investigational Exhibit No. 10502-20
In the matter of AMA
Date 1/16/79 Witness
Reporter TSN
By

INFORMATION SERVICES DEPARTMENT

This Department responded to more than 700 requests for services, including reports, special listings and labels. The Physicians Record System, Personnel System and Members Retirement System has been coverted to an Information Management System to provide for more flexible and reliable service.

A basic study and review of the AMA data processing operation was undertaken by Arthur Young and Company. Results of this review brought new stimulus to improve AMA data processing capability through a planned action program.

OPERATING SERVICES DEPARTMENT

The Contract Printing Section and Publication Production Section renegotiated the printing contract for Today's Health. The Reproduction Section and the Processing & Distribution Section processed more than 7,000 individual "in-house" printing jobs, valued at $540,000. Over 250 tons of paper were consumed for "in-house" work. The Purchasing-Transportation Section processed 3,900 orders for materials and supplies and 3,930 requests for transportation. The Job Printing Section processed 1,215 individual jobs purchased from outside sources.

PERSONNEL AND OFFICE SERVICES

This Department services AMA personnel requirements, administers pamphlet and film distribution, and provides for telephone, mail, cafeteria and medical services.

The Employee Relations and Training Section prepared and distributed a computerized benefit statement to AMA employees. Approximately 250 newly hired employees attended orientation programs, and service recognition awards were made to 113 employees completing from five to 25 years of service. A "management by objectives" program was developed for selected departments. As a special consultant to AAMSE Continuing Education Committee, the section prepared several management programs and presented them at six AAMSE regional meetings. A management development program was also presented to the California Medical Association. A wide range of skill-development programs on the clerical and technical level were continued for over 200 employees of all Divisions.

The mail unit distributed approximately five million pieces of first-class mail. Of the 1,500 health education titles in storage, total movement for the year was more than six million copies.

The Compensation and Benefits Section offered group and individual orientation programs for every non-exempt employee hired, and individual pension

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plan consultation for eligible AMA personnel. Various new and revised insurance plans--such as the Disability Income Replacement, Accidental Death and Dismemberment, Provident Life Insurance and the Excess Major Medical plans--were communicated to the AMA staff. Retirement counseling services were provided to 52 employees. Twelve employees, with a total of 218 years of service to AMA, retired.

A total of 4,417 visits were made to the Employee Health Office. Group Assurance Program (Blood Bank) had a membership of 448, and 143 pints of blood were obtained in a blood drive.

AMA EDUCATION AND RESEARCH FOUNDATION

The AMA-ERF received $1,698,068 in contributions during the period covered by this report. This was an increase of $261,962 over the preceding 12 months. Physicians individually accounted for $556,188 of the total contributions, and the Woman's Auxiliary, individually and collectively, accounted for an additional $629,199. The remaining $512,681 came from foundations, medical organizations, corporations and laymen.

Of the total gifts, $1,041,930 was designated for medical schools, $210,892 for the regular loan guarantee program, $70,152 for interest-free loans to disadvantaged and deserving students, and $117,971 for the unrestricted fund. The total also included an additional bequest of $198,949 to the Dr. Rock Sleyster Memorial Fund, which made it possible to establish a medical student scholarship program scheduled to begin in the 1973 Fall semesters.

Medical students, interns and residents obtained 3,120 loans, totaling $4,266,006 through the Foundation's guarantee program. Since the program's inception in 1962, the AMA-ERF has backed 50,330 loans worth $57,462,581. As of June 30, 1973, there were 19,692 loans outstanding worth $33,534,221.

Since October 1971, when the Medical Student Opportunity Loan Plan was initiated, 111 interest-free loans totaling $182,350 have been guaranteed for disadvantaged and deserving medical students. Acceptance of these loans committed AMA-ERF to approve and guarantee up to $606,000 of additional loans for the 93 students in this program during their years in medical school. Interest paid on these loans by the AMA-ERF totals $10,237, of which $9,127 came from a special grant of $12,000 for this purpose by the Alfred P. Sloan Foundation. During the period of this report, the interest-free loan program was exercised only in California. It is scheduled for expansion to Illinois and New York late in 1973.

FEDERAL TRADE COMMISSION
File No. 9064 Commission 1050Z-21
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In the matter of AMA
Date 10/18/77 Witness ____
Reporter FSH
By ____

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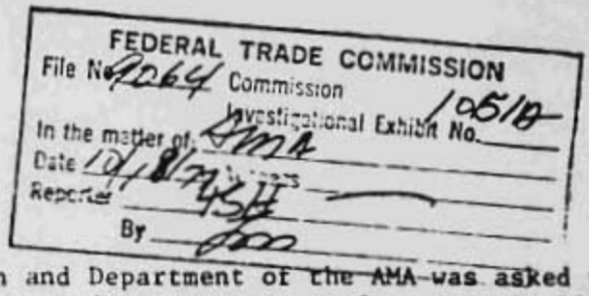
AMERICAN MEDICAL ASSOCIATION

ANNUAL REPORTS

JULY 1, 1973 TO JUNE 30, 1974



Each Division and Department of the AMA was asked to prepare an annual report of its activities from July 1, 1973 to June 30, 1974. These reports contain detailed information regarding the programs and contributions of the Standing Committees of the House as well as the Councils, Committees and Commissions of the Board of Trustees.

The following summary of AMA activities is included in the Delegates Handbook to acquaint the Delegates and Alternate Delegates with the comprehensiveness of the Association's program. No action will be requested of the Delegates other than to accept these reports as information without referral.

Department of Medicine and Religion 2
Office of the General Counsel 2
Center for Health Services Research and Development 7
Division of Scientific Publications 9
Division of Scientific Activities 11
Division of Medical Education 17
Division of Medical Practice 24
Public Affairs Division 33
Communications Division 40
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AMA Education and Research Foundation 47

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FEDERAL TRADE COMMISSION
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DEPARTMENT OF MEDICINE AND RELIGION

The Department develops and provides resources for programs to increase the effectiveness of the working relationship between physicians, clergy and chaplains in the treatment of and consultation with patients and their families. The programs are conducted through state and county medical society committees, other medical groups, and institutions. Regional workshops are held each year for state and county committee chairmen to provide them with resource materials, program suggestions, and the opportunity to exchange ideas. The workshops also serve as reactors to new programs being projected by the Department.

Resource materials and local consultation are provided to committees that cooperate with seminaries in developing seminars or courses on medicine and religion. The purpose is to help theological students understand their role in working with physicians in the total care of their parishioners. Medical schools are encouraged to include medicine and religion in the education of medical students. An increasing number of continuing education departments of medical schools plan seminars or symposia on subjects included in medicine and religion. For example, the University of Kansas Medical Center will hold its tenth course this year. Most of these events are approved for continuing medical education credit and for credit toward the AMA's Physician's Recognition Award.

The Department works with the National Congressional Committee on the National Prayer Breakfast held annually in Washington, D.C., for government, professional, and business leaders. A seminar for professional persons is planned in conjunction with the breakfast. The AMA Board of Trustees sponsors an Interfaith Prayer Breakfast at the time of the Annual Convention. The Department assists a growing number of state medical societies in planning similar programs at their annual meetings. The Women's Auxiliary to the AMA and state auxiliaries also hold such breakfasts.

Increasing interest is shown in the Department newsletter, and films prepared by the Department continue to be used by a large variety of groups and organizations. During the year the Department assisted the American Hospital Association in completing standards for hospital pastoral care departments. These are recommended for adoption by the Joint Commission on Accreditation of Hospitals. The Annual Convention program on medicine and religion was "The Family--Hope of the Future."

OFFICE OF THE GENERAL COUNSEL

This report covers the Office of the General Counsel, the departments under its jurisdiction, and the following Councils and Committees staffed by the Office: Council on Constitution and Bylaws, the Judicial Council, the Committee on Quackery and the National Conference of Representatives of the AMA and ABA.

FEDERAL TRADE COMMISSION
File No. 9064 Commission 1051B
In the matter of AMA
Date 10/18/72 Witness
Reporter TSH
By

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The Office continued to function as a source of information on developments in the medicolegal field. Information on such subjects as delineation of hospital medical staff privileges, physician-hospital disputes, physicians' unions, chiropractic, informed consent, peer review and PSRO activities, professional corporations, Food and Drug Law problems, delegation of patient care functions to ancillary personnel, and many other topics were sent to physicians and organizations on request.

Cease and desist letters were written to 18 companies and organizations to prevent unauthorized use of the AMA's name or copyrighted materials for promotional purposes.

The Office participated in and supported litigation filed by an organized medical staff to contest the legality of the hospital governing board's unilateral recision of the medical staff bylaws and in a criminal action contesting the legality of utilization of a trained assistant to follow a physician's standing orders in a community venereal disease center. Briefs amicus curiae were prepared and filed on behalf of the AMA in a case contesting the constitutionality of a federal law mandating retirement for federal civil service employees at age 70, and in a case contesting the constitutionality of Title IX provisions that discriminate against beneficiaries committed to state mental institutions. Dismissal of the Association in a suit filed by a county chiropractic society was achieved.

Council on Constitution and Bylaws: The Council held four meetings and submitted reports to the House of Delegates at the Annual and Clinical Conventions.

CORPORATE LAW DEPARTMENT

The Department handles, for the AMA and AMA-ERF, all the business law matters involved in the operation of corporations. It also concerns itself with the legal aspects of membership benefit programs which involve, for example, state professional corporation laws, Internal Revenue Service laws, and regulations respecting professional contracts, disability insurance programs, other insurance programs offered by the AMA to its members, and pension legislation.

The Department negotiated contracts for the purchase of property and services, and royalty contracts connected with permission to use certain AMA property. It prepared the Registration Statement and Prospectus for filing with the Securities Exchange Commission in connection with AMA Membership Retirement Plan Program, acted as legal counsel to the AMA's Committee on Insurance, engaged in extended negotiations for a new plan for the AMA Members Disability Insurance Program, and consulted with the IRS concerning the status of AMA's request for technical advice as to the applicability of the law to advertising income. The Department was involved in the acquisition of certain business properties and real estate for the AMA and the AMA Membership Retirement Plan.

FEDERAL TRADE COMMISSION
File No. 4064 Commission 1051C
Investigational Exhibit No.
In the matter of AMA
Date 10/18/77 Witness
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FEDERAL TRADE Commission
File No. 1264 Investigational Exhibit No. 1051D
In the matter of: AMA
Date 10/18/77 Witness
Reporter BH
By

DEPARTMENT OF INVESTIGATION

The Department continued its intensive campaign against health quackery in general and against chiropractic in particular.

Health Quackery in General: The Department continued to collect and supply information on all forms of health quackery. This information is disseminated to state medical societies, physicians, governmental agencies, and the public. After a professional survey, a program was initiated to modernize and better systematize methods of data collection, storage and retrieval. The Department's library of health quackery information is the most comprehensive in the world. The Department coordinated its activities with federal agencies and national health organizations also fighting quackery. Semi-annual meetings of the Coordinating Council on Health Information were held.

Major areas of activity involved acupuncture, the Mexican "border clinics" (primarily for cancer and arthritis), medical imposters, cellular therapy, Simeons treatment clinics for obesity (featuring human chorionic gonadatropin injections), chelation therapy (use of endrate in the treatment of arteriosclerosis), directory schemes, psychic surgeons in the Philippines, face peeling, hypnosis, hypoglycemia, and several mental health type promotions, Scientology, and "biofeedback" firms such as Silva Mind Control.

Screening of membership and licensure applicants, hospital staff appointments, etc., conducted in cooperation with the Department of Circulation and Records, continued to increase. They totaled 76,870 during the year, including license applications, 20,064; membership applications, 8,381; hospital appointments, 32,863; placement service, 3,259; specialty boards, 5,113.

Committee on Quackery: The Committee worked toward insuring strict standards and regulations and scrupulous enforcement of the limited chiropractic inclusion in Medicare/Medicaid. The AMA, state medical societies and physicians protested the lack of specificity in the standards and regulations. Conferences were held with Department of Health, Education and Welfare officials, and data were supplied.

The U.S. Senate Appropriations Committee appropriated up to $2 million to the National Institute of Neurological Diseases and Stroke for a study of the "fundamentals of the chiropractic profession" and "chiropractic research to be performed by chiropractors." Letters from the AMA, state and local medical societies, national specialty organizations, national health organizations and many physicians have urged NINDS to conduct a thorough study into chiropractic fundamentals, including a determination of the validity of what is taught in chiropractic schools. Also, the National Academy of Sciences has been asked to undertake an in-depth study of chiropractic education and practice.

The Committee and the AMA Council on Medical Education continued opposition to applications by chiropractic groups for recognition as the accrediting agency for chiropractic schools. The Committee and Council also protested "certification" of chiropractic schools through the so-called "three-institutional-certification" approach. The U.S. Department of Transportation denied a

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chiropractic request that chiropractors be permitted to perform medical examinations of drivers of vehicles in interstate commerce. The AMA, medical societies, and a number of other organizations and individuals had protested this chiropractic maneuver.

The Committee continued its series of Regional and National Conferences on Health Quackery-Chiropractic. Regional Conferences were held in Philadelphia, Anaheim, Calif., and Jacksonville, Fla. The National Conference was in Chicago.

DEPARTMENT OF MEDICAL ETHICS

The Department provides staff support to the Judicial Council. In addition, it works closely with the staffs of state and county medical societies when questions of medical ethics arise on issues such as advertising, fee splitting, disposal of records, or when issues on bioethics arise, such as in vitro fertilization of human ova, use of aborted fetal tissue in experimentation, behavior control, clinical investigation. The Department also answers inquiries on ethical subjects from physicians, the public, governmental agencies, and the media.

The Department presented papers to medical society meetings on "sick doctor" statutes and on medical discipline. It prepared articles for JAMA and state medical journals. It presented papers on the application of principles of medical ethics and on "definitions of death" for, respectively, a group of medical management consultants and a state chapter of the American Cancer Society. It distributed thousands of copies of the Principles of Medical Ethics and Opinions and Reports of the AMA Judicial Council.

Judicial Council: The Judicial Council held four regular meetings. It prepared reports for the House of Delegates on "Death," "The Physician and the Dying Patient," "Human Artificial Insemination," and "Human Experimentation." Requests for the report on "The Physician and the Dying Patient" have been unusually heavy. The Council rendered an interpretation of the AMA's bylaws at the request of the Council on Constitution and Bylaws. It answered a number of inquiries from medical society ethics committees and others. The Council also began an in-depth study and review of ethical principles related to advertising and solicitation of patients.

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In the matter of: Amer
Date 10/18/77 Witness
Reporter TSH
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HEALTH LAW DEPARTMENT

The Department, established June 1, 1974, will provide--

1. Legal assistance in the interpretation and analysis of proposed and enacted health care legislation and regulations to other AMA Divisions and Departments;

2. Technical legal advice to the Board of Trustees and to other organizations and physicians on health care laws enacted by the Congress and state legislatures;

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Reporter TSH

3. Technical legal advice and direct assistance to AMA departments, medical organizations, organized hospital medical staffs and individual physicians on the legal aspects of hospital-physician relations;

4. Legal assistance, as required, to the AMA Commissioners of the Joint Commission on Accreditation of Hospitals;

5. Direct assistance to attorneys engaged in representing AMA members in disputes and litigation involving hospitals and government agencies where violations of the rights of physicians or patients have occurred.

LEGAL RESEARCH DEPARTMENT

The Department developed and made available to members and medical societies a variety of informational and instructional materials. Twenty-four issues of THE CITATION, the newsletter of the Office of the General Council, were published. Materials for 22 unit presentations of "Questions and Answers," "Leading Cases," and "How Would You Decide?" were prepared for the "Medicolegal Rounds" section of JAMA.

Thousands of copies of the 600 available items of medicolegal information were distributed, usually with a specific response to a particular question. The book, The Best of Law and Medicine, 70-73, the third of a series, was published. Plans for a revised and enlarged edition of Alcohol and the Impaired Driver were begun. Guidelines on informed consent in medical practice, an analysis of the varying state laws and a compilation of cases on this subject were prepared and distributed to state medical associations. Technical assistance was provided to the University of Chicago School of Medicine and to the continuing Medical Education Department in developing courses on prevention of medical malpractice claims.

Medical Liability Commission: Assistance was given the Commission and its Executive Committee, especially with regard to legal advice on organizational and developmental tasks. A Commission newsletter, Medical Liability Commentary, was prepared and distributed.

National Conference of Representatives of AMA and ABA: This is the official liaison agency between AMA and the American Bar Association. The Conference met twice, centering much of its activity on planning the National Medicolegal Symposium to be held at Las Vegas, Nev., in March 1975. This bi-annual session is primarily the responsibility of the AMA in 1975. The proceedings of the 1973 National Medicolegal Symposium were published. The Conference continued its liaison with the National Conference of Commissioners on Uniform State Laws so that both associations can be kept advised of proposed legislation.

Ad Hoc Committee on Blood Grouping Tests for Determination of Questions on Disputed Paternity: The Committee, which was appointed by the Board of Trustees to cooperate with the Committee on Paternity of the Section on Family Law of the American Bar Association in the development of a model law, completed work on a

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FEDERAL TRADE COMMISSION
File No. 9064 Commission 1051P7
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In the matter of: AMA
Date 10/4/77 Witness
Reporter FSH

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draft report on paternity testing and distributed copies to recognized experts for comment. In light of a request from the chairman of the ABA Committee that the Ad Hoc Committee provide assistance in developing the necessary criteria for qualifying the regional blood testing laboratories under pending federal legislation, the continued existence of the Committee was approved.

CENTER FOR RESEARCH AND DEVELOPMENT

The Center for Research and Development conducts and encourages socioeconomic research on the environment within which medicine is practiced. The Center consists of departments of Economic Research, Health Programs Research, Statistical Analysis, and Systems Research. The four departments provide 1) research and analyses on the economics of medical practice and health care delivery; 2) research reports to assist in the formulation of AMA policies; 3) assistance to medical societies in health services research and development. They also provide a link between AMA and other sectors of the health services research community; accumulate an information base on environmental changes and trends which affect health care delivery; collect data which describe the distribution of medical and health manpower, as well as sociodemographic and financial characteristics of medical practice; and provide statistical and research services to constituent and specialty societies.

Economics of Medical Practice: Staff is engaged in a joint study with the University of Florida involving physician reimbursement, pricing and supply of working time. One paper, on determinants of physicians' fees, has been accepted for publication. Two additional manuscripts--one concerned with the role of health insurance in the market for physician services, and another addressing the effects of physicians' incomes on the quantities of working time supplied by physicians--have been submitted to professional journals for publication.

The Center, jointly with the Human Resources Research Center of the University of Southern California, completed the fourth year of a research project on the economics of alternative forms of medical practice. Data were collected through two surveys--one of 2,000 group practices and one of 10,000 physicians. Empirical research focused on the following topics: medical practice costs and economies of scale; effects of practice scale and specialty mix on practice productivity; determinants of prices and profit mark-up in medical practice; factors affecting the demand for allied health personnel; extent and determinants of task delegation to allied health personnel; effects of practice size and utilization of allied health personnel on patient waiting time; means for classifying group practices to permit comparisons between group practices and fee-for-service solo practices of similar characteristics; and the hiring sequence of allied health personnal. Two papers, resulting from this project have been published and another has been accepted for publication by Inquiry; five papers were presented at professional meetings and conferences; and ten more are being submitted to professional journals.

Health Manpower Research: The Center is engaged in a project funded by the Johnson Foundation to review the literature on the specialty and geographic

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distribution of physicians and factors which affect physician mobility and occupational choice. AMA researchers conducted a similar study (in cooperation with the Rand Corporation) which involved the effects of preceptorship programs on physicians' location choices. An article on this subject has been accepted for publication by Medical Care. A preliminary report on the project was published in Prism in April, 1974.

A study concerned with specialty differences in referral of patients was also completed during the year. It was carried out in association with staff of the University of Chicago, Center for Health Administration Studies. Findings from this project have been submitted for publication.

Public Affairs Research: Staff provided research support and other assistance to the AMA representative to the Health Industry Advisory Committee of the Economic Stabilization Program (ESP). Staff also conducted statistical analyses and prepared white papers which served as the basis for Congressional testimony on ESP. Prior to expiration of the ESP, a Physician's Guide to Phase IV was published to assist physicians in complying with the regulations. With expiration of the ESP, Center staff prepared guidelines for physicians who wished to increase their fees in keeping with a "Voluntary Fee Restraint Program" adopted by the AMA. The program provides physicians with information on practice costs, productivity, and fees.

Staff participated in AMA's 1974 National Leadership Conference. It had full responsibility for the seminar on the "Role of the Physician as a Purchasing Agent for the Patient." Two documents, Don't Survey Physicians and Trends in Health Care Delivery Regulation, were prepared for the Conference.

The Center developed cost estimates of Medicredit and an evaluation of its environmental impact. It also prepared a proposal for the development of an academy to train PSRO administrators and assisted in the preparation of the application for a "Project to Develop Model Sets of Criteria for Screening the Appropriateness, Necessity, and Quality of Medical Services in Hospitals."

Research for AMA Planning: The Center has begun the environmental analysis function for the AMA's long-range planning system. Staff has concentrated on methodology through which the analysis of the environment can best be conducted and utilized by AMA planning units.

Census of Physicians: The triennial census of the entire physician population was conducted early in 1973. This census is the basic source of information for updating the "current variables" portion of the AMA Physician Masterfile. The latter part of 1973 and early 1974 were devoted to editing of questionnaires, cleaning of file, analysis of changes, and verification of the file prior to its release to users of the data.

AMA Physician Masterfile: An important activity is the continuing review and quality control of the weekly procedures for keeping the Masterfile current. Staff establishes guidelines for data editing procedures, validation of physicians' records, year-end processing of the Masterfile, and overall policy relating to specific data collection procedures and distribution of data from the Masterfile. A report describing the development and maintenance of the Masterfile was prepared for inclusion in the 1974 American Medical Directory.

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Eighth Periodic Survey of Physicians: The Periodic Survey of Physicians (PSP) is designed to collect information on hours worked, patient visits, income, expenses, fees, and other practice-related financial and sociodemographic characteristics. The eighth survey in this series was conducted in the fall of 1973. The questionnaire for the ninth survey was mailed in September, 1974. Plans include quarterly surveys to assist the Association in the development of guidelines for voluntary control of fee increases.

AMA Survey of Drug Prescribing Patterns: Staff designed and conducted a survey to collect information on the frequency with which physicians prescribe opiate drugs and synthetic substitutes for opium. Reports have been submitted to the National Academy of Sciences, which funded the project. The Academy plans to publish the results during the fall of 1974.

Group Practice Data Base: Staff has conducted several group practice surveys since 1965 and has incorporated the data into the group practice data base. A questionnaire was completed for a census survey of group practice to be conducted in the fall of 1974.

Weiskotten Survey: The Weiskotten Survey collected data on the characteristics and activities of members of the 1960 graduating class of U.S. medical schools. The survey results are being analyzed and papers presenting the results are in preparation.

Membership Reports: Each year staff compiles the official AMA membership counts. The data are presented in a report comparing current membership with membership figures in prior years. A tabular report of the membership of each specialty society, by AMA membership, also is prepared.

Date Requests: Each year staff responds to numerous requests for information, usually in the form of data from the AMA Physician Masterfile. These include requests for biographical data on physicians, either on computer tape or in tabular form, or samples of physicians for research projects. The requests are carefully screened and decisions to provide data are carefully considered. Protection of the AMA data base and protection of the individual physician are of paramount concern. In the past year 53 major data requests were granted to assist state and county medical societies, specialty societies, other health organizations, universities, and federal and state agencies.

Publications: The Center published the following volumes: Distribution of Physicians in the U.S., 1972; Physician's Guide to Phase IV; Don't Survey Physicians; Distribution of Physicians in the U.S., 1973; Socioeconomic Issues of Health, 1974; and Profile of Medical Practice, 1974. Numerous articles and reports also were published.

DIVISION OF SCIENTIFIC PUBLICATIONS

On October 1, 1973, Robert H. Moser, MD, was appointed director of the Division of Scientific Publications and editor of The Journal of the American Medical Association. He succeeded Hugh H. Hussey, M.D., who assumed the title of editor of emeritus and remained a full-time staff member, with responsibilities

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not only on JAMA but for coordinating publication of the specialty journals.

A 27-man Editorial Board representing virtually every major subspecialty in medicine was created for JAMA. The Board consists of Charles D. Aring, M.D., Cincinnati; Harry Arnold, Jr., M.D., Honolulu; Daniel L. Azarnoff, M.D., Kansas City, Kan.; Leonard B. Berman, M.D., Cleveland; C. E. Butterworth, Jr., M.D., Birmingham, Ala.; William H. Crosby, M.D., La Jolla, Calif.; George E. Ehrlich, M.D., Philadelphia; Heinz F. Eichenwald, M.D., Dallas; George L. Engel, M.D., Rochester, N.Y.;Alvan R. Feinstein, M.D., New Haven, Conn.; Benjamin Felson, M.D., Cincinnati; Maxwell Finland, M.D., Boston; Emil J. Freireich, M.D., Houston; Arnold H. Greenhouse, M.D., Grand Junction, Colo.; Dalton M. Howell, M.D., Hana on Maui, Hawaii; Irving H. Leopold, M.D., New York; Mortimer B. Lipsett, M.D., Bethesda, Md; Jack Love, M.D., Santa Barbara, Calif.; George D. Lundberg, M.D., Los Angeles; Don Harper Mills, M.D., Los Angeles; George E. Omer, Jr., M.D., Albuquerque; Eddy D. Palmer, M.D., Morristown, N.J.; Jack W. Pearson, M.D., Indianapolis; Robert M. Senior, M.D., St. Louis; Raymond L. Teplitz, M.D., Duarte, Calif.; Ilza Veith, Ph.D., San Francisco; Weldon J. Walker, M.D., Los Angeles.

These "section editors" were selected for their international reputation, ability to write, and eagerness to participate in the mission of JAMA. They function as an extension of the eyes, ears and brain of the editorial staff and ensure that JAMA contains information in their area subspecialty that has pertinence to the readership. They are authorized to solicit articles from acknowledged experts; they are called upon to write editorials in their areas of expertise; they encourage colleagues to submit contributions to AMA publications; they are involved in the creative aspects of publication.

Sustaining features are being added to provide current information in specified areas. These new features, each edited jointly by a member of the editorial board and one of the senior editors, cover the gamut of new information--pathophysiologic mechanisms, new disease, new diagnostic techniques, new forms of treatment (drugs and procedures), and social-psychologic events of importance to working practitioners. All manuscripts are screened for pertinence, perspecuity and brevity. An attempt is made to maintain a reasonable balance between original contributions (unsolicited) and sustaining features (solicited). The general quality of unsolicited contributions has been improving, and a slight increase in quantity has permitted more discriminate selection.

The editor, in conjunction with other AMA Divisions, has explored the possibility of foreign language editions of JAMA. Contract negotiations are under way with Spanish, French and Italian publishers. A pilot issue in Spanish is planned in October, with Volume 1, No. 1, in January 1975. Methods of increasing the number of English language subscriptions are being explored.

Over the past year JAMA has undergone major changes in format, including cover logo, cover style, and heading-type style. More color is being used in graphics. Each section of JAMA was reviewed, and modification made where indicated. Effective with the January 4 issue, the gate-fold cover was abandoned and a conventional four-page cover was adopted. The table of contents, which formerly appeared on the cover flap, was moved to pages three and four. The title of the "Law and Medicine" section was changed to "Medicolegal Rounds." The "International Comments" section has enlisted the aid of a cadre of foreign correspondents.

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New sections are: Commentary (essays), Ruminations, Clinical Pathologic Conferences (updated), Clinical Grand Rounds, Trends in Therapy, Practical Nephrology, Practical Gastroenterology, Clinical Cardiology, How to Use the Clinical Laboratory, Debates in Medicine, Critique and Cavil (revived), What To Do When Your Patients or Friends Ask You About (vitamins, diet, exercise, etc.)

The annual Book Number of The Journal was discontinued. The Medical News Section was transferred from the Communications Division to the Division of Scientific Publications.

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SPECIALTY JOURNALS

The specialty journals continue to function with autonomous editorial boards. The director of the Division of Scientific Publications and the editor emeritus maintain communication with all chief editors in matters of content, format and planning.

DIVISION OF SCIENTIFIC ACTIVITIES

The Division of Scientific Activities is responsible for the seven departments and the Division Office that are organized to provide services to other AMA elements, state and county medical societies, and the membership. In addition, staff services are provided to four councils and 12 committees.

The Division Office provides staff services for the Advisory Committee on Medical Science, the Advisory Committee on Cancer, the Committee on Hypertension, the Committee on Maternal and Child Care, the Committee on Transfusion and Transplantation, and beginning in the fall of 1974, the newly appointed Committee on Acupuncture.

Advisory Committee on Cancer: This Committee closely followed the activities of the National Cancer Institute which was established in 1971. The Committee supported the development of a new book on cancer based on the series of articles published in JAMA under the heading "Current Concepts in Cancer Therapy." The book is now available from AMA.

Committee on Hypertension: The Committee maintained liaison with the national effort against hypertension led by the U.S. Department of Health, Education, and Welfare. In 1974, the AMA was one of five primary sponsors for the first National Hypertension Month (May). The Committee developed a scientific article on the treatment of hypertensive emergencies that was published in JAMA, and presented a symposium on the office management of hypertension at the Annual Convention.

Committee on Maternal and Child Care: This Committee participated in an ad hoc committee effort to establish guidelines for the implementation of Report J (C-71) regarding centralized perinatal intensive care. Also participating were the American College of Obstetricians and Gynecologists, the

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American Academy of Pediatrics, the American Academy of Family Physicians, and the National Foundation-March of Dimes.

Committee on Transfusion and Transplantation: This Committee advised the Board on Federal activities relating to blood banking and transfusion facilities and services. The Committee directed most of its attention in 1974 to the development and promotion of a plan to implement the National Blood Policy, a plan that would assure local control and medical leadership in blood programs.

DEPARTMENT OF ENVIRONMENTAL, PUBLIC, AND OCCUPATIONAL HEALTH

The Department and the Council on Environmental, Occupational, and Public Health maintained liaison with the Environmental Protection Agency, the Council on Environmental Quality, the National Institute of Occupational Safety and Health, the Occupational Safety and Health Administration, Center for Disease Control, other governmental agencies and non-governmental associations.

The AMA provided assistance and support for the International Conference on Environmental Health in Primosten, Yugoslavia (October 1973). Program speakers were from Austria, Brazil, Bulgaria, Czechoslovakia, France, Great Britain, Hungary, India, Japan, Norway, Russia, Sweden, United States, West Germany, Yugoslavia, and Zambia. The 75-100 participants from the United States made up the largest group from one country; more than 300 persons from 26 countries attended the conference. After the Conference AMA representatives met at the World Health Organization headquarters in Geneva with members of the WHO Environmental Health Section.

The Council advised the Board of Trustees on federal legislation that provided for extensions of the provisions of the Clean Air Act, provisions of the Solid Waste Disposal Act, support for the continuation of programs of direct federal assistance to schools of public health, and the continuation of the Lead-Based Poison Prevention Act. Other reports included a progress report on developing standards for medical services under the Occupational Safety and Health Act of 1970; a review and recommendations for adoption of Resolution 69 (C-73) on VD Control; and AMA approval of Immunization Action Month.

The Council, with the cooperation of six constituent medical societies, presented a Symposium on Venereal Diseases in Washington, D.C., (May 1974) for physicians, interns and residents, medical students, and others.

Staff has produced or has in preparation the following publications: Physician's Guide to Inorganic Environmental Contaminants, Physician's Guide to Solid Waste Management, Physician's Guide to Population Growth, and Physician's Guide to Animal Diseases Transmissible to Man. Other new publications include: The Occupational Physician and the Psychiatrist, Physician's Guide to Medical Advice for Overseas Travelers, Company Medical Policies for Occupational Health Programs, and Multiphasic Health Testing in Industry.

The Department plans to present the annual Congress on Occupational Health in Chicago (September 1974) and the Air Pollution Medical Research Conference (December 1974) in San Francisco. It has coordinated the activities of AMA

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in Immunization Action Month in 1973 and in 1974. The Council presented AMA's 33rd Annual Congress on Occupational Health at Philadelphia in September 1973. Symposia were on the Occupational Safety and Health Act; workmen's compensation; chest radiology in pulmonary diseases; and antidiscrimination in employment of women.

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DEPARTMENT OF DRUGS

The second edition of AMA Drug Evaluations was published in September 1973 by Publishing Sciences Group, Inc., Acton, Mass. Approximately 50,000 copies were sold in the first ten months.

Departmental publications in JAMA included four monographs on new drugs, seven statements on new developments in therapeutics, and six editorials. The nomenclature section published 12 listings of new nonproprietary names in JAMA and two editions of the nomenclature print-out.

Liaison was maintained with many governmental agencies, the pharmaceutical industry, and medical organizations. Staff answered 1,616 inquiries from the public and physicians, mailed 9,626 reprints and pamphlets, and staffed 12 exhibits at scientific meetings.

Ad Hoc Committee on Antibiotic Utilization: The Board of Trustees appointed this Committee in 1973 to evaluate the utilization of antibiotics in the U.S.A. The Committee, which is staffed by the Department, is investigating methods for extracting antibiotic utilization information from several computer-based data banks.

Committee on Cutaneous Health and Cosmetics: The Committee sponsored a Conference on Cosmetic Legislation in Washington, D.C. Seven scientific articles resulting from other Committee-sponsored symposia were published during the year in addition to one article prepared by staff.

DEPARTMENT OF FOODS AND NUTRITION

The Council on Foods and Nutrition is deeply interested in the nutritional care of patients in hospitals. A project was begun to study current dietary practices, to determine the possibility of reducing the number of therapeutic diets in hospitals, and to determine the effect industry has on hospital dietary practices. A Resource Conference on Health Care Feeding and Dietary Practices brought together representatives from medicine, dietetics, and the food industry, from which recommendations will be developed.

An AMA-sponsored International Conference on Parenteral Vitamins was attended by scientists, representatives from regulatory agencies, and manufacturers of parenteral vitamins. Several manufacturers are preparing formulations based on the guidelines established at the conference and plans are underway to establish clinical studies to determine the safety and efficacy of parenteral vitamins.

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The Council, with its Food Industry Liaison Committee, held a Resource Conference on Nutrient-Nutrient Interactions to determine inter-relationships that exist between nutrients and how these interactions relate to disease.

A symposium entitled "Can We Prevent or Treat Alcohol Toxicity by Diet?" was held in conjunction with the annual meeting of the American College of Physicians. A symposium on "Obesity: The Cause and Management" and a Postgraduate Course on Total Parenteral Nutrition were presented at the Annual Convention. The Western Hemisphere Nutrition Congress IV was held in Florida.

A number of books were published this year based on conferences sponsored by the Council: 1) Nutritional Qualities of Fresh Fruits and Vegetables, 2) Environmental Quality and Food Supply, 3) Total Parenteral Nutrition, and 4) a series of three volumes entitled Nutrients in Processed Foods (covering vitamins and minerals, proteins, and fats and carbohydrates). The book Let's Talk About Food was revised. A syllabus on "Digestion and Absorption" was prepared as an adjunct to the video-tape teaching film on Absorption and Digestion: Normal and Abnormal.

The Goldberger Award in clinical nutrition was presented to Robert E. Olson, M.D., for his research on lipid transport and metabolism and his comprehensive studies of the fat soluble vitamins, notably of vitamin E. Fifteen medical students were awarded research fellowships in honor of the Goldberger Award recipient. AMA Lectures in Medical Sciences were given at 78 colleges by 15 lecturers.

The success of the AMA-ERF approved pilot community nutrition education program at the Daniel Hale Williams Health Center in Chicago was evidenced by the fact that funding for the continuation of the program has been taken over on a full-time basis by Model Cities-Chicago Committee on Urban Opportunity.

CURRENT MEDICAL INFORMATION AND TERMINOLOGY

The Office of Current Medical Information and Terminology completed its contribution to the preparation of the third edition of Current Procedural Terminology and turned its attention to preparation of the fifth edition of Current Medical Information and Terminology. This edition will include many new terms and definitions of diseases and conditions. It will provide code numbers for symptoms as well as for disease entities, an innovation that will increase the usefulness of this publication in reporting those cases where a final diagnosis has not been determined.

DEPARTMENT OF SCIENTIFIC ASSEMBLY

Clinical Convention--Anaheim, Calif., Dec. 1-4, 1973: With emphasis on Continuing Medical Education, the Convention featured 30 courses and six

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general sessions which were well attended. The interest in PSRO was apparent from the large number of physicians who attended that conference. Overall physician registration was 3,179, up by 1,000 from the 1972 figure.

Annual Convention--Chicago, June 22-26, 1974: Continuing Medical Education was the dominent theme of this Convention. Category 1 credit toward the Physician's Recognition Award was offered at more than 35 courses and sessions. Continuing Medical Education with Category 1 credit will set the tone for the future. Specialists from across the nation presented 24 courses, and many were sold out. Most popular were "Workshop on Human Sexuality," "Acid-Base, Fluid & Electrolyte Balance," "Dermatology for Non-Dermatologists," and "Cardio-Pulmonary Resuscitation."

The American Society of Clinical Pathologists conducted a series of courses at its Chicago headquarters. Each of the six medical schools in the area produced films that were shown in informal evening "Fireside Forum" sessions with faculty present for discussion. Well over 2,000 physicians attended and participated in these courses and sessions. Physician registration at the Convention was 7,391, down from 8,756 in New York in 1973.

Scientific Exhibit: Demonstration exhibits, two of which offered Category 1 credit, proved popular in Chicago. Many sessions attracted overflow audiences. Individual exhibits continue to be well attended and the number of exhibits remains at about 250 for the Annual Convention and 100 for the Clinical Convention.

Medical Motion Pictures and Television: Category 1 credit was introduced to the film program at the Annual Convention for the "Symposium on Abdominal Trauma." Other special programs offered at the two conventions were symposiums on "Infertility" and "Production of Medical and Surgical Films." Staff acted as jury for medical films entered in the Industrial Film Festival and the Council for International Non-Theatrical Events. A total of 23 film reviews prepared by staff were published in JAMA. Nearly 24,000 films were distributed to hospital groups, medical schools and societies.

DEPARTMENT OF MENTAL HEALTH

Council on Mental Health: PSRO, insurance coverage for psychiatric illness, public and private therapeutic trends, and service capabilities of state and local mental health facilities were the chief topics discussed at the AMA's Southeast Regional Mental Health Conference in Atlanta, Ga. Scientific conferences of the Council and the Department have been approved for Category 1 continuing education credit by the Council on Medical Education.

An exhibit on the "Sick Physician," based on the AMA position paper developed by the Council, was displayed at the AMA Annual Convention, at which time the AMA Model Act on Disabled Physicians was distributed.

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Testimony was presented by the Council chairman before the Subcommittee on Public Health and Environment of the House Interstate and Foreign Commerce Committee. It supported a two-year extension of the federal community mental health centers program. The testimony stated that the bill would "strengthen and revitalize the delivery of psychiatric services on a community level" and recommended that a provision be added to make funds available to the centers for local evaluation.

Committee on Alcoholism and Drug Dependence: The Board of Trustees replaced this Committee with two separate committees, effective January 1, 1974, since the issues and concerns in these areas are too complex to be handled adequately by a single five-member committee. The AMA Conference on Medical Complications of Alcohol Abuse, held in Washington, D.C., attracted more than 300 persons. A monograph based on the proceedings is available from the Department of Mental Health. The two new Committees contributed to the development of standards for alcoholism and drug abuse programs being formulated by the Joint Commission on Accreditation of Hospitals.

The Committee on Drug Dependence reaffirmed its decision that evidence of abuse is insufficient to warrant placing propoxyphene (Darvon) under the Controlled Substances Act. The Committee encouraged the continuation of research into the efficacy of Darvon-N in detoxification and maintenance of heroin addicts. The Committee also reviewed the AMA policy statement on marihuana, adopted in 1972, in the light of subsequently-published reports on adverse consequences of marihuana use. It declined to recommend any changes.

DEPARTMENT OF HEALTH EDUCATION

Major areas of activity continue to be health education of the public, school and college health, safety education and administration, medical aspects of sports, physical fitness, and automotive safety.

Staff answered more than 60,000 requests for information from the public and 10,000 inquiries from health professionals. New and updated publications include: Your Blood Pressure, So You Have High Blood Pressure, Smoking: Facts You Should Know, Are You Fit to Drive?, Safety Belts Save Lives, Why Health Education, and Tonsils and Adenoids. Ten issues of Health Education Service for Schools and Colleges (circulation 23,000) and 12 issues of More Life for Your Years (circulation 47,000) were published.

Committee on the Medical Aspects of Sports: The 15th National Conference on the Medical Aspects of Sports was attended by 350 persons in Anaheim. The Committee published a new book entitled Comments in Sports Medicine and developed a statement on "Female Athletics." A statement on "Epileptics and Contact Sports" was published in JAMA. Liaison was maintained with 25 national health and safety agencies.

Committee on Exercise and Physician Fitness: The last two sections of the Guide to Prescribing Exercise Programs--"Testing the Patient with a Problem with Respect to Participation in an Exercise Program" and "Basic Exercise

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Principles"--were completed. A statement on "Allied Health Personnel Responsibilities for Stress Testing in Exercise Programs" was developed, as was a Q&A for JAMA on "Exercise Programs--Legal Liability." The manuscript for Basic Bodywork, a pamphlet on fitness and health, was prepared. With the President's Council on Physical Fitness and Sports, the Committee co-sponsored the American Academy of Orthopedic Surgeons Continuing Education Course on Physical Fitness.

Joint Committee on Health Problems in Education of the National Education Association-American Medical Association: Resolutions were adopted on day care facilities, accreditation of comprehensive health education and health services programs in secondary schools, support of the Comprehensive Health Education Act, parenting education, and violence on television. Statements were also developed on the dispensing of medicine in schools, health examinations by school personnel, maternity and paternity leave, and vision screening. Manuscripts were prepared for the sex education series and the book Health Education.

AMA-American College Health Association Liaison Committee: The Committee surveyed the activities of state medical associations in the area of college health and is actively promoting the establishment of college health committees within the state medical associations.

A National Conference on the Aging Driver was co-sponsored with the American Association of Motor Vehicle Administrators. The consensus was that licensure programs for older drivers should have as their primary objective the identification of high-risk drivers through processes that do not penalize drivers solely on the basis of chronological age. "The Comprehensive Scale," the second part of a system for rating the severity of tissue damage from automobile crashes, was prepared. Initial plans were completed for a major campaign to revitalize the role of medical advisory boards to motor vehicle administrators.

The 14th National Conference on Physicians, Schools and Communities considered, as a sequel to the AMA Congresses on the Quality of Life, the impact of schools on the quality of life. A pre-Conference meeting of representatives of state medical associations explored use of the health education package program by the associations' school health committees.

DIVISION OF MEDICAL EDUCATION

The fields of medical and allied health education continued to expand during the year, necessitating an increase in the accreditation activities of the Division. The major growth areas were continuing medical education and allied health education.

The number of institutions accredited for their continuing education programs increased from 248 to 384 during the year. In addition, 15 new state medical associations were approved by the Council on Medical Education

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as accrediting agencies for institutions offering intra-state continuing education programs, making a total of 28 state societies now so recognized. The number of continuing education courses reported by accredited institutions was 3,677, an increase of 50%.

In the allied health field the AMA now has collaborative accrediting activities with 29 allied health and medical specialty societies for over 2,700 educational programs of 25 allied health occupations. The U.S. Office of Education extended its recognition of the Council on Medical Education as the accrediting agency, in collaboration with the other societies, for the accreditation of 11 additional allied health occupations, bringing that number to 18.

Activities also increased in undergraduate and graduate medical education. There are now 114 medical schools with students enrolled, and over 14,000 first-year medical students. New residency review committees were established in nuclear medicine and in allergy and immunology. There was major growth in the number of family practice residencies to 203.

A major portion of staff time was devoted to providing service for new liaison organizations. The new Coordinating Council on Medical Education met five times in its first year and the subsidiary Liaison Committee on Graduate Medical Education held an equal number of meetings. The National Council for International Health met four times. Subcommittees of these groups also met frequently during the year. The Division provides staff services for all of these bodies.

The Second AMA International Health Conference was held in Australia, under the direction of the Department of International Medicine. The 70th Annual Congress on Medical Education, held in Chicago in February, was attended by more than 1,500 physicians, educators, students, residents, administrators and representatives of licensing bodies.

The 73rd annual report on "Medical Education in the United States" was published in JAMA. The Directory of Approved Internships and Residencies included the 46th annual report on graduate medical education. Medical Licensure Statistics for 1972 was the 71st annual report on this subject.

DEPARTMENT OF ALLIED MEDICAL PROFESSIONS AND SERVICES

The Council on Medical Education collaborates with 29 allied health and medical specialty societies in the accreditation of educational programs for 25 allied medical occupations. During this year, "Essentials" for the accreditation of educational programs for the surgeon's assistant were adopted by the House of Delegates, and the Council recognized the American Academy of Physicians' Assistants and the American Thoracic Society as collaborating organizations.

The 2,700 allied medical education programs accredited by the Council graduate approximately 19,000 allied health workers a year. During this past year, the Council acted on 552 recommendations concerning accreditation. Of

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the 440 educational programs accredited, 89 were new programs. At the request of the sponsoring institutions, 58 programs were discontinued. The U.S. Commissioner of Education recognized the Council on Medical Education as the coordinating agency for the accreditation of educational programs for 18 allied medical occupations, an increase of 11.

The Council and collaborating organizations developed a model Self-Analysis Outline for use in measuring program quality in the accreditation process and to assist the 14 review committees in complying with a USOE criterion for recognition.

A study committee on accreditation with representatives from the National Commission on Accrediting, the American Society of Allied Health Professions, and the AMA developed a proposal for the establishment of a Joint Council for the Accreditation of Allied Health Education. The proposal was approved by the House of Delegates and the other two sponsoring organizations and has been submitted to the 29 collaborating organizations for their consideration.

The Allied Medical Education Newsletter has a monthly circulation of over 5,100, including more than 1,200 physicians, and 10,000 copies of the 1974 edition of the Allied Medical Education Directory were printed. Information on education for allied medical occupations is provided by the Department's National Information Center on Allied Medical Education.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

One hundred and thirty-six institutions and organizations were granted accreditation by the Council on Medical Education after review by the Advisory Committee on Continuing Medical Education. On June 30, 1974, there were 384 accredited institutions--79 medical schools, 160 hospitals, 95 specialty societies, and 50 others, including medical societies, voluntary health and governmental agencies. The list of "Continuing Education Courses for Physicians," published as a supplement to JAMA, includes 3,677 courses offered by 876 institutions and organizations.

The AMA Physician's Recognition Award, established in 1968, is now in its second three-year cycle. During this time 53,585 physicians, of whom about 40% were in residency training programs, qualified for the Award. Revision of the criteria for the Award has given added emphasis to the AMA accreditation program.

Eleven state medical societies now require continuing medical education as a condition of membership: Alabama, Arizona, Florida, Kansas, Massachusetts, Minnesota, New Jersey, North Carolina, Oregon, Pennsylvania, and Vermont. Four states--Kansas, Kentucky, Maryland, and New Mexico--have permissive legislation giving their medical licensing agency authority to require continuing medical education as a condition for re-registration of the license to practice. New Mexico and Maryland are implementing this provision of their laws.

More than half of the constituent medical societies have expressed interest in carrying out accreditation programs as an extension of the national AMA

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accreditation program. Twenty-eight state medical associations, an increase of 15 over last year, have had their accreditation programs approved by the Council and are implementing these programs.

Through its Self-Assessment Resource Center, the Department continues to explore new methods, media and equipment to make physician self-assessment more attractive and effective. It promotes self-assessment in continuing medical education, furthers improvement in educational quality, and acts as a clearing-house and consultation resource for those who intend to initiate programs or wish to improve those they already have.

This was the second and final year of the grant from HEW's National Center for Health Services Research and Development to the AMA for developing and pilot-testing methods and materials for self-assessment. Additional tests were developed with the Center for Educational Development of the University of Illinois Medical Center. One of these, a computerized system, was demonstrated at the Annual Convention in cooperation with eight specialty societies.

The second edition of the Directory of Self-Assessment Programs for Physicians was published, listing 21 programs sponsored and distributed by medical organizations, including 19 specialty societies. The Continuing Medical Education Newsletter has a mailing list of about 4,200. The Fourth Biennial Conference was held in Chicago in October 1974.

A pilot project utilizing a name-imprinted card to automate the recording of continuing medical education activities was carried out at the Annual Convention. Cooperative pilot projects for the Physician's Recognition Award Computer Tabulated Information Service have been proposed for several state medical and medical specialty societies.

DEPARTMENT OF GRADUATE MEDICAL EDUCATION

Review of Residency Programs: The efforts of the Department in review and evaluation of programs in graduate medical education have expanded this year. A new residency review committee has been created in immunology and allergy. Other residency review committees have been examining and revising their procedures, their structures and functions, guides to program directors, and the essentials of residencies in various fields. These reviews were undertaken in the light of changes in the content of knowledge, the change in the relationship of the first year of graduate medical education to subsequent years, the further developments of interrelationships among programs and of undergraduate to graduate medical education. They are also related to the recognition of public responsibilities and to the development of the Liaison Committee on Graduate Medical Education.

The growth of family practice residencies has resulted in closer cooperation of the AMA staff and the staff of the American Academy of Family Physicians in working out arrangements which will encourage the development of residency programs of high quality and will expedite consultation by the AAFP and the processing of applications for review by the Residency Review Committee for Family Practice.

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Liaison Committee on Graduate Medical Education: The Department staffs the LCGME. Although the by-laws of the LCGME have not yet been approved by the CMSS, the LCGME has, at two meetings, worked out procedures for review and approval of programs on recommendation of residency review committees. The staff is developing uniform forms for the collection and recording of data common to all residencies and drafting revisions of the general essentials of residencies. These will be reviewed by staff, the residency review committees and the LCGME during the year. As the LCGME establishes its functions, there will be further review and revision of guides to program directors, of structures and functions of review committees, of the mechanism to handle appeals, and of the essentials of approved programs. It is anticipated that during the coming year the LCGME will seek U.S. Office of Education recognition as the official body for the approval of programs in graduate medical education.

Legislation: In both the Senate and the House of Representatives, legislation has been introduced to control the numbers and distribution of residency positions by specialty and by geography. The staff has analyzed the bills and prepared testimony and background information. The Department will continue to be heavily involved in matters related to federal and state legislation.

The First Graduate Year of Medical Education: Implementation of the change in the planning, conduct, and review of the first year of graduate medical education in accordance with the action of the AMA House of Delegates in accepting the "Millis Commission" report has occupied a great deal of staff time. A number of documents have been prepared and circulated. National and regional informational meetings have been held in most of the major areas of the United States, with representation from hospitals, medical schools and program directors. The hospital information has been revised and the directory redesigned to reflect the changes in policy and listing.

Foreign Medical Graduates: The issues which surround foreign medical graduates, both U.S. citizens and foreign nationals, are frequently inaccurately recognized. The subject is dealt with in legislation introduced in the Senate and in the House of Representatives. Most reports and recommendations fail to recognize the great complexities and the human and cultural concerns, as well as the social and political aspects, of the questions which surround FMGs in the United States. The Department has had increasing numbers of inquiries from FMGs who have ECFMG certification but cannot find places in training institutions.

The problems of finding first-year places in graduate education will increase as enrollments of U.S. schools rise and FMG's will be most adversely affected. The staff has discouraged FMGs who inquire about positions from coming to the U.S. unless they have ECFMG certification and a position assured in a training program.

DEPARTMENT OF INTERNATIONAL MEDICINE

The Department continued to provide administrative assistance to the National Council for International Health, the Vietnam Medical School Project and

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the new Association of American Volunteer Physicians, in addition to handling most of AMA's international affairs.

National Council for International Health: This Council with representatives from the AMA and nine other health organizations met four times and its committees and subcommittees held 20 meetings. The Council provides international expertise for use by legislators, and has provided guidance in preparation of a proposal for developing a center for the collection, collation and dissemination of information for organizations and individuals working in the international health field. The Council is studying the problem of foreign medical graduates, with international as well as domestic approaches, and is formulating plans for a conference. The Council maintains liaison with the World Health Organization through scientific representation on study and advisory groups and through the government's representative to that organization. Plans were developed for the second International Health Conference, October 16-18, 1974, in the Washington, D.C. area.

Vietnam Medical School Project: This project was undertaken by the AMA at the request of the Agency for International Development in July 1966 and is scheduled to continue through December 1975. The purpose is "to improve medical education in Vietnam." Through the years, sub-contracts have been arranged with 16 separate departments of 14 U.S. medical schools to support the teaching programs of the Faculty of Medicine of the University of Saigon. More than 40 long-term (1½ years or more) and 150 short-term (6-12 weeks) U.S. faculty have participated. The primary goal was the self-regeneration of the faculty and the training of additional faculty for other schools in Vietnam. To this end, the Faculty of Medicine at Saigon has been encouraged to establish its own post-graduate training programs and certification methods. At the request of the Vietnamese faculty, current activities have emphasized graduate medical education and community medicine.

Volunteer Physicians for Vietnam: Through a contract with the Agency for International Development (AID), the AMA administered the Volunteer Physicians for Vietnam program from July 1, 1966, to its termination on September 30, 1973. A total of 774 American physicians served 1,029 tours to provide direct medical service, medical educational assistance, and promotion of preventive medicine and public health in Vietnamese hospitals. In acknowledging the AMA's final report on the project, AID commended the AMA for the efficiency shown in the fulfillment of program objectives.

Association of American Volunteer Physicians: A number of the physicians who served in the Volunteer Physicians for Vietnam Program have formed a self-sustaining organization. The Department encouraged and provided administrative assistance towards the formation of the organization, and the group held its first meeting at the 1974 AMA Annual Convention. While the founding members are primarily physicians who served in the VPVN program, membership will be open to physicians who have served overseas with other voluntary organizations and agencies with similar goals.

Other Activities: With the success of the AMA's first meeting outside the United States, the Department developed the second AMA International Health Conference, held in Australia, March 22-April 7, 1974. It was co-sponsored with

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the Australian Medical Association and with the Postgraduate Federation in Medicine, the New South Wales Branch of the Australian Medical Association, and other Australian medical organizations and medical schools. The scientific portion of the conference included three days of sessions presented by professors from Australian institutions and Australian medical leaders. The Department played a major role in planning and arranging for the AMA delegation's visit to the People's Republic of China, July 9-30, 1974. The delegation's 16 members observed aspects of the health care delivery system, health educational programs, and techniques and procedures of Chinese medicine. The Department continued its liaison with counterpart medical associations abroad and arranged visits by AMA officials with officials of Associacao Medica Brasileira, Australia Medical Association, British Medical Association, Guam Medical Association, and U.S. Trust Territory. The Department continued to provide assistance to American Medical Missionaries and to physicians in developing countries by providing information and access to medical journals and literature.

DEPARTMENT OF UNDERGRADUATE MEDICAL EDUCATION

One new school opened in the early summer of 1973, making a total of 114 medical schools enrolling students. These schools provided 14,044 first-year places. Interest in the development of new schools has continued, with at least seven likely to enroll students in the next three years.

Through the Liaison Committee on Medical Education, a joint activity of the AMA Council on Medical Education and the Association of American Medical Colleges, accreditation surveys were made of 36 existing and developing schools including five Canadian institutions. In addition, consultation and pre-accreditation visits were made to several prospective new schools.

The current year marked the entrance of the Veterans Administration into undergraduate medical education with grants to five prospective new schools and financial assistance to several existing schools. In both types of grants, the Liaison Committee on Medical Education was asked to evaluate the proposals and, where feasible, to issue "Letters of Reasonable Assurance" that the planned programs were considered accreditable. Committee members and staff conducted studies and made numerous visits to the schools.

The number of applicants to U.S. medical schools has continued to increase. There are at least three applicants for every available place. The staff has been besieged with requests for information, particularly from students who have been unable to gain access to U.S. schools. Many of these students are considering study abroad. Approximately 5,000 U.S. citizens are now studying medicine outside the United States. In addition to encouraging students to utilize the "COTRANS" and the "ECFMG" routes to return to the mainstream of U.S. medicine, attention has been paid to "Fifth Pathway" programs now in operation at 17 schools, including two in Canada. At least 115 students are obtaining training in the "Fifth Pathway."

The document "Special Criteria for Programs in the Basic Medical Sciences" was accepted by the AMA House of Delegates and the Assembly of the Association

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of American Medical Colleges. It provides an updated document to guide the development of programs which are part of medical student education in institutions not awarding the MD degree.

The Advisory Committee on Undergraduate Medical Education met three times and was concerned with the further development of proposals relating to the teaching of team management and ethics in medical schools. The Advisory Committee oversees the procedures used by the Department in awarding the AMA-ERF Rock Sleyster Memorial Scholarships, a program through which qualified students interested in careers in psychiatry receive substantial financial support.

DIVISION OF MEDICAL PRACTICE

The Division of Medical Practice focused on the organization, delivery and financing of health care. Unit plans were prepared by 22 Division departments, sections, councils, commissions and committees.

New Projects: The Division initiated a project to improve health manpower distribution, implemented a national certification program for primary care physician's assistants, conducted a seminar on the role of the medical director in the long-term care facility, and assisted 20 state medical societies in carrying out practice management workshops for new physicians. The Division also provided staffing support to the AMA Advisory Committee on PSRO and six of its task forces, sponsored nine regional PSRO workshops to provide basic PSRO information to state and local medical societies, established a series of emergency medical response system workshops to assist communities in improving emergency care, designed new procedures to improve medical care for members of the Armed Forces through the efficient utilization of medical and allied health personnel, expanded the scope of Project USA, and developed plans for a computerized national medical data base. In addition, the Division increased its involvement with state medical society rural health committees to lend support and guidance to their efforts at reducing the degree of medical maldistribution, and established a committee to develop medical standards and a national health and medical certification program for the nation's prisons, jails and correctional facilities.

New publications were Action Plan, a pamphlet presenting guidelines for community physician recruitment programs; a brochure on Current Procedural Terminology; and a pamphlet on the uniform claim form for accident and health insurance. "Mini" editions of CPT-3 were developed for the specialties of pediatrics, internal medicine and neurology. Tape cassette highlights of the 8th National Congress on the Socio-Economics of Health Care and the 27th National Conference on Rural Health were prepared jointly with the Department of Radio, Television and Motion Pictures. The publication, The Business Side of Medical Practice, A Planning Guide for Physicians' Medical Facilities, and the Dimensions booklet listing Division publications, conferences, departments, sections, councils, committees, and topics of current interest, were revised.

Conferences: Conferences sponsored by councils and committees included the 27th National Conference on Rural Health, the 8th National Congress on the

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Socio-Economics of Health Care, a Medical Services Conference held in conjunction with the 1973 Clinical Convention, and seminars on "The Role of the Medical Director in the Long-Term Care Facility" and "Extension Specialists in Health Education and Related Fields." The Division also participated in AMA's 1974 National Leadership Conference and Congress on Improving the Quality of Life in Later Years.

Computer Systems in Medicine: This Section centers its activities around developing computer applications which will directly affect the practice of medicine in both financial and patient care areas. The Computers and Medicine newsletter subscription list has grown from 1,300 to 3,000, and agreements with several medical specialty societies to publish "mini" CPT-3's have been reached. An exhibit on the use of computers in medicine was shown at the 1973 Clinical and 1974 Annual Conventions as well as at several meetings of outside groups, and staff spoke on AMA activity at many medical meetings. The Section has completed its plans to develop a national medical data base.

Government Medical Services: Activities consist of maintaining Medicare data, handling correspondence concerning government medical programs, and liaison involvement with the Veterans Administration, Public Health Service, Medical Services Administration and Social Security Administration. The Section also provides staffing for the Committee on Government Medical Services and the Advisory Committee on PSRO's Task Force on Rules and Regulations. Guidelines were drafted for the definition of actual providers of health services in federal health planning programs.

Physicians' Placement Service: During the past year, physician registrations for full-time positions within the United States rose from 4,534 to 5,034 and the number of registrants seeking overseas positions, locum tenens and part-time openings also increased. The Service staffed exhibits at the 1973 Clinical and 1974 Annual Conventions and at the 1974 Annual Meeting of the American College of Physicians. Staff spoke about AMA placement activities at the 27th Conference on Rural Health. The development of a computerized procedure for processing Placement Service records is nearly complete.

Practice Management: Activities of the Section included audio surveys on practice productivity and telephone use in the physician's office, development of a 30-minute color video cassette on the latter subject, development of a special training program for the American Association of Medical Assistants, preparation of a telephone guide for use in medical offices, co-sponsorship with 15 state medical societies of practice management workshops for new physicians, and drafting of a brochure regarding medical facility condominiums. Staff began drafting a textbook on practice management and a medical practice office manual, and completed plans for a pilot seminar on financial management in October 1974. Liaison was maintained with associations and firms providing practice management-related services. The Joint Liaison Committee of AAMC-AMA-MGMA is staffed by the Section.

Council on Medical Service: Council reports submitted to the House of Delegates at the 1973 Clinical and 1974 Annual Conventions concerned national health insurance, surgical predetermination forms, health care of migrant workers, confidentiality of medical information, third party rounds, prospective admissions and retrospective denials, proper usage of physician titles,

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health care of American Indians, physician-hospital relations, Medicare payment procedures, renal dialysis and transplant under Medicare, financing medical education, structure of hospital boards of trustees, a physicians' bill of rights, the Comprehensive Health Planning definition of providers, professional-lay health councils, Medicare regulations, definition of cosmetic surgery, the JCAH-DHEW listing program for selected chronic diseases, and the AHA quality assurance manual, as well as several reports concerning professional standards review organizations.

The Council sponsored a Medical Services Conference on the subject of PSROs preceding the 1973 Clinical Convention. "Medicine's Accountability to the Public" was the theme of the 1974 Socio-Economic Congress, co-sponsored by the Council with the California Medical Association and the AMA Interspecialty Council.

Committee on Aging: The Committee assisted in planning the 1974 AMA Quality of Life in Later Years Congress; represented the AMA on the Steering Committee of National Voluntary Organizations and the Accreditation Council for Long-Term Care Facilities; began development of a series of "Health Hints for Older Americans;" made plans to co-sponsor with Action for Independent Maturity a workshop on retirement planning; cooperated with the American Geriatrics Society to explore the feasibility of incorporating principles of elderly health care in family practice, internal medicine and psychiatry residency programs; and drafted a provision for long-term care which the Committee believes should be included in all national health insurance proposals now being considered by the Congress. During the 1974 Annual Convention, the Committee presented a continuing education seminar on the role of the medical director in a long-term care facility.

Committee on Community Health Care: The Committee participated in the improvement of CHP agencies and monitored such improvement efforts undertaken by the federal government and private organizations, and promoted the inclusion of home health care benefits in state health insurance legislation. It presented AMA testimony concerning health of the elderly before a subcommittee of the Senate Special Committee on Aging, and undertook studies of the quality and effectiveness of several varied community health care delivery mechanisms, including neighborhood health centers, free clinics, multiphasic health testing, surgicenters and industry medical programs. The Committee maintains liaison with SAMA's Local Community Health Projects Review Committee and has initiated plans to develop a demonstration community health delivery program.

Committee on Government Medical Services: The Committee continued to monitor the Veterans' Administration, Indian Health Service, Medicaid and Federal Employees Health Benefits programs. The Committee undertook a study of CHAMPUS to determine potential problem areas. It reviewed Bureau of Disability Insurance operations at the Bureau's request and was successful in recommending that the Bureau reimburse physicians for medical evidence of impairment to a significantly greater degree than under the Social Security Disabili- program. The Committee also consulted with the Rehabilitation Services Administration on the Rehabilitation Act of 1973 and maintained liaison with the National Health Service Corps.

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Committee on Health Care Financing: The Committee monitored and evaluated the experimental health maintenance organization program and, with the passage of the HMO act, made plans to develop a pamphlet for physicians concerning all aspects of the program. It developed recommendations regarding "no-fault" auto insurance, assisted in revising the Peer Review Manual, and developed guidelines concerning confidentiality of care and health insurance claim form and published a brochure of instructions for users of the form. Liaison was continued with Blue Shield, Blue Cross and the private health insurance industry.

Committee on Health Care of the Poor: The Committee met with the inner city poor in Cleveland to help resolve basic pediatric needs and, as a result, a pediatric clinic was established. The Committee provided Congressional testimony on the inadequacy of migrant health care and developed principles for a nationwide migrant health insurance program which could be introduced to Congress. It also was instrumental in the introduction of an Indian health bill into Congress, and contracted with HEW's Medical Services Administration to seek means of involving health providers in Early and Periodic Screening, Diagnosis and Treatment. The Committee initiated, with the County Medical Society of New York City and representatives of several New York medical schools, consumer groups and television companies, a comprehensive program to develop health education for the poor. The Committee completed two demonstration programs in East Harlem on drug abuse and school health examinations, made plans to produce a 30-minute film on inner-city health care, and provided liaison to a wide variety of national and state professional, governmental and consumer organizations involved in poverty programs.

Committee on Private Practice: The Committee completed its revision of the 1964 Report on Physician-Hospital Relations, began development of a cooperative effort between hospital medical staffs and local medical societies, and initiated a program to increase the number of physicians engaged in office-based primary patient care. The Committee continued its efforts to encourage young physicians at the intern and resident levels to actively participate in organized medicine and embarked on a project to stimulate formation of private practice committees by all state medical associations within the next two or three years. Liaison was maintained with the Federation of American Hospitals, the American Hospital Association and the Joint Commission on Accreditation of Hospitals.

Joint Liaison Committee of American Association of Medical Clinics, American Medical Association, Medical Group Management Association: In its effort to develop better liaison and coordination of member research projects concerning medical group practice, the Joint Liaison Committee prepared a statement for Judicial Council consideration on the subject of charging interest on patients' past-due accounts, completed a survey of the number of medical clinics that provide for lay employees' participation in profit-sharing and pension plans, and revised its definition of group practice. The Committee continued to explore the possibilities of joint coordination of research activities and requests for research funds, and to work towards more extensive media coverage of group practice-related activities and programs.

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DEPARTMENT OF COMMUNITY HEALTH

The Department provided staff support for the Board of Trustees' Commission on Emergency Medical Services and Committee on Community Emergency Services and two committees of the Council on Medical Service: Committee on Community Health Care and Committee on Health Care of the Poor.

Staff assisted in preparing testimony for AMA representatives before Congressional committees and in writing a legislative proposal on emergency medical care. Staff continued to work with the Emergency Medical Services triage program at Chicago's O'Hare International Airport and assisted the Committee on Health Care of the Poor, under an HEW contract, to develop a "Guide for Professional Health Provider Participation in Early and Periodic Screening, Diagnosis and Treatment of Children under the Medicaid Program." Staff also collaborated with the Section on Government Medical Services in preparing draft guidelines for the definition of actual providers of health services in health planning and similar programs, and has been approached by DHEW to apply for a contract to convene a task force to consider proper physician participation in home health care.

Commission on Emergency Medical Services: The Commission completed revision of the "Guide for Program Planning--Emergency Medical Service Technician," and added two new organizations to its membership--the University Association for Emergency Medical Services and the U.S. Department of Transportation. The Commission continues to circulate over 4,000 copies monthly of the Emergency Medicine Today newsletter, and has entered into a new operational phase intended to broaden the Commission's scope of activities and to incorporate the activities of additional organizations with an interest in EMS systems. The Commission formulated guidelines for training emergency medical service technicians and provided comments and suggestions concerning the Model Ambulance Ordinance to the National Safety Council for consideration.

Committee on Community Emergency Services: A major activity concerned planning the program development and implementation of a series of four workshops on emergency medical response systems designed to help community groups and institutions improve emergency care in their regions. These workshops, funded by a grant from the Robert Wood Johnson Foundations, will be carried out during the fall of 1974. The Committee made many recommendations which are contained in the EMS legislation adopted as federal law in November 1973 and, working with AMA's Legislative Department, developed recommendations on long-range emergency medical services communications needs for submission to the Federal Communications Commission.

DEPARTMENT OF HEALTH INSURANCE

The Department staffed four task forces of the AMA Advisory Committee on Professional Standards Review Organizations, published the PSRO Report on a twice-monthly basis, and presented a series of eight regional conferences on PSRO.

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The Peer Review Resource File was maintained and information regarding insurance practices and peer review and quality assessment programs was disseminated to the medical profession, health care organizations and the public. Two updates to the Peer Review Manual were prepared, and a $1,000,000 grant was received from HEW to oversee the development, by medical specialty societies, of criteria for screening the necessity, appropriateness and quality of medical services in hospitals.

The Department continued to provide AMA liaison with foundations for medical care, and provided assistance to AMA representatives serving on the Board of Directors of the American Association of Foundations for Medical Care. Staffing support was provided to the Council on Medical Service's Committee on Health Care Financing, the Joint Conference Committee of AMA-NABSP, the Ad Hoc CMS Committee on Foundations for Medical Care, the Work Group on Attending Physician Report Forms, the Committee of AMA representatives on the Private Initiative in PSRO Project and the Committee of AMA Representatives on the NABSP Board of Directors.

Joint Conference Committee of American Medical Association and National Association of Blue Shield Plans: The Committee met in an attempt to resolve matters at issue between the Medical Society of the County of Erie and Blue Shield of Western New York, Inc. The Committee concluded that although some progress has been made, it will not be able to provide a mutually satisfactory solution.

AMA Representatives on NABSP Board of Directors: Items of interest to the AMA discussed during the past year at meetings of the NABSP Board of Directors included Medicare claims-processing activities, Blue Shield-Foundation relationships, the Federal Employee Program, economic stabilization controls, outpatient diagnostic services, PSROs, the NABSP bylaws and budget, and national health insurance.

DEPARTMENT OF HEALTH MANPOWER

The Department staffed the Council on Health Manpower and its three committees on Certification, Registration and Licensure, Emerging Health Manpower, and Manpower Utilization. The Ad Hoc Advisory Committee on the Physician's Assistant advised the Council and the National Board of Medical Examiners concerning development of a national certification program for primary care physician's assistants. An Ad Hoc Committee on Foreign Medical Graduates was established, and the Committee on Liaison with Related Health Professions was discharged.

The Department revised Horizons Unlimited, published two new brochures entitled The Challenge of Medicine and Financing a Health Career, developed a statement regarding "Distribution of Physicians by Medical Specialty" and a "Directory of Programs: Training Physician Support Personnel, School Year 1973-74," published a new booklet, Employment and Use of Physician's Assistants: A Guide for Physicians, and completed a survey of "Health Care Functions and Responsibilities of Physician's Assistants."

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Council on Health Manpower: The Council made plans for the Congress on Health Manpower in October 1974, made recommendations to the Board of Trustees regarding relicensure requirements, developed jointly with the Council on Medical Education a report on physician competence, discussed proposals or made recommendations for development of emergency medical technicians, ultra-sound technologists, and renal dialysis technicians, and met with a number of federal agencies to discuss health personnel certification, the need for expanding the Health Resources Administration's moratorium on licensure, provision of federal financial assistance to allied health education, identification of health service scarcity areas and manpower analysis activities of the U.S. Department of Labor.

The Council was instrumental in the establishment of the National Commission on Certification of Physician's Assistants, recommended AMA participation in an exploratory study of developing a uniform licensing code or model licensing laws for health professions, planned with the Council on Medical Education a workshop on primary care, and recommended a two-year extension of the moratorium on health occupations licensing and suspension in implementation of physician relicensing laws.

Section on Nursing: This Section staffs the Committee on Nursing and the Interorganization Liaison Committee of the AMA-ANA-NLN, and provides liaison to the National Joint Practice Commission and to the growing number of national nursing specialty organizations. An exhibit was staffed at the American Nurses' Association Biannual Meeting, the National Student Nurses' Association Convention, the National Federation of Licensed Practical Nurses Convention, and the National Association for Practical Nurse Education and Service Convention.

Staff also participated in the JCAH Nurse Audit Advisory Committee, the Interagency Council on Nursing Statistics, the Interagency Council on Library Resources for Nursing, and the Advisory Committee to the National Commission for the Study of Nursing and Nursing Education. Presentations were made at two separate institutes sponsored by Hospital Financial Management Educational Foundation. Some 4,000 requests for information on nursing careers, nursing education and the new "nurse practitioner" were answered.

Committee on Nursing: Three meetings were held during the year. The Committee studied reports on the pediatric nurse practitioner credentialing problem, the JCAH proposed method of "nursing audit," changes in federal programs affecting nursing, the growth and programs of the Nurses Association of the American College of Obstetricians and Gynecologists, concerns of the Association of Operating Room Nurses about problems in nursing education, and the geriatric nurse practitioner. Resolutions adopted by AORN were reviewed and forwarded to the Board of Trustees, and several reports on the JCAH "nursing audit" were written for the AMA Committee of JCAH Commissioners. The Committee also assisted in the development of a substitute resolution, "Certification of Nurses in Expanded Roles," which was adopted by the House of Delegates in June 1974.

AMA-ANA-NLN Interorganization Liaison Committee: Items discussed included peer review, quality of patient care assessment programs, foreign nurse graduates, certification of physician's assistants, federal health and manpower

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legislation, recognition and credentialing of nurse practitioners, and programs of the participating organizations.

National Joint Practice Commission: A three-year $326,620 grant was received by AMA-ERF from the W. K. Kellogg Foundation to support the activities of the NJPC. A staff director was employed, an office opened in Chicago, program implementation begun, and statements were issued on "medical and nurse practice acts" and "certification of nurse and physicians."

DEPARTMENT OF HOSPITALS AND HEALTH FACILITIES

The Department staffed the Board of Trustees' Committee of AMA Commissioners to the Joint Commission on Accreditation of Hospitals and two Committees of the Council on Medical Service: Committee on Aging and Committee on Private Practice. The Department continued publication of two bi-monthly newsletters, Medical Staff-in-Action and Perspectives in Long-Term Care, and maintained liaison with the American Hospital Association, the American Nursing Home Association and other organizations in the hospital, long-term care and aging fields.

Staff participated in the 1974 National Leadership Conference and assisted in writing reports for the 1973 Clinical and 1974 Annual Conventions on the subjects of hospital administrators as presidents of hospital boards of trustees, third party rounds, use of the title "family physician" or "family doctor," physician-hospital relations, guidelines for housestaff contracts, structure of a hospital board of trustees, a physician's bill of rights, AHA's Quality Assurance Program Manual, and the JCAH-DHEW listing program for selected chronic diseases.

Committee of AMA Commissioners to the Joint Commission on Accreditation of Hospitals: The JCAH emphasized that clinical privileges of physicians need not be specified in minute detail and permitted medical staff delegation of certain medical functions to allied health personnel. The JCAH also approved new standards for free-standing ambulatory care facilities, continued four pilot projects for coordination of JCAH surveys with those conducted under various state auspices, and revised its pre-survey hospital questionnaire. The Committee of AMA Commissioners met with representatives of the American Dental Association to discuss ADA representation to the JCAH, and met with the AMA Committee on Nursing to discuss the JCAH's nursing audit program.

Of the 2,637 hospitals surveyed by the Joint Commission during 1973, two-year accreditation was granted to 2,018, 518 hospitals received one-year accreditation, and 101 hospitals were not accredited. Surveys of 140 California hospitals were conducted jointly by the JCAH and the California Medical Association.

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DEPARTMENT OF MILITARY MEDICIN

The Department provided assistance to the medical profession on matters involving the medical and health aspects of the national security, particularly those pertaining to the utilization, mobilization and coordination of medical and health resources. Staff maintained liaison with the Department of Defense, the Surgeons General of the Armed Forces, the Selective Service System, and the National Health Resources Advisory Committee.

The Department expanded Project USA, which began in 1972 through an HEW grant to provide temporary, short-term physician replacements for National Health Service Corps personnel. By March of 1974, Project USA had filled over 85% of NHSC requests for physician replacements, recruiting physicians for 52 shortage areas. In June 1974 Project USA was expanded to enroll mid-career primary care physicians in long-term NHSC assignments and to encourage local medical societies to assist NHSC assignees in establishing their practices. The Project USA exhibit appeared at several national medical meetings, including the 1973 Clinical and 1974 Annual Conventions.

The Department established the AMA Committee to Improve Medical Care and Health Services in the Nation's Prisons, Jails and Correctional Institutions. To date, the Committee has developed a statement of purpose "to involve organized medicine on all levels in the establishment and improvement of ongoing medical care and health services for the inmates of the nation's correctional institutions," and has established program priorities to compile project data, communicate the need for and aims of the project, coordinate the program with law enforcement officers and prison wardens, and to certify programs which have instituted the program.

DEPARTMENT OF RURAL HEALTH

Major goals of the Department are improvement in the health care delivery system for the rural population, community organization for health services, and liaison efforts with national farm, educational, research, informational and allied health organizations interested in improving the quality of rural life. Staffing is provided for the Council on Rural Health and its Advisory Committee. Publication of the Rural Health Newsletter was continued.

The Department, in cooperation with the AMA Center for Health Services Research and Development, has begun a research report on a survey of 1960 medical school graduates regarding factors which influenced their selection of a practice location, and has embarked on a similar project with the Center and the Rand Corporation to survey 1965 medical school graduates. Staff also prepared manuscripts concerning a variety of rural health subjects, initiated preparation of a rural health education monograph, and participated in a number of rural health conferences and seminars.

Council on Rural Health: The Council continued liaison function with the Washington Rural Health Project funded by the Washington State Medical Association, and provided assistance to the U.S. Department of Agriculture, Farm

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Foundation and DHEW in development of a synthesis of rural health research. The Council revised its Health Care Delivery in Rural Areas pamphlet and drafted a bill to improve rural health which was introduced into Congress. The Council prepared reports to the Board of Trustees on the "Washington State Rural Health Project" and the "Addition of American Bankers Association to CRH Advisory Committee."

The 27th National Conference on Rural Health, "Rural Health is A Community Affair," was held in Detroit in April 1974 with an attendance of 896 from 46 states. Other meetings included the eleventh Seminar for Extension Specialists in Health Education and Related Fields, a meeting with state medical association rural health committee chairmen, and a joint meeting with representatives of the American Veterinary Medical Association. A joint meeting was also held with the American Agricultural Editors' Association.

PUBLIC AFFAIRS DIVISION

DEPARTMENT OF FIELD SERVICE

Legislative Activities: Each of the 12 field representatives provided close liaison between component and constituent medical societies and the AMA's Legislative Department and the AMA Washington Office. The field representatives served as consultants to the states on legislation of interest to the profession, especially as it related to the NHI issue. Staff mounted a strong effort in opposition to the extension of the Economic Stabilization Act and Phase IV; conducted educational efforts on the development of PSROs; and did periodic surveys of state medical society PSRO policy. The field staff also sponsored two regional meetings for state lobbyists to discuss trends in state health legislation. A special "hot line" telephone service links the Department in Chicago with state and county medical societies.

Political Education: The field representatives worked closely with state political action committees by providing direct assistance in the development of membership programs, political education workshops, and campaign management expertise. Membership in AMPAC set a new record. This political education program was supported by the creation of audio-visual materials and manuals on PAC and campaign organization.

Speakers and Leadership Services: Fifteen speakers and leadership training seminars were conducted in 11 states, reaching more than 900 key physician leaders. Four speakers training seminars were held at the Marriott O'Hare Hotel. This new program is projected through 1975. The AMA Speakers Bureau on National Health Insurance placed physician speakers before scores of lay and professional audiences and millions of listener/viewers via broadcast media. It keeps speakers informed through special briefings and a newsletter. This Section also conducted special programs for the National Leadership Conference, Woman's Auxiliary, and the New Medical Executives School.

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Officers Services: The Department assumed primary responsibility for handling the scheduling of commitments for both the President and the President-Elect in their almost daily appearances on behalf of the AMA. The President set these individual priorities -- giving Congressional testimony, making major national appearances on national health insurance and other socioeconomic issues; and participation in AMA meetings and state medical society programs. The President-Elect set his major priorities on participating in county and state medical society meetings. The two officers appeared before approximately 50,000 physicians during the year. The Department also coordinated the AMA's continuing Trustee Visitation Program with constituent and component medical societies. At least one officer or trustee served as a resource person and program participant at all but three of the 51 constituent medical association programs during the year.

AAMSE Regional Meetings: Six American Association of Medical Society Executives regional meetings were held on the subject of management training. Field Service provided staff backup for this series of meetings. The subject material was developed and coordinated by the Department in conjunction with outside management experts.

1974 AMA-AMPAC Public Affairs Workshop: Staff provided assistance to AMPAC Board of Directors and staff in planning the AMA-AMPAC Public Affairs Workshop. The 700 participants participated in discussions on campaign techniques and management; campaign laws; membership; and health legislation.

1974 AMA National Leadership Conference: Staff planned and implemented the second AMA National Leadership Conference which was held in January at the Marriott Hotel, Chicago. The meeting was designed to provide technical skills and information on priority subjects to physicians and staff in leadership positions in constituent, component, and specialty medical societies. Workshop sessions centered on such topics as local and federal regulatory challenges; medical society surveys; national health legislation; membership promotion; public relations; relicensure, recertification, and continuing medical education; the physician as a purchasing agent; and medical staff organization. Attendance was more than 700. The multi media presentation, Federation Evesdrop, shown at the opening session, was duplicated for use by medical societies.

Communications: Special communications tools were developed for use by field representatives as they worked with component and constituent societies on legislative activities. These included an update of the Medicredit slide-sound presentation and a new slide-sound presentation on PSRO. Printed materials included two pamphlets on Medicredit, Medical and Health Care For All, and Better Health and Medical Care in America--What Does Your Doctor Prescribe?; and publication and distribution of ACTIONLINE, an NHI newsletter.

General Services: The Department conducted three invitational surveys of the organization, structure, administrative policies, membership programs and services, and community posture of constituent societies. Field representatives also served as liaison between component and constituent societies and the AMA's Membership Department, providing specific consultation on the AMA's new state and county membership incentive plans and membership campaigns initiated by the societies themselves.

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LEGISLATIVE DEPARTMENT

The Legislative Department continued its primary assignment of reporting on national legislative activities of medical interest. An ever-increasing number of health bills were anaylzed as introduced in Congress, as modified in Congressional committees, conferences, and floor action, and as finally enacted into law. The analyses, as well as summaries of lengthy bills, were distributed to appropriate AMA Committees, Councils, and Departments, and to state and specialty medical societies. Comments on these bills were encouraged in order to provide the Council on Legislation with the most complete information upon which to base its recommendations.

Another major activity has been the monitoring of proposed regulations, rules, and final regulations published in the Federal Register. In addition to a distribution to AMA Councils, Committees and staff, a substantial distribution is made to state and specialty medical societies. Comments received from these societies are considered in the position which is taken and in submitting comments on these proposals.

Council on Legislation: The Council met seven times. It reviewed legislation of medical interest and made recommendations to the Board of Trustees. Representatives of the specialty societies attended and participated in two of the meetings. Legislation studied by the Council included such subject areas as: the major national health insurance proposals; expiring health programs under the Public Health Service Act; health services for migrant workers; drug abuse; medical library assistance; family planning; catastrophic illness insurance; cosmetic safety; emergency medical care; drug and alcoholism treatment programs; protection of human subjects in medical experimentation; occupational safety and health amendments; various amendments to the Social Security Act including out-patient drugs under Medicare and Medicaid, renal dialysis under Medicare; Medicare and Medicaid fee schedules, and the creation of an independent Social Security Administration; community mental health centers, biomedical research fellowships and traineeships; developmental disabilities; Keogh Pension Act Amendments; various amendments to the Food and Drug Act; neighborhood health centers, special pay for physicians in the uniformed services; Indian health care; National Health Service Corps; health planning; and health manpower.

General Services: Publication of Legislative Roundup continued with a weekly distribution now of approximately 5,000. The Department also began publication of a new periodical, State Health Legislation Report. New federal regulations and changes, as proposed and as finally promulgated, were disseminated to state, county and specialty medical societies. Proposed regulations covered subjects affecting: skilled nursing facilities under Medicare and Medicaid; physical examination of commercial vehicle drivers by chiropractors; payment for services of teaching physicians under Medicare and Medicaid; transfer of barbiturates from Schedule III to Schedule II; home health care programs under Medicare and Medicaid; chiropractic services under Medicare, labeling of deodorant sprays; Cost of Living Council control proposals; gasoline allocation for physicians and other health care users;

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information to patients on prescription drugs; preadmission approval under Medicare and Medicaid; PSRO area designations; procedural terminology under Medicare; maximum allowable cost for drugs under Medicare; national blood program; limitation on coverage of costs for uncovered services under Medicare; and implementation of the Health Maintenance Organization Act.

Development of Proposed Legislation: Legislative bills prepared by the Council were reviewed for introduction in the 93rd Congress. They included:

--Rural Health Care Delivery Improvement Act. This would establish an Office of Rural Health in HEW. The Director would have the authority to award grants, contracts, loans and loan guarantees for projects to examine existing models of rural health care delivery, to determine their applicability and transferability to other rural areas, and to assist in the study, planning, development, experimentation, and demonstration of rural health care delivery models.

--Amendments to PSRO Provision of Social Security Amendments. Eighteen changes in the Social Security Act were developed to remove objectionable provisions and requirements. These amendments were combined into a single legislative proposal.

--Disabled Physician's Act. This is a model state bill for the restriction, suspension, or revocation of the license of any physician because of his inability to practice medicine with reasonable skill and safety to patients by reason of physical or mental disability.

The Council continued its active support of the following AMA bills which were previously approved for introduction in the 93rd Congress:

--Medicredit. This national health insurance proposal would provide comprehensive protection against ordinary and catastrophic expenses of illness for all persons and families, regardless of income levels, through a voluntary system. The benefits include full hospitalization, all physician services, out-patient care, home health services, skilled nursing home services, and specified dental care. The program would be financed through the use of tax credits on a sliding scale with the greater financial assistance being provided to low-income individuals and families. The cost of the catastrophic coverage would be paid by the government for all persons.

--Emergency Medical Services. This bill would establish a comprehensive emergency medical service system throughout the country. While direction and financial assistance would be provided at the federal level, the program is focused at the community level. Communities would be assisted in establishing and operating an emergency medical service program as a part of an overall state program.

--Blood Bank Legislation. The AMA bill would amend the antitrust

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laws to provide that the refusal of nonprofit blood banks and of hospitals and physicians to obtain blood and blood plasma from other blood banks would not be deemed to be acts in restraint of trade.

--Establishment of a U.S. Department of Health. Created within the Executive Department, at the Cabinet level, would be a separate Department of Health headed by a Secretary of Health who would be a doctor of medicine appointed by the President, with the consent of the Senate. This Department would administer all programs relating to health now under the jurisdiction of HEW.

--Labeling of Containers of Prescription Drugs. The AMA draft bill would amend the Federal Food, Drug, and Cosmetic Act to require that the label of drug containers, as dispensed to the patient, carry the established or trade name, the quantity and the strength of the drug dispensed, except when otherwise specified by the prescribing physician.

--Social Security Cash Pension Benefits For Physician: This draft legislation would amend the Social Security Act to change the qualifying dates so that physicians would receive equitable treatment under Social Security in order to qualify for cash benefits.

--Free Choice of Physicians and Hospitals for Veterans. This proposal gives to the veteran the choice of receiving his hospitalization in a Veterans Administration hospital or a local community hospital.

--Amendment to the Internal Revenue Code to Permit Individuals to Deduct Expenses for Medical Care. This AMA bill would remove the 3% and 1% limitations on medical and drug deductions and would permit a taxpayer to deduct the full amount of medical expenses and drug expenses.

Medical Bills Enacted Into Law: Among the new enactments in the 93rd Congress during the reporting period were: PL 93-82, Veterans Medical Care Act of 1973; PL 93-112, Rehabilitation Act of 1973; PL 93-151, extension of the Lead Paint Poisoning Prevention Act; PL 93-154, Emergency Medical Services Systems Development Act; PL 93-155, which continues the operation of the Public Health Service hospitals; PL 93-222, Health Maintenance Organization Act; PL 93-270, Sudden Infant Death Syndrome Research Act; PL 93-274, special incentive and continuation pay for physicians in the uniformed services; PL 93-281, Narcotic Addict Treatment Act of 1974; PL 93-282, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1974; and PL 93-296, Institute on Aging Act.

AMA Testimony: The AMA testified on amendments to the Keogh Plan Retirement for the Self-Employed; medical devices; availability of opiates for medical purposes; human experimentation; HEW appropriations; food supplements; fuel allocation to health providers; National Cancer Act; National Health

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Service Corps; Indian Health Service; Economic Stabilization Act; migrant health; health revenue sharing; family planning; Neighborhood Health Centers; Community Mental Health Centers; health planning; Medical Libraries Act; Military Special Pay Act; Biomedical Research; National Health Insurance; Drug Utilization Improvement Act; PSRO; Comprehensive Health Manpower Training Act Amendments; Occupational Safety and Health Act; Nurse Training Act; Allied Health Training; and Medical Facilities Construction Assistance Act.

Pending Legislation: At midyear 1974, about 23,000 bills had been introduced in the 93rd Congress, 2,200 being of medical interest. Several important measures are awaiting action by either or both Houses. Among these are national health insurance; the establishment of an Office of Rural Health Care in HEW; the creation of a cabinet level Department of Health; health planning; medical education; the National Health Services Corps; allied health training; medical facilities construction; community mental health centers; migrant health; Indian health; neighborhood health centers; medical devices; health planning; nurse training; and various amendments to Medicare and Medicaid.

AMA OFFICE IN WASHINGTON

The Washington Office continued its operation of collecting, evaluating and reporting information and observations concerning proposed legislation and regulations, as well as supplying a fast and accurate flow of information between the AMA and the federal government and all Washington-based health related organizations and agencies. Day-to-day informational services to national communications media also continued to expand. Much of the Office's activity this year was related to NHI and PSRO regulations and amendments.

A major activity of the Office continues to be the briefing of state and specialty society representatives during their visits to Washington. Forty-two briefings were conducted by Washington staff during the report period. In addition, 51 speaker requests from medical and non-medical groups were filled.

Department of Congressional Relations: During the period of this report, about 1,075 bills relating to medical and health care were introduced into the Congress. Proposed and already enacted legislation of concern to the AMA included:

--National Health Insurance: Twelve major NHI proposals continued to occupy the Department. AMA's Medicredit proposal still led in terms of sponsors.

--Economic Stabilization Program: Much activity centered on the removal of controls on physician fees, and the subsequent ending of this program.

--Health Maintenance Organizations: The Department monitored the funding of this program, reporting its findings to appropriate bodies.

--Professional Standards Review Organizations: The Department

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concerned itself with certain amendments to the law, and with repeal measures.

--Pension Reform (Keogh): The Department was successful in persuading Congress to liberalize certain portions of this legislation.

For the first time the Department conducted a survey of member attitudes on key health legislation. Activity also continued in the briefing of AMA witnesses, and in obtaining Congressional speakers for various groups.

Department of Governmental Relations: Three major areas of activity were the Economic Stabilization Program; implementation of Public Law 92-603, particularly the PSRO provisions; and national health insurance. Other activities included maintenance of contacts with government officials and arrangements for meetings between AMA representatives and governmental officials, including the President of the United States.

Department of Communications: Day-by-day services of increasing frequency were furnished to national news media, private health related organizations and agencies, health field publications, and the federal government. Speeches were produced; radio and television interviews arranged; news releases prepared and delivered; news conferences arranged; press room services provided; public relations council and advice given; topics researched; background materials assembled; information kits prepared; increased services provided to constituent societies; and increased input provided in the drafting of statements and testimony. The Department continues to provide Washington and Eastern U.S. reportial services to American Medical News, JAMA, and the AMA Newsletter.

Washington Library: More than 12,000 inquires from staff, congressional offices, executive branch agencies, private organizations, the medical community, and the public were answered. Groundwork for a major reorganization of library materials was established during the year to improve and expand information and research services. Working relationships were maintained with more than 50 libraries in the federal government and health-related organizations.

DEPARTMENT OF SPECIALTY SOCIETY SERVICES

Specialty Societies: Staff liaison with 26 specialty societies continued, and five legislative briefings for specialty group representatives were scheduled in cooperation with the Washington Office staff. Staff support for Section Councils and the Association of Section and Service Delegates was continued.

Interspecialty Council: The Council held three meetings during the year. Its discussions included health legislation, specialty representation in the AMA House of Delegates, peer review, AMA's scientific programming, medical education, AMA's planning process and economic controls. The only new society added to the Council was the American Council of Otolaryngology.

Medical Students: Officers of the Medical Students Business Session began their formal activities after their election at the 1973 Annual Convention.

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Two meetings of the Business Session have been held, and resolutions on the subjects of involving physicians in training in organized medicine, effective teaching in medical schools, confidentiality of medical student records, service vs. medical education, preceptorships in primary care, and due process for medical students were submitted to the House of Delegates. Programs for students attending the 1973 Clinical Convention and the 1974 Annual Convention were presented on the subjects of involving medical students in organized medicine and financing medical education. The officers held two meetings and were primarily concerned with planning convention activities. Medical student membership appeals were included in four issues of Online, the AMA student newsletter. Student membership increased 1,067 to 3,300 in 1974.

The Department also continued to staff the Task Force on Communications and Education and the AMA Advisory Committee on PSRO.

DEPARTMENT OF MEMBERSHIP DEVELOPMENT

The Department of Membership Development is responsible for increasing the percentage of dues-paying AMA memberships more than proportionate to the growing physician population. Encompassed in this responsibility is the nation's medical student population. The 1974 AMA dues-paying membership increase will by far exceed one-half of the increase in the nation's physician population. This is being accomplished by the development of new pamphlets, programs and communications to all segments of the physician and medical student population. The year 1973 ended with an increase of approximately 5,000 dues-paying AMA memberships over 1972, when the membership effort was initiated. This figure was double the largest dues-paying membership increase of any of the preceeding 12 years. In addition, 45 state medical associations exceeded their 1972 AMA membership year-end total.

The 1974 membership year can be identified as an improvement over 1973. By mid-June AMA dues-paying membership had exceeded the 1973 year-end total. At the end of July membership figures were over the 1973 year-end total by 4,000, with five months of reporting yet to go. A total of 31 medical societies had exceeded their 1973 year-end total. All categories of membership reporting had gone over the top. Intern and resident membership had increased by 1,400 and medical student membership had tripled by July 31, 1974, over the preceeding year. Projections are that the AMA dues-paying membership increase for 1974 will double the increase of the record year of 1973. During 1974 the AMA will exceed its all-time high in dues-paying membership.

COMMUNICATIONS DIVISION

In the area of general, non-clinical information, the Communications Division serves as an link between the AMA and physicians, the news media, and the general public.

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NEWS BUREAU

Press Relations: This Section handles many requests from newspapers, wire services, and radio-TV networks and stations for information and assistance on stories about the socioeconomics of medicine. Staff also assists AMA officers and departments by serving as liaison with the press, and it operates press rooms at the Annual and Clinical Conventions and at other AMA events.

AMA News Features continued to provide stories for medium and small-size daily newspapers, but also expanded into a new role of highlighting reports from Today's Health and Prism magazines. Many editors indicate that they keep AMA News Features material to use as a source for developing local stories.

Science News: This Section prepares news releases, staffs press rooms for scientific meetings, and renders research service to writers on medical scientific subjects. Some 400 news releases were issued in support of AMA scientific programs and meetings and based on papers published in JAMA and other AMA scientific publications. Press rooms were staffed for 18 scientific meetings, including the Annual and Clinical Conventions. Some 1,700 queries by telephone and mail were received from writers, many seeking AMA policy in scientific areas, others seeking basic medical facts. "Health Tips," the weekly column of health information for the public which is distributed through the press, continued to be popular. The Section conducted the AMA Medical Journalism Awards program, which drew 480 entries. Five awards of $1,000 each were presented for outstanding journalism advancing public understanding of the science and art of medicine. The Section maintains liaison with writers and editors in all media as a part of a continuing program that makes the AMA the authoritative source of information about medical science.

Magazine Relations: This staff alerts editors and writers to story ideas and assists in story development. It handles, on the average, three requests for editorial assistance daily. A number of stories were prepared specifically for national publications, including Saturday Evening Post, Parents' Magazine, and Medical Dimensions. Detailed rebuttals to inaccurate articles were prepared. Background interviews were arranged between the AMA President and the editors of Harper's, Reader's Digest, and Business Week. Representatives were placed on TV and radio, including the "Today Show," "CBS News," Mutual radio, "Not for Women Only," and local shows in Chicago, New York, and Los Angeles. The section again handled public relations for the Quality of Life Congress. It also continued its program of personal contact with editors and reporters.

Speakers Services: Staff assisted AMA officers and members of the Board of Trustees in the research and preparation of 92 speeches on various socioeconomic and clinical topics. Other writing projects included articles in media ranging from The Wall Street Journal and Physician's Management to The American Farmer, plus initial copy for an audiovisual script on medical progress. Staff also wrote summaries of House of Delegates actions at the Annual and Clinical Conventions.

AMA Update, which now goes to nearly 15,000 American thought leaders, continues to be widely quoted in the media. Update's national health insurance

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report was reprinted to fulfill requests from medical societies, educators, media people and government agencies.

RADIO, TELEVISION, MOTION PICTURES DEPARTMENT

This Department serves both the media and constituent societies. During the past fiscal year it assisted in the creation and production of the television program Today's Health. The program, designed for commercial syndication, is produced by Phillip Gittelman Associates in cooperation with Today's Health magazine.

Public service announcements produced for television were broadcast by more than 600 stations and the "instant radio news service," offering prerecorded news and health messages, was used by more than 500 major radio stations each week. More than 18 million persons saw AMA films during the year. Audio cassette highlights were produced for every major AMA meeting and more than 15,000 cassettes were sold.

TODAY'S HEALTH

The magazine continued its efforts to provide consumers with current and authoritative information in the areas of physical and mental health. A series on "Pain Exploiters" chronicled medical abuses in the treatment of such ailments as arthritis and cancer. A second series, "Environmental Life Preservers," continues to celebrate the many positive ecological developments effected by an aware and crusading public. In the past year, Today's Health won ten awards in graphics competition.

PRISM

The magazine continued to build increased acceptance both within medicine and with the general media. Some 9,000 doctors of osteopathy were added to Prism's subscription rolls, and mail from readers has reflected overwhelming support for the publication.

By the end of 1974, Prism will have published material from five Nobel laureates and many of the leading medical and scientific writers in the country. Prism articles were picked up or quoted in the Atlantic Monthly, Time, Reader's Digest, Saturday Review, The Wall Street Journal, The Los Angeles Times, and other national publications. Within the past year, Prism has received 31 graphic arts awards.

SPECIAL PROJECTS DEPARTMENT

The Department produced a wide variety of materials (over 1,200) for and

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in cooperation with virtually all departments and divisions of the AMA. Those materials included books, pamphlets, charts, forms, newsletters, mailers, ads, posters, subscription materials, exhibit and display designs, as well as photographic services.

Substantial efforts were made to encourage attendance and enrollment at AMA conventions, meetings, national and international seminars, charter flights and group tours. Today's Health magazine circulation development received special emphasis through a variety of programs. In cooperation with the Committee on Printed Materials and various AMA departments, Special Projects put into action a plan to produce AMA literature more economically and efficiently.

DEPARTMENT OF PROFESSIONAL COMMUNICATIONS

This Department is responsible for the AMA Newsletter, American Medical News, the Annual Report published in the Clinical Convention Handbook and Proceedings, the Daily Bulletin, and the 535 Reporter. The Department also staffs the Sheen Award Committee and performs various editorial services for the Office of the Executive Vice President.

AMA Newsletter: Bulk shipments of the "Green Sheet" are now sent to 134 state, county and specialty medical societies for distribution to their officers. In Brief, a monthly page of short items, is distributed to medical society editors for reprinting in journals and bulletins.

American Medical News: Effort was directed at reporting, both in news accounts and in major feature stories, the events affecting the practice of medicine. These included the nation's discussions of national health insurance, professional standards review organizations, price controls on physicians and hospital-physician relations. Other subjects reported in depth included professional corporations, health care delivery, manpower, computers and medical data, and health care in prisons. Demographic editions were begun. A new feature, "My Opinion," featuring specially written articles by physicians and others, was started.

MANAGEMENT SERVICES DIVISION

The Purchasing and the Transportation Sections were transferred from the Operating Services Department to the Management Services Division Office. The Purchasing Section processed 4,300 orders for materials and supplies during the reporting period. The Transportation Section processed 3,084 travel requests, in addition to arranging charters from Chicago and New York to Anaheim, Calif. Travel arrangements were made for a group of 250 members attending the 2nd International Health Conference in Australia and for a group of 16 AMA representatives to the Peoples Republic of China.

The Office undertook a study of arranging travel for AMA members, officials and staff through a commercial travel agency and completed an agreement

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with Marriott Travel Agency to handle AMA travel requirements and AMA Travel Seminars. A contract was negotiated with Group Travel Unlimited to function as the coordinating travel agency for the 1975 Clinical Meeting in Honolulu.

BUILDING SERVICES DEPARTMENT

Third floor alterations consisting of architectural, ventilation, ceiling and lighting. During the year, the Department responded to 3,886 calls for custodial and mechanical services, as well as requests for carpentry, electrical, lighting, plumbing and decorating services.

CIRCULATION AND RECORDS DEPARTMENT

This Department is responsible for the distribution of all regularly published AMA periodicals and maintains the biographical and historical records of physicians as well as the medical students and AMA membership records. AMA membership showed a continuing growth for the second year. Requests for information and services averaged more than 2,600 per day.

Of the 18 regularly published periodicals, six had increases and 12 had slight decreases with a total number of 3,511,000 copies per month. Today's Health has the largest circulation, 478,000. American Medical News has a distribution of more than 360,000 copies per week.

CONVENTION SERVICES DEPARTMENT

Arrangements were made for the Clinical Convention in Anaheim and the Annual Convention in Chicago, with total attendance of 8,259 and 17,702 respectively. In addition, 387 separate meetings and social functions were handled at the headquarters hotels during these two Conventions.

During the reporting period, 213 ancillary meetings were held, 204 of which were handled by the Department. In the AMA exhibit program, 204 exhibits were displayed in 90 cities for a total of 2,214 show days. They were viewed by two million persons. Twenty-three exhibit construction projects were completed.

GENERAL SALES DEPARTMENT

The General Sales Office has instituted a number of changes and improvements. Advertising income was increased by means of market penetration and further reorganization of the sales staff. The incentive program was refined for proper salesman motivation. In order to provide complete data on AMA publications as well as all competitive publications, a number of surveys were conducted and shared computer time purchased. A sales promotion manager was

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added to the staffing system was developed for the computerization of billing, sales reporting and record-keeping, and territorial responsibilities were realigned to respond to current marketing needs.

DATA SERVICES DEPARTMENT

The Department has concentrated on stabilization and reorganization of staff and staff responsibilities during the past year.

The Board of Trustees approved implementation of AMCAP (American Medical Computer Assistance Program), which offers a variety of computer assistance services to county, state and specialty medical societies. The program will provide a sophisticated system of information collection, storage and retrieval. Services will include dues billing, membership rosters, label production, annual meeting attendance and continuing education record keeping. A brochure has been developed outlining in detail the various services available under AMCAP.

Computer configuration was upgraded through the installation of the IBM 370/158 system purchased in December 1973.

OPERATING SERVICES DEPARTMENT

The Contract Printing Section and the Publication Production Section negotiated new printing contracts for Archives of Dermatology, Archives of Environmental Health, Archives of Neurology, Archives of Ophthalmology, Archives of Otolaryngology and Archives of Pathology. These contracts provide for totally integrated production and, as a result, an annual savings of $100,000 can be expected (before inflation).

The Reproduction Section and Processing and Distribution Section processed more than 7,100 individual "in-house" printing jobs valued at $480,000. Over 260 tons of paper were consumed for "in-house" work.

The Job Printing Section processed more than 1,100 jobs purchased from outside sources, expenditures of which amounted to approximately $820,000.

PERSONNEL AND OFFICE SERVICES DEPARTMENT

This Department services AMA personnel requirements, administers pamphlets and film distribution, provides for telephone, mail, cafeteria and medical services and is responsible for negotiating publishing arrangements for AMA books other than journals.

During the reporting period, 70 exempt employees and 210 non-exempt employees were employed. The Employment Section provided counseling that resulted

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in the promotion and/or transfer of 48 employees. Equal employment opportunity activities were increased during the year and a new updated affirmative action plan was submitted to HEW. The Section also instituted a policy of internal job posting.

The Compensation and Benefits Section accelerated its programs of employee-benefit counseling, job anaylsis and marketplace salary data gathering, and conducted benefit orientation meetings for new employees twice monthly. The Section provided retirement counseling to 69 employees, reviewed and classified 75 clerical positions and participated in four salary surveys.

Fourteen employees retired during the year. A new system of notifying all departments of employee salary anniversary dates was begun. New computer programs were designed to provide information on those participating in the benefit plans, and a program was initiated to generate estimated pension amounts for employees nearing retirement.

The Employee Relations and Training Section conducted a wide range of training, educational and orientation programs for employees on all levels in Washington and Chicago. Approximately 25 various training activities and classes were completed by 424 employees and 160 more attended orientation programs. Management development programs were prepared for federation executives. Approximately 250 executives attended seven such programs. The following regular activities were continued: AMA Visitor Tours, Service Recognition Program, AMA Services Organization Guide and Benefit Communications.

The Office Services Department entered into contractual negotiations with Association-Sterling Films to handle the AMA Film Library promotion and distribution operation.

The mail unit distributed approximately five million pieces of first-class mail. Of the 1,300 health education titles in storage, total movement for the year was more than five million copies.

In July 1973, AMA converted from its present dial telephone system to a Centrex 3 telephone system. The conversion resulted in improved services and expansion capabilities.

A total of 4,720 employees visited the Medical Department. The total membership in the Group Assurance Program (blood bank) is 325 and the last blood drive resulted in 179 pints of blood.

AMA COPPORATE AND MEMBER'S INSURANCE

This Department staffs the Board of Trustees Committee on Insurance which was established in June 1973 to develop and administer insurance plans for AMA members and employees. Seven Committee meetings were held during the reporting period. Since the current carrier elected not to renew its contract to underwrite the disability insurance program, the Committee and staff negotiated with a number of major insurance carriers to select one that would underwrite the best possible program for members. The Board of Trustees approved appointment

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of Sentry as the underwriter, Marsh & McLennan as the broker, and MICA as the administrator for the new plan, which became effective September 1, 1974.

Other developments included: (1) Offering to Texas physicians an amended Group Term Life Insurance Plan which complied with restrictive state insurance statutes; (2) introducing two new programs to members--In-Hospital Indemnity and Accidental Death & Dismemberment; (3) conducting a resolicitation of the Excess Major Medical Program. A brochure entitled Patterns of Protection, which describes the various insurance programs available to AMA members, was published and distributed to members and non-members. The Department and the Committee are making an in-depth study of current problems relating to the underwriting of malpractice coverage for AMA members.

AMA EDUCATION AND RESEARCH FOUNDATION

Contributions to the AMA-ERF during the period of this report totaled $2,029,115, an increase of $331,047 over the preceding 12 months. Gifts from physicians totaled $704,068; from the Woman's Auxiliary to the AMA, $752,817; and $572,230 from foundations, medical organizations, corporations and laymen. In the preceding year these sums were $147,880 from physicians, $123,618 from the Auxiliary, and $59,549 from the other sources.

Increases were also recorded in each of the program categories designated by the contributors. A total of $1,244,647 was earmarked for medical schools, $211,767 for the regular loan guarantee program, $80,145 for interest-subsidized loans to disadvantaged and deserving students, $196,603 for the unrestricted fund, $189,321 for categorical research grants, and $106,632 for the National Joint Practice Commission.

The upward trend was also noted in the Medical Education Loan Guarantee Program. Medical students, interns and residents obtained 3,198 loans, totaling $4,306,817. Since the program's inception in 1962, the AMA-ERF has backed 53,528 loans worth $61,769,398. As of June 30, 1974, there were 19,611 loans outstanding worth $33,147,193.

Since October 1971, when the Medical Student Opportunity Loan Plan was initiated, 220 interest-free loans totaling $395,450 have been guaranteed for disadvantaged and deserving medical students. Acceptance of these loans committed AMA-ERF to approve and guarantee up to $1,088,400 for the 169 students in this program during their years in medical school. Interest paid on these loans by the AMA-ERF totals $29,317. During the period of this report, the interest-free loan program operated in California, New York, and Illinois. Expansion of the program to other states is planned.

FEDERAL TRADE COMMISSION
File No. 4064 Commission Investigational Exhibit No. 1051-Z-22
In the matter of AMA
Date 10/18/77 Witness
Reporter
By

Ex. # 24

AMERICAN MEDICAL ASSOCIATION
ONE BUCKMINSTER PLACE • FRAMINGHAM, MASSACHUSETTS 01701 • PHONE (617) 879-7700 • TWX 710 380 7594

PUBLIC AFFAIRS DIVISION
WHALEN M. STROBHAR,
Director

DEPARTMENT OF FIELD SERVICE
RICHARD G. LAYTON,
Director
RAYMOND T. SULLIVAN, JR.
Assistant Director

CX 1786

March 30, 1973

Samuel Climo, M.D.
291 Whitney Avenue
New Haven, Connecticut 06511

Dear Doctor Climo,

I checked with the AMA's Judicial Council, and they do not have any regularity with the publication of their actions. The only thing available, is the "OPINIONS AND REPORTS OF THE JUDICIAL COUNCIL" which underwent it's most recent revision in 1972. I have arranged for twelve copies to be sent to you. I hope this will be sufficient for your needs.

If I can help in any other way, please do not hesitate to contact me.

With every good wish,

Ray Sullivan

Raymond T. Sullivan, Jr.

RTS/cia
cc: R.G. Layton

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 1786
In the matter of: AMA
Date 9-15-77 Witness: WARREN
Reporter EC
By MEC

315

Ev. # 25

January 19, 1970

CX 1398

FEDERAL TRADE COMMISSION
File No. 9064 Commission Investigational Exhibit No. 1398
In the matter of: AMA
Date 9/7/77 Witness Schaller
Reporter EC
By 64

David B. Weihaupt
AMA Field Service Office
1020 15 St.
Suite 304
Denver, Colorado 80202

Dear Dave:

Dave sent your memeorandum of January 7, regarding the December 23 Bulletin of the Colorado Society of Internal Medicine, over to me Friday. In that Bulletin the statement is made "Since the AMA has stated that the charges for office laboratory work should not include "profit"..."

In your memorandum you state that you are unable to interpret this statement or find anything in the policy regarding it. I find nothing in AMA policy that supports this statement, and I find it difficult to interpret the statement made in the Newsletter.

AMA believes in the free-enterprise system. The free-enterprise system does admit to profit and nowhere have I ever heard it argued that profit is considered illegal or unethical.

AMA policy regarding laboratory billing procedures is pretty well represented in Report A of the Judicial Council and is reaffirmed in Reference Committee'E Report from the July, 1969 session. We must rely on statements in these documents rahter than strange interpretations of Association policy.

With all good wishes, I am,

Sincerely,

Edwin J. Holman

1398

Missouri State Medical Ass.
Ex # 26 p.1

CX 1791A

July 30, 1969

Ray McIntyre, Ex. Secy.
Missouri State Medical Association
515 E. High St.
P.O. Box 1028
Jefferson City, Missouri 65101

Dear Ray:

The Judicial Council would like to meet with you and with the chairman of the committee of your state medical association which is responsible for deciding matters of ethics to discuss current ethical issues and to establish better communications between the Judicial Council and members of your Association. This will be a regional meeting. Invitations are extended to the medical association in Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, Ohio and Wisconsin. The meeting will be held in Chicago at the Marriott Hotel adjacent to O'Hare Field on Sunday, October 5. The meeting would convene at 9:30 a.m. and adjourn at approximately 4 p.m. so that all could return home that evening.

The purpose of the meeting is to promote discussion about ethical problems and to improve communications between the state ethics committee and the Judicial Council. An agenda will be prepared with your assistance. We would like you to let us know as soon as possible, and no later than September 5, just what matters in your opinion should be made agenda items for this meeting. With your advice we can get background material and provide helpful staff assistance.

Among the items that occur to me at this moment are the question of clinical laboratory services, disciplining physicians who abuse Medicaid or other third party payors, peer review, the relationship of physicians to non-medical practitioners of the healing are (optometrists, psychologists, podiatrists, etc). I am sure that you will think immediately of other matters that should be discussed.

9 1 7 1 2 5 4 2 2 1

CX 1791B

Unfortunately the Judicial Council will not be able to pay the expenses incurred by you and your chairman. It will try to make up for this by having a nice luncheon for all of you Sunday noon.

May I have your reaction to this suggestion and your acceptance of the Council's invitation so that I can start making reservations for the meeting. May I also have your suggestions as to what items we should place on the agenda.

Very truly yours,

Edwin J. Holman

EJH/pjd

FEDERAL TRADE COMMISSION
File No. 9064 Commission Investigational Exhibit No. 1791B
In the matter of AMA
Date 9-29-71 Witness Browne
Reporter AG
By MEC

Agenda Item
Ex # 27

February 27, 1970

CX 1792A

Oliver E. Ebel, Ex. Dir.
Kansas Medical Society
1300 Topeka Blvd.
Topeka, Kansas 66612

Dear Mr. Ebel:

The Judicial Council will hold a regular meeting in New Orleans on April, 4, 1970. It would like to have a regional meeting of chairmen of state ethics committees on April 5. It would be more than pleased if the chairman of the committee responsible for ethics in Kansas can attend this meeting.

The Council has had three such meetings (Atlanta, Las Vegas, and Chicago). The meetings have proved mutally advantageous.

The purpose of the meeting is to improve communications between the state committees and the Judicial Council and vice versa. The Council believes that communications are a very serious problem in this day and age. The meetings would be informal. Representatives from your state and Arkansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee and Texas have been invited to attend this meeting. The agenda will be arranged so that problems of most concern locally are discussed. And that is the key to these meetings--full discussion of practical ethical problems.

The Judicial Council extends a most cordial invitation to the Chairman of your state ethics committee and to you to attend this meeting. It will be held at the Roosevelt Hotel on Sunday, April 5, 1970, from 9:30 until 4:00 so

2003

CX 1792B

that those who wish can make a one day trip of it and not take too much time away from the office. Our budget does not permit us to pick up the tab for travel expenses, but we will provide a nice luncheon with all the trimmings Sunday noon.

We would hope that you can attend this meeting and more importantly, that you will suggest ethical issues of importance for discussion by those present.

May I hear from you at your earliest convenience.

Very truly yours,

Edwin J. Holman

EJH/pjd

FEDERAL TRADE COMMISSION
File No. 9064 Commission Investigational Exhibit No. 1792B
In the matter of AMA
Date 9-24-77 Witness Browne
Reporter AG
By MEC

Legis Medical

Ex #28

CX 1793A

January 19, 1970

Mr. C. Lincoln Williston
Executive Secretary
Texas Medical Association
1801 North Lamar Boulevard
Austin, Texas 78701

Dear Mr. Williston:

The Judicial Council will hold a regular meeting in New Orleans on April 4, 1970. It would like to have a regional meeting of chairmen of state ethics committees on April 5. It would be more than pleased if the chairman of the committee responsible for ethics in Texas can attend this meeting.

The Council has had three such meetings (Atlanta, Las Vegas, and Chicago). The meetings have proved mutally advantageous.

The purpose of the meeting is to improve communications between the state committees and the Judicial Council and vice versa. The Council believes that communications are a very serious problem in this day and age. The meetings would be informal. Representatives from your state and Oklahoma, Arkansas, Louisiana, Mississippi and Tennessee have been invited to attend this meeting. The agenda will be arranged so that problems of most concern locally are discussed. And that is the key to these meetings--full discussion of practical ethical problems.

The Judicial Council extends a most cordial invitation to the Chairman of your state ethics committee and to you to attend this meeting. It will be held at the Roosevelt Hotel on Sunday, April 5, 1970, from 9:30 until 4:00 so

CX 1793B

that those who wish can make a one day trip of it and not take too much time away from the office. Our budget does not permit us to pick up the tab for travel expenses, but we will provide a nice luncheon with all the trimmings Sunday noon.

We would hope that you can attend this meeting and more importantly, that you will suggest ethical issues of importance for discussion by those present.

May I hear from you at your earliest convenience.

Very truly yours,

Edwin J. Holman

EJH:jg

FEDERAL TRADE COMMISSION
File No 9064 Commission
Investigational Exhibit No. 1793B
In the matter of AMA
Date 9-29-77 Witness BROWNE
Reporter AG
By MEC

Utah State Medical Association

January 8, 1969

CX 1796A1

Mr. Hoyt W. Brewster, Executive Secfetary
Utah State Medical Association
42 S. Fifth East St.
Salt Lake City, Utah 84102

Dear Mr. Brewster:

The Judicial Council willhhold a regular meeting just preceding the 1969 National Medicolegal Symposium in Las Vegas.

Because of the wide interest thathphysicians have in this Symposium and because Las Vegas is so accessible to members, the Judicial Council voted to hold a Regional Meeting on March 12 for the Chairman of the State of Ethics Committee of Washington, Montana, Wyoming, Idaho, Oregon, California, Nevada, Utah, Colorado, Arizona, and New Mexico. (A similar meeting was held last March in Arlanta which proved to be eminently successful.)

The Chairman of the Committee 6f the State Medical Associations responsible for deciding and interpreting ethical issues and the Executive Secretaries of the State Medical Associations would be invited to attend this meeting. An agenda will be developed according to the wished and suggestions of the states involved. The meeting itself will be informal. Its purpose will be to acquaint the members of the Hudicial Council with the practical problems and questions confronting State Ethics Committees.

At this time on behalf of the Judicial Council may I extend a cordial invitation to you and the Chairman of your Ethics Committee to attend this meeting on March 12. May I solicit your reactions and obtain from you your suggestions as to subjects which should be included on the agenda and discussed. (It occurs to me, at this time, that grievance committees,

CX1796B

the osteopathic question, bank cards, billing procedures, solicitation of patients are some items which might be worth looking into.)

The meeting is scheduled for Wednesday, March 12, and would run from 9:30 or 10:00 a.m. until 4:30 or 5:00 in the afternoon. The invitees would be guests of the Judicial Council for a luncheon Wednesday noon. They would be expected to pay their own expenses otherwise. Those who so desire would then attend the Medicolegal Symposium. We are trying to hold the meeting in Caesar's Palace.

May I have your reactions as soon as possible.

Very truly yours,

Edwin J. Holman

EJH/pjd

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 1796B
In the matter of: AMA
Date 9-29-77 Witness Broome
Reporter AG
By MES

Powers

Ev # 30

MEMORANDUM

CX 1797

TO: Mr. David Powers

THROUGH: Bernard D. Hirsh

FROM: Edwin J. Holman

SUBJECT: Meeting of the Judicial Council

DATE: January 16, 1969

The Judicial Council will meet in Las Vegas on March 11-12, hopefully at Caesars Palace. This meeting precedes the National Medicolegal Symposium jointly sponsored by the AMA and the ABA.

An invitation has been extended to the Chairman of the Ethics Committee of the State Medical Societies of Washington, Montana, Wyoming, Idaho, Oregon, California, Nevada, Utah, Colorado, Arizona, and New Mexico. They have been asked to meet with the Judicial Council on March 12. The Executive Secretaries of the State Medical Societies have also been invited.

An agenda will be developed after discussion with representatives of the several states concerned.

The meeting will be informal. Its purpose will be to try to bring the Judicial Council closer to the State Ethics Committees and visa versa. The Judicial Council believes it must have a greater awareness and appreciation of the ethic questions that are of concern at the local level.

It was just one week ago that the invitations were extended. I have no response to the invitations as yet.

My purpose in this is two fold. First of all, I want to acquaint you in what the Council had in mind. Secondly, I would appreciate the good help of your staff in talking up this meeting to the extent that it may be necessary.

Edwin J. Holman

07464

Ek. 21, p.1

CX 1798A

THIRD NATIONAL CONGRESS ON MEDICAL ETHICS

Saturday, Septmeber 19, 1970 — Ambassador West

Chicago, Illinois

THE ETHICAL PHYSICIAN

The ethical physician

9:30-10:00 does not solicit patients

10:00-10:30 does not become an intellectual dropout

10:30-11:00 does not charge excessive fees

11:30-12:00 does not constantly practice in a gray area

LUNCHEON 12-15-1:30 — THE ETHICAL PHYSICIAN IS Dr. Bornemeier

THE UNETHICAL PHYSICIAN

1:30-2:30 It's wrong to steal (patients)-or is it? A hearing before a board of censors Dr. John Doe is accused of unethical conduct in seeking additional patients.

3:00-4:30 Panel Discussion: The Unethical Physician & Medicine's Responsibilities (Each panelist will comment briefly. Then the panel will participate in a question & answer session with the audience)

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CX 1798B

Sunday, September 19, 1970

Discipline and Medical Ethics

9:30-10:00 An assistant attorney general looks at medical discipline.

10:00-11:00 The Board of Medical Examiners Disciplines a vignette of a disciplinary proceeding before a board of medical examiners

11:00-11:30 Medicine's ethical obligations

11:30-12:00 Questions & Answers

Alternative

The Old, A New Or Something In Between
The Physician and the Communication Media
(A dialogue between a physician and a public relations man)

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 1798B
In the matter of: AMA
Date 9-29-77 Witness Boccone
Reporter AG
By MEC

CX1798C

THIRD NATIONAL CONGRESS ON MEDICAL ETHICS

September 19-20, 1970 Chicago, Illinois

Ambassador Hotel

9:00-9:15 Welcome E. G. Shelley, MD

WHAT MEDICINE MUST DO

9:15-10:15 Medicine, Ethics & the Future

10:15-11:00 The Intellectual Dropout

11:00-11:15 Break

11:15-12:00 Ethics & the Law

12:00-1:30 Luncheon

Walter C. Bornemeier, M.D

WHAT MEDICINE HAS DONE

1:30-2:15 An Attorney General Speaks

2:15-4:30 Panel--The Unethical Physician & Medicine's Responsibility

Indoctrination In Ethics

Incompetents

Addicts

Abusers of Third Party Payor Programs

07354

CX 1798D

WHAT MEDICINE IS DOING

9:00-10:30 Panel--The Ethical Physician

Does not practice in the gray area

Does not OVER charge, OVER utilize, OVER prescribe

Does not solicit patients or commercialize the profession

Questions for Audience

10:30-11:30 An Ethics Committee Hearing
"It's wrong to _____"

_____ committee members _____ the physicia who did

11:30-12:15 Medicine's Ethical Responsibilities

12:15 Adjournment

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 1798D
In the matter of: AMA
Date 9-29-77 Witness Browne
Reporter AC
By MEC

3 1 2 1 0 2 5 4 2 4 3

Cordrey

Ex. 32

CX 489

January 15, 1975

FEDERAL TRADE COMMISSION
File No. 9064 Commission
Investigational Exhibit No. 489
In the matter of: AMA
Date: 9/15/75 Witness: WAGNER
Reporter: EL
By: MC

L.J. Cordrey, M.D.
1102 W. Cass Street
Tampa, Florida 33606

Dear Dr. Cordrey:

Receipt is acknowledged is your letter of January 8 protesting opinion #6 under section 7 of Opinions and Reports of the Judicial Council. This section has to do with billing for completing routine health insurance claim forms.

Your letter will be presented to the Judicial Council for consideration at its next meeting. In the meantime, I would suggest that the application of all the opinions in Opinions and Report is the obligation of the county medical society. If there appears to be vagueness or uncertainty about the application of an opinion the advice of the county medical society should be sought.

As soon as the Council has the opportunity to consider your letter on March 16, I will report its opinion to you.

Sincerely,

Edwin J. Holman

EJH/lk

1215

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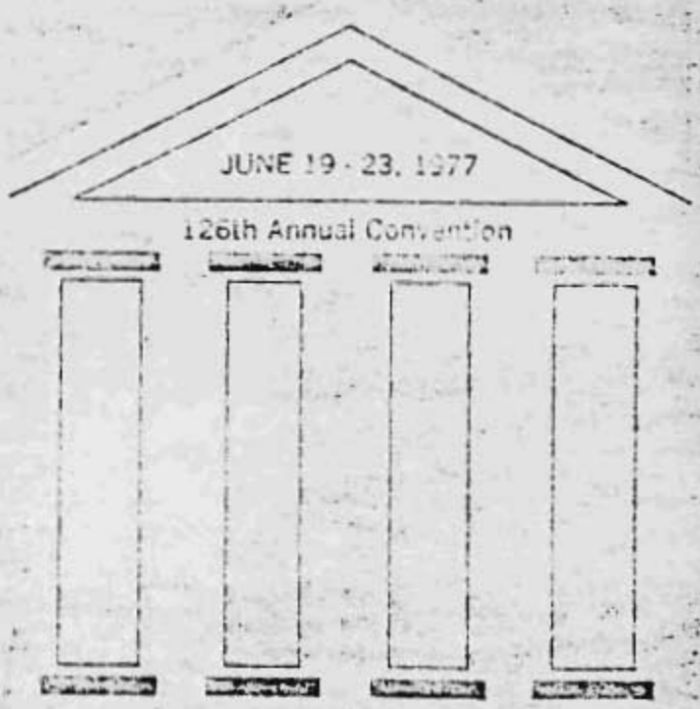
SAN FRANCISCO, CALIFORNIA



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AMERICAN MEDICAL ASSOCIATION
PROCEEDINGS OF THE HOUSE OF DELEGATES

126th ANNUAL CONVENTION
JUNE 19 — 23, 1977

8 1 0 7 5 1 0 3 6

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(AMA-ERF)

The Audio Digest Foundation has been a stalwart contributor to the AMA-ERFover the years as you may know. I understand that the total of the Audio Digest gifts exceeded a million dollars back in 1975. It is a pleasure for me to invite Dr. John G. Morrison and Mr. Claren Oakley of the Audio Digest Foundation to come up to the podium once again to make a gift to AMA-ERF — Dr. Morrison, Mr. Oakley, in behalf of our Foundation and the profession, I want to thank you most sincerely.

The AMA-ERF is many things to many people, but all the things we are are only possible because the Foundation enjoys the dedicated interest and support of the AMA Auxiliary and the medical family. It is an extreme pleasure to invite Mrs. Norman H. Gardner, President of the Auxiliary, to join me on the podium — the profession is in your debt, thank you Mrs. Gardner. We Tennessee grads owe a special thanks to you this year.

Ladies and gentlemen, thank you for your attention and support. The American Medical Association Education and Research Foundation is a source of great pride to me, and I hope that I have been able to share some of my enthusiasm with you today.

(The following contributions were made to the AMA Education and Research Foundation in San Francisco: American Medical Association Auxiliary $1,512,566; Audio Digest Foundation $50,000; Fifty Year Club of American Medicine $5,000.)

REPORT OF THE EXECUTIVE VICE PRESIDENT: James H. Sammons, M. D., Executive Vice President of the AMA, presented the following report to the House on Sunday, June 19:

HOUSE ACTION: FILED, and James H. Sammons, M. D. commended for his inspired leadership

(Reference Committee F, page 311)

In making this third report of the Executive Vice President to the House of Delegates, I find it a welcome change not to have to spend much time on the financial condition of the American Medical Association. Our reserves, especially our liquid reserves, are at appropriate levels and approaching the targets this House set when dues were increased at the 1975 annual meeting. Our operating statement is equally healthy, partly because membership is at a level above our projections, partly because advertising revenues are stronger than we expected, and partly because we were a bit too optimistic about the speed with which we could fully implement new authorized programs.

While the financial figures look good, I want to caution you that there remain unresolved two potentially substantial liabilities, in respect to the U. S. Internal Revenue Service and the U. S. Postal Service. In looking at long range commitments, I would remind you also that we are pledged to test the constitutionality of the Health Planning Act and to defend our ethical position against the complaint of the Federal Trade Commission. Just what those commitments will entail in terms of outside legal fees is hard to determine.

In view of all those indeterminable considerations,we must continue the 1975 policy adopted by the House of Delegates to maintain strong financial reserves. To do otherwise would be foolhardy.

(EVP Report)

Reflecting further on the important events of the past six months, I think it appropriate to report on the beginnings of our relationships with members of the new administration. We have had meetings with HEW Secretary Califano and other key people in the Executive Branch, all of them generally constructive. Yet we have come away from them with a widely shared feeling that the administration right now appears long on shadow but short on substance. I am personally uneasy that there is too much gesture, too much vagueness in Washington now — some hard thinking possibly, but soft programming, a lot of head but little beer.

As an example of the sort of thing I refer to, I would cite the handling of the National Health Insurance Advisory Committee. This Committee was formed with representatives of all points of view, including ours, presumably to have input into HEW's proposal. But now it is clear that the Committee is neither to make a report nor to have any real input into the development of the administration's thinking. Why bring in important people, and then tell them, at the first meeting, that their deliberations are not really going to count? It is an empty gesture indeed. And we are not alone in recognizing it.

Certainly we want to keep the lines of communication open, and we will do so. But as we are all aware, meetings for the sake of meetings are the emptiest gestures of all.

I have expressed our fears that the new organizational structure within HEW will weaken the role of the Assistant Secretary for Health, thereby diminishing the purely medical side of HEW's decision-making process. That is not in the best interests of the health of this country, nor is that in the interests of physicians. We are on record as seeking a free-standing federal Department of Health, taking the H out of HEW and making it independent under a Secretary of Cabinet rank. Short of that, we would urge a Department of Defense structure for HEW, with a Secretary of Health on the same level as the Secretary of the Army, Navy, and Air Force. The health of the American people is important enough to justify that sort of emphasis.

It is clear to me, though, that health is not the top priority in the new administration. Cost control is. Witness the creation of the powerful new Health Care Financing Administration. Witness the unworkable legislation proposed to cap hospital revenues. I would add parenthetically that we are truly dwellers in Cloudland if we do not anticipate some similar future move to cap physician fees.

As someone just back from a good look at the British National Health Service, let me tell you what happens when cost becomes the overriding factor in medical decisions. First you get rationing of care to patients. Next you get second-rate medical equipment. Then there is a predictable pinch on physician training. And finally, somewhere down the road, you wake up one day to find you have a second-rate medical care system instead of a first-rate system. I do not think that HEW's efforts at cost containment will be permitted to go that far. But the temptation is there. So is the political appeal to the pocketbook.

Frankly, I think HEW tends to listen too much to computers rather than to people. There is a unilateral quality to HEW decision-making that I find disturbing. I really have to ask, for example, what segments of the American people benefit from that incredibly botched list of Medicare recipients last March. Or who is going to benefit from the three-quarters of a million dollars now pledged to develop the new, improved list of physicians serving elderly patients. I certainly should think that HEW could come up with a more people-oriented way of spending $750,000 from our national health resources.

Just what sort of national health insurance proposal is contemplated by the Carter administration is hard to say. But no matter what it is, it will likely work at cross-purposes with those in HEW who consider curbing the rise in medical care expenditures the main item of priority. In health policy as well as others, there are strongly competing dynamics in Washington, and their resolution is far from clear.

Because the plans of the Carter administration for major health legislation are still only general, I do not want to make any specific forecasts. However, there is no question but that important challenges lie ahead for our profession. It therefore seems appropriate to give you my evaluation of the AMA's organization position as we face these challenges.

I would remind you, first of all, that the major issues before us are public issues. While they will not be resolved by plebiscite, they will certainly be resolved within the participatory climate of these times. Public opinion, or more precisely what legislators think is public opinion, therefore becomes a matter of urgent importance to us.

When you review the independently gathered public opinion data that is available to us through the Gallup organization and the Spencer/Roberts study, done in conjunction with Market Opinion Research, a picture of surprising AMA strength emerges. The credibility of the AMA, relative to other institutions of our society, rings out loud and clear. In terms of credibility of communications — which I think is a fair index — there is not a business, trade, professional, labor or governmental group that outranks us. Public confidence in the AMA is high. Seventy-one percent of the public says it has either a "great deal" or a "fair amount" of confidence in the AMA. This is an impressive score in these times of general distrust of establishment organizations. As medicine goes into its challenges, we open with a hand that holds encouragingly high cards.

Physicians themselves still rank first in public ratings of various professions for honesty and ethics, slightly ahead of engineers and college teachers, considerably ahead of journalists, lawyers and legislators. I cannot help but be concerned, however, that high as physicians stand, relative to others, 44 percent of the public rates our honesty and ethics as average, low or very low. Our marks are poorest among non-whites and families where income is less than $3,000 per year, and that is disturbing.

Generally speaking, though, the public expresses satisfaction with the care it receives. You have seen various polls reporting consistently that 80 percent or 85 percent of the people are either satisfied or well satisified with their care. Our recent Spencer/Roberts-Market Opinion Research report, which asked consumers about their last medical experience, found that 56 percent reported a "good" experience, only 18 percent a "bad" experience. This same study identified cost as the overwhelming concern to the public — and to physicians too. Hospital costs received the principal focus, yet consumers feel that physicians represent the single largest controlling factor in hospital costs. Availability is the second major public concern. But for every person who identifies that as a key issue, nearly three others list cost. I am going to come back to the subject of cost. But I want to say here that each member of the medical profession has got to acquaint himself better with the patient cost of every procedure he orders and to think twice about those of marginal cost/benefit value. By the same token, the public must be aware of what their behavior adds to cost because of nuisance suits or the threat of malpractice.

What I find particularly interesting in our public opinion surveys is the method by which the public forms its impressions of medicine. The main source of information is not the one we worry about most — newspapers, magazines or TV; it is word of mouth. There are now 2.9

million visits per day between patients and physicians, and the public attitude is formed overwhelmingly by that experience, not by what is said or is not said by the media. It is the way in which we as individual physicians deal with people as individual patients that counts. It is not what the media says that forms public opinion, but what we do. Public perception of medicine is basically the vast sum of millions of small daily reactions by patients to the way they are dealt with, talked to and treated, medically and personally. That is how the physician image is formed.

The other important element in the public perception of us relates to that part of the AMA's activities that have public visibility. Much of what the AMA does, especially in terms of continuing education, informational services, and the monitoring of standards, is only vaguely visible to the public. What the public does see of the AMA as an organization falls into two categories: what the AMA does as perceived as being in the physician's interest and what the AMA does as perceived as being in the public's interest. It is my impression that an important trade-off exists here. We are a professional organization, representing physicians, and part of our energies are directed to the legitimate interests of the profession. The public is not surprised by that, nor is the public offended. But the public will consider those pursuits justified only if it believes that we, as an Association, are simultaneously and energetically living up to our public responsibilities as well.

On the strength of this purely personal assumption of a quid pro quo, it is reassuring to be able to cite a number of programs addressed to our public obligations. Possibly the most visible recently is our action on TV violence, a subject on which there is a more detailed report to you from the Board of Trustees. I would only add that this kind of alert to a possible medical harm is only what is expected of us. We have worked closely with the PTA, the National Citizens Committee on Broadcasting, Action on Children's TV and other groups. We have also had constructive discussions with important advertisers, notably the General Foods Corporation. Sears, Roebuck, Greyhound, Eastman Kodak, Pillsbury, General Motors, and Schlitz are just a few companies among many that I might list who have expressed recent concern with this issue. A reduced amount of violent programming seems to be in the cards for next fall's network schedules. And I would add that it greatly becomes the networks to assume a posture of shrinking violence.

I cannot claim that the apparent improvement is attributable to us alone, or any other one group, for that matter. But this year the on-going outcry against violent programming has had a heavier impact than ever before because this year the weight of medical opinion was added to it.

The AMA program on the state of medical care in jails — a scandal in many places — represents another instance of meeting our responsibilities as the public perceives them.

Although it is still a long way from a final report, the AMA Commission on the Cost of Medical Care represents another case of responsive action. In terms of meeting our public responsibilities on this important public concern we have taken a first step through the establishment of the Commission on Costs. But to meet those responsibilities fully, we must be ready to hear some things maybe all of us will not want to hear when the final report is made. If the recommendations are hard and disturbing to us — or to our patients — let's not shy away from them. This House of Delegates will probably have to make some very tough decisions arising from the Commission's findings, and we must not shy away from them either.

More than anything else, the public expects the AMA to police its ranks. That is something I think the public expects of all professional and trade associations. And I think it is something

the public has a right to expect. In recent months in particular the AMA has demonstrated a more vigorous, a more effective, and a more visible initiative. In respect to the impaired physician — the physician with emotional problems, drinking problems or narcotic problems — 30 states have now enacted legislation backed by state medical societies and based on model legislation developed originally by the AMA and approved in this House. Possibly more important may be the action of at least 25 state societies in initiating programs of their own to deal with the small fraction of impaired members of our profession.

We have also suggested to the state societies model legislation intended to broaden the scope of state medical licensing boards. This legislation provides for better reporting, for more accessibility to information and for a wider range of options for disciplinary actions. By giving the licensing board something more than the Draconian choice between revoking or not revoking a license, the AMA believes that more appropriate, and more effective, and more frequently imposed discipline will result. Six states have adopted legislation along these lines. Some thirty already had similar statutes in place.

We are seeing a great change in medical discipline. In a survey that includes figures from 47 states, the AMA has found that in contrast to 1,300 in 1971 nearly 4,200 disciplinary cases were initiated in 1976. Medical discipline should be more of an educative than a punitive process. But the threefold increase in disciplinary actions should be noted. And the initiative shown by organized medicine in helping the licensing boards move in that direction should be noted as well.

Yet I must add that we still have a way to go. Great progress has been made in many states. But in others the old problems still exist: underfinanced licensing boards, lack of staff, poor quality of staff, bad liaison with the profession itself and that traditional bane, politics. When any board is constituted by political appointment, political pressure — or the threat of political pressure — can be applied. And that should simply cease to be.

It is unfortunate that most of the public believes that the profession itself does the licensing and therefore the delicensing, that the state medical society or the AMA holds the real disciplinary powers. In the public mind we are charged with the responsibility for disciplining doctors, but we both know that we lack the accompanying authority. The best way out of that squeeze is to do what we have been doing — exerting more pressure on the licensing boards to act as we might act if we had their powers. Where appropriate, I urge state societies to continue the effort for wider adoption of the AMA's stronger licensing bills.

While I see us meeting our public responsibilities in a more forceful way, I wish I could see more movement in terms of professional unity. That is not to say we are losing ground. We are not. But progress toward a unified profession should be dynamic rather than static. On broad legislative issues our effectiveness is in direct ratio to the unanimity we display. The achievements at the state level that I have just referred to, for example, came about where the profession was united in its position. Our recent success in modifying HR 3816 exemplifies what a unified effort can do. Thanks to efforts by many medical organizations the provisions of this bill, granting ruinously arbitrary powers to the FTC over nonprofit organizations, was dropped in Congressional committee hearings. That was an important legislative victory, not only for us, but also for organizations like the Boy Scouts, the Heart Association, the NAACP and the American Civil Liberties Union.

Probably the single most effective step we can take toward greater unity is before you — in the form of the Council on Long Range Planning and Development's report on specialty society representation in the House of Delegates.

Much of the disunity in medicine coincides with the post-World War II trend toward greater specialization, in itself a result of explosive growth in medical knowledge. As physicians have become more specialized during this period, loyalties have tended to diffuse. In a purely scientific sense this may have had a strengthening effect. But in other respects, particularly in regard to the broader issues that should concern the physician universe, the effect has been to disperse our power.

I think it is time to seek an adjustment in our system of representation, a time to expand our House of Delegates so that the specialty society structure that exists may be more realistically recognized and its views more properly incorporated. Medicine is pluralistic, a condition which has been acting strongly as centrifugal force. But, through the suggestion before you, that same energy can be converted into an equally strong centripetal force. It is critical that we merge our forces on the broad issues. This House of Medicine must not be a house divided.

Finally, I want to remind physicians again of the importance of wider, individual membership and personal involvement at all levels — county, state, specialty society and national. Think how much stronger we could be if only each current member could bring into the federation next year just one colleague who does not now belong. If any state wants to launch a program like that, we'll help set up the names for a one-on-one membership drive. Constituting only 7 one hundredths of one percent of the U. S. population, we need every bit of clout we can develop in terms of numbers.

We are respected as a profession. And our national organization — the AMA — is respected. It scarcely needs saying that we — and by that I mean every physician in this country -- face tremendous challenges. And we can only face them successfully if we face them together — all of us -- not half of us -- or two-thirds of us — or some other fraction.

I am sure that during at least one post-mortem over a lost political fight you have said, as I have said many, many times "Why couldn't we have stopped the in-fighting among ourselves? Why didn't we close ranks, forget our differences, as the opposition did? And for God's sake, why didn't we get the voters out?" Sounds familiar? I'm sure it does. But I am not talking now about Republicans versus Democrats. I am talking about the future of your profession and mine, and what is ultimately best for our patients.

The plain and simple truth of the matter is that we cannot afford to go on as we sometimes do, jealous over fiefdoms, squabbling among ourselves, so concerned with skirmishes that we lose track of decisive objectives. Do we want to go the way of our colleagues in England? They are a perfect example of what disunity can produce. If we cannot hang together better than we have been doing, we don't deserve to win the battles we have ahead of us.

In the AMA, the medical profession has a workable mechanism for airing viewpoints and democratically arriving at consensus. Your AMA is now a strong organization financially. It knows the ropes in Washington. It stands high in public credibility.

If it is to accomplish objectives for the profession, then the profession must understand this: Physicians are individualistic men and women — by training, by inclination and by experience. And individualism is a fine thing. But carried to an extreme, individualism can badly weaken the unified effort we must be making. At one point in history there was a European parliament so constituted that each member had veto power. You can imagine how much was accomplished.

Organized medicine just cannot accommodate that kind of divisive luxury and still hope to repel the deadening weight of the governmental bureaucracy. It is a cancerous, relentless, mindless blob of a force that oozes through the cracks and seeps under the doors, and as soon as you can stop it in one direction, it creeps in on you from another.

Let's keep our individualistic ways and attitudes. But let's also show some restraint. For if we don't, then a strong, united profession is impossible. And without that, there is not going to be much individualism left for any of us.

AMERICAN MEDICAL POLITICAL ACTION COMMITTEE: The following address was presented by Michael P. Levis, M. D., Chairman, Board of Directors:

This body, the AMA House of Delegates, can be likened unto the Congress of the United States — both are comprised of duly elected representatives from the fifty states. Just as members of the Congress are political leaders, we are considered leaders by the rank and file physician. The grassroots physician respects us because of the position we have achieved and the responsibilities we have shouldered. There are other medical leaders. Certainly the AMA Board of Trustees, the President and President Elect of the AMA, the Executive Vice President of the AMA, the various members of the AMA Committees and Councils, and the President and President Elect of your state medical association. All of these physicians have attained leadership positions in our chosen field — medicine.

Back in 1961, medicine's leaders did something which required a great deal of courage at that time. The American Medical Political Action Committee was created by a resolution of the House of Delegates that year. While this decision was carefully considered and studied before action was taken, nevertheless it required bold and decisive action. As a result of this leadership other medical organizations followed suit.

Today there are medical political action committees in fifty states, the District of Columbia and the Virgin Islands. Those PACs join with AMPAC in fund-raising efforts and, through the hard work and good example of the medical leadership, AMPAC has surpassed every year's membership record for nearly a decade. In our early days, AMPAC spent most of its fund-raising energies recruiting the $10 AMPAC member and, by the way, even in light of galloping inflation, contributions to AMPAC have always been and continue to be $10 for the active member.

AMPAC has always had a sustaining membership program which recruited $50 from the sustaining member. AMPAC's 99+ pin, signifying sustaining membership, has been worn with pride by medical leaders since 1962. At first, this prestigious pin was worn by just a few. But year after year, the numbers grew. In the early seventies, something miraculous and wonderful happened to our sustaining membership program. Because of a combination of many factors, physicians and their spouses began to make sustaining membership in AMPAC a way of life — much like paying association dues, buying new license plates every year and paying taxes. It became a habit for many of us, a habit I am proud of and one I hope some day that everyone in this room will develop.

Last year, the AMPAC Membership Committee, enjoying the best sustaining membership year ever, as well as the best active membership year ever, decided it was time to acknowledge and thank our creators for their continued commitment to PAC. With the gracious permission of your Speaker, AMPAC has been given the opportunity to present leadership certificates to those states

(AMPAC)

whose leaders are 1977 sustaining members of AMPAC. I wish that I could stand here and say that every AMA delegate and alternate delegate, every president and president elect, every state PAC chairman is a 1977 AMPAC sustaining member. I cannot say that but I can say that 133 delegates are sustaining members, 117 alternate delegates are, 27 presidents are, 27 presidents elect are, and 32 state PAC chairmen are.

Now, I would like to thank and acknowledge those states whose leadership became 1977 sustaining members and earned them AMPAC's leadership recognition award — Florida, Hawaii, Idaho, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Montana, New Jersey, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas and Virginia. There are also many also-rans — states that came very close and worked very hard for this award. I don't have enough time to mention them, but I would like to give you all a big thanks on behalf of AMPAC for your efforts. I hope next year that you will be able to receive this prestigious leadership recognition.

You have been very generous in giving AMPAC your time and attention this afternoon so that we could thank you for your continued support. I don't have to tell you, the leadership of medicine, that the profession is fighting a continuous barrage of onslaughts from the federal government and other outside forces. Your contributions to AMPAC in helping to fight against the evils of big government have never been more badly needed or more carefully dispersed. AMPAC knows the problems that beset our profession today are never going to go away — they are with us year in and year out. The government will never cease to try to interfere with the practice of medicine. We have learned to live with the fact that our battle goes on continuously. We know that medicine must not put all of its eggs in one basket and rise or fall on one issue or one political party.

We must continually fight for the way of life in which we believe; our right and obligation to treat patients in the way we see fit; and we must continue to participate in politics in as open and honest atmosphere as possible. Therefore, we are not just going to ask you to contribute to AMPAC and your State PAC. We ask you, the leaders of medicine, to commit yourself to politics as a way of life and rank it as one of the most important activities to which you can commit your time and your resources.

MEMORIAL — JOE T. NELSON, M.D.: The House of Delegates adopted the following statement in memory of Joe T. Nelson, M. D., which was presented by the Board of Trustees:

Joe T. Nelson, M. D., who was a member of the AMA Board of Trustees at the time of his death on April 11, combined organizational leadership, professional excellence, and active service in community affairs. He became President of the Southern Medical Association, a member of the Texas Medical Association Board of Trustees, Chairman of the University of Texas Board of Regents' Medical Affairs Committee, a member of the Board of Directors of the American Medical Political Action Committee, Chairman of the Texas Delegation to the AMA, and a member of the AMA Board.

His devotion to his community was recognized when he was named Outstanding Citizen of Weatherford, Texas, the city he served as a family physician.

Doctor Nelson was a graduate of North Texas State University and received his MD degree from Baylor College of Medicine. He served on the Board of Regents of North Texas State University, was named the Outstanding Alumnus of Baylor College of Medicine in 1973, an

(AMPAC)

whose leaders are 1977 sustaining members of AMPAC. I wish that I could stand here and say that every AMA delegate and alternate delegate, every president and president elect, every state PAC chairman is a 1977 AMPAC sustaining member. I cannot say that but I can say that 133 delegates are sustaining members, 117 alternate delegates are, 27 presidents are, 27 presidents elect are, and 32 state PAC chairmen are.

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INAUGURAL ADDRESS

John H. Budd, M. D., was inaugurated as the 132nd President of the American Medical Association on Wednesday, June 22, 1977. Following is his Inaugural Address:

VOLUNTARY ASSOCIATION VERSUS COMPULSORY GOVERNMENT

As I accept the honor of your Presidency, I see in my mind's eye not only the American Medical Association, great as it is, but the American way of life it represents. For this federation of ours has long been the classic example of private, totally voluntary associations in our country. And, in being that, it is a citadel for the survival of voluntary action, as opposed to the expanding power of centralized government; in other words, a chief defender of political pluralism, which means the distribution of civil responsibility. Hence, associations such as this one are important not only for themselves but for society as a whole.

As Alexis de Tocqueville argued almost a century and a half ago, in his "Democracy in America" — "If each citizen did not learn to combine with his fellow citizens for the purpose of defending his freedom, it is clear that tyranny would unavoidably increase."

The Federal government's efforts to plan and arrange the socioeconomic lives of its people are a threat to more than freedom. They threaten to disarrange life itself. They gradually usurp the citizen's sense of responsibility toward his fellow citizens and his own sense of identity and purpose.

As centralized government expands in power and influence, it infuses people with a depressing sensation of powerlessness, of hopelessness in coping with planners, experts, would-be experts and powerful government agencies. The result, as described by historian John Lukacs, is "A sickening inward feeling that self-government is becoming more and more meaningless, even though the outward and legal forms of democracy remain." Let me add that a decline in the people's sense of power and the growth of Federal power can become a vicious circle unless groups like the AMA resist.

Many zealots who politically are left of center would contend that greater Federal authority is the only answer to the strength of what they refer to as "the Establishment," which to them is a nasty word. But what does the Establishment really mean? According to the dictionary, it means "the existing power structure in society." Well, what could be more of a power structure than the government? At all levels, — federal, state and local — it spends almost 40 percent of the Gross National Product and accounts for about 18 percent of total civilian employment, or 15 million people.

There are those who want the Federal government to have another big slice of the Gross National Product by means of a National Health Insurance Program that would be Washington controlled. The Congressional Budget Office has estimated that an NHI plan financed wholly by taxes could raise Federal health spending $168 to $200 billion by fiscal 1982. That prospect does not seem to faze Senator Kennedy, Congressman Corman, and supporters of their NHI bill in labor unions and on Capitol Hill. In pleading the umpteenth time for the bill, Senator Kennedy wrote in the "National Observer" last March that "our present methods of getting and paying for health care are dangerously near collapse." The Senator and his fellow believers routinely blare the foghorn, even though the skies have become steadily clearer.

(Dr. Budd)

Thanks to the present pluralistic system, health services and their availability have strengthened over the last fifteen years, according to two scientists of the Robert Wood Johnson Foundation, including David E. Rogers, M.D., its President. Writing in JAMA, they observe that the system "does work, and perhaps better than we are sometimes wont to recognize." They note that racial and economic gaps in care have largely closed, and the death rate has fallen in general and in various basic categories. Moreover, some 80 percent of the people under sixty-five are financially protected to some degree, at least by private health insurance.

So the greatest threat of collapse, to repeat the Senator's scare word, is not medical via the present system of care, but fiscal via his proposed system of NHI. This proposal has been grandstanding so long that it is often taken as a synonym of National Health Insurance. Slightly more than half the public identifies NHI with government control or financing or both, according to an American Council of Life Insurance survey. The word National in National Health Insurance has tended to strengthen that impression, even in the ranks of medicine. Let me emphasize that what is national needn't be Federal, any more than is the National League in baseball, or the National Button Society, or the National Society, Colonial Dames XVII Century.

Our bill would bolster and protect the private focus of care and expand the present system. It would do this by depending mainly on employer-employee contributions, and use tax money to cover only the poor and jobless. That money would come from general revenue rather than the Social Security tax. Under our bill, the additional fiscal cost would be about $5 billion. Compare that with the $168 to $200 billion under a totally tax-financed program. To the extent that political power accrues from taxes, our measure would check any net gain in that.

So think of our proposal not as National Health Insurance, but as the People's Health Assurance. Describing it thus would be highly appropriate because its basic premises tally with what a plurality of the people want, as shown by a Gallup Poll. We cannot ignore the poll's indication that most Americans want some form of NHI — nor can we ignore the declaration by HEW Secretary Califano that NHI is "a cornerstone in the President's domestic policy." Califano has backstopped those words by appointing an Advisory Committee on NHI issues.

To borrow a figure of speech from my favorite sport — the ball the Administration pitches is likely to have a Kennedy-Corman curve. And, believe me, we've got to have a bat, namely, our own fine bill. Angry oratory simply won't stop that darned ball!

In addition, we must be aware that the private costs of care, not just the fiscal costs, are bound to be a major issue in the health-insurance showdown. The Johnson Foundation, while lauding improvements in care, added that "costs may prove to be the Achilles' heel of this country's arrangements for health services."

That issue throws a double challenge in our direction. On the one hand, we must get behind any rational and realistic means of curbing expenses, and eagerly await the recommendations of our own National Commission on the Cost of Medical Care. On the other hand, we must publicly pinpoint the basic relationship between medical cost and the quality, sufficiency, and availability of medical services. We must pinpoint the harm that any federal crackdown on costs could do to those three elements of care. Not that I think the public is greatly aroused about charges.

I think most patients share the sense of values reflected in a letter from a Portland, Oregon, resident to "Newsweek" magazine, protesting an article therein. The letter said:

> "My house, my car and I have all needed repairs. Mine involved my regular physician and four specialists. Taking into consideration actual time spent on the job, from none of the medics did I get a bill as high as I did from carpenters, concrete men, linoleum layers, furnace repairers, plumbers, electrical repairmen, and, above all, auto mechanics. So far all the repairs to me have held up well, but all the others have gone to pot."

My reason in urging a greater public understanding of medical costs is not so much the people, as the eagerness of government to exaggerate and exploit the issue in the name of the people. Cost control has been made a precondition for the Administration's NHI proposal, and it's an underlying objective in the Federal Trade Commission's harassment of our AMA federation, and our profession.

In contesting us on such matters as medical advertising and medical school accreditation, the FTC regards our profession as a trade. It overlooks the distinction drawn by so esteemed a federal figure as the late Supreme Court Justice Louis D. Brandeis, who said:

> "A profession is an occupation for which the necessary preliminary training is intellectual in character, involving knowledge and to some extent learning, as distinguished from mere skill. It is an occupation which is pursued largely for others and not merely for one's self. It is an occupation in which the amount of financial return is not the accepted measure of success."

Certainly the vast majority of physicians are recognized for their service to others rather than their income. Yet, if we physicians are to conform fully to Justice Brandeis' definition of a profession, we must think of altruistic service in all of its spectrum. We must think of patients in all of their needs, including their needs just as human beings.

Various studies show the public is increasingly disturbed by a lack of personal attention from doctors, long waits in their reception rooms, and an aloof attitude on the part of office staffs. These signs of indifference are not only more irksome to the patient than are medical costs, but they can arouse ill-founded suspicion about those costs.

No matter how hard the AMA strives to speak and act for all of medicine, the patient's concept of our profession starts with his own physician, and the national concept of physicians is that personalized concept multiplied. However, the Gallup Poll shows that doctors' organizations, such as the AMA, enjoy the confidence of 71 percent of the people, exceeding other categories involved in health policy, especially federal health officials, 49 percent, and labor unions, 47 percent.

The AMA justifies the public confidence in many public-spirited ways, such as our role in planning and staffing rural care, our cosponsorship of a program to coordinate and upgrade inner-city care, our cooperation with six state medical societies in a project aimed at setting national standards for jailhouse care, our campaign against television violence, and, of course, our NHI bill. We justify the public confidence by our relevance to human needs, while the Federal bureaucracy, as it gains in power, has tended to become more irrelevant to those needs, a world unto itself.

(Dr. Budd)

Nevertheless, to the extent that any patients feel dehumanized by their own doctors, the AMA may appear that much less an association of professionals, and that much more an association of tradesmen, much to the delight of the FTC and our other assailants.

Let me hark back once more to the Brandeis distinction that a profession acts largely for others. To do our best for the public and for medicine itself, we as physicians must act constructively and effectively for each other, through the AMA. To be the means of such action, the AMA must have optimum numerical strength. At the end of 1976, we had 172,000 dues-paying members. But there are some 150,000 physicians who are not members of our federation at any level – national, state or local. Where are they? And how can we get them to join?

As President, I will be going to many places, and making an outsider's appeal for membership. But a more intensive appeal from community insiders, such as you Delegates, is sorely needed. I can come from around corners, but it takes you to cut them. You, and your respective societies, can directly communicate with non-members in the hospital, the medical college, the research center, and wherever.

Hundreds of the component societies deny membership to doctors who are housestaff, academics, unlicensed industrial employees, and so forth. But, to be a counterweight to Federal intervention, we must have the collective weight of our profession. If the AMA is to help preserve the American tradition of private, voluntary associations, all types of physicians must be associated with it.

Members of this House of Delegates — I urge each of you to take formal and informal action in behalf of greater membership. Let our federation, which is the House of Medicine, be filled. For increasingly as dangers ride herd against us, this home is our castle.

REPORTS OF BOARD OF TRUSTEES

The following reports, A–II, were presented by Raymond T. Holden, M. D., Chairman:

A. AUDITOR'S REPORT
(Reference Committee F, page 303)

HOUSE ACTION: **FILED and the Officers, Board of Trustees and staff commended for their outstanding fiscal leadership**

The following auditor's statements cover operations for the fiscal year ended November 30, 1976, and the balance sheets as of that date, together with the opinion and footnotes of Arthur Young & Company, independent public accountants, and were published in the May 9 issue of JAMA:

AUDITOR'S REPORT

ARTHUR YOUNG & COMPANY
One IBM Plaza
Chicago, Illinois 60611

We have examined the accompanying balance sheet of the American Medical Association at November 30, 1976 and 1975, and the related statements of revenue, expenses and Association equity and changes in financial position for the years then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

As more fully discussed in Note 8, the Association's federal income tax returns for the years 1968 through 1974 are under examination. No report on the examination has been issued. However, the examining revenue agent has indicated an intention to propose tax deficiencies. If federal income tax deficiencies are proposed and eventually sustained, material income tax liabilities could result for the years 1968 through 1976. It is management's opinion that the federal tax returns for the years involved have been properly filed by the Association, and accordingly no provision for income taxes has been made in the accompanying financial statements. The ultimate outcome of this matter cannot presently be determined.

In our opinion, subject to effects on the financial statements of the ultimate resolution of the income tax matter discussed in the preceding paragraph, the statements mentioned above present fairly the financial position of the American Medical Association at November 30, 1976 and 1975 and the results of operations and changes in financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis during the period.

Arthur Young & Company

January 14, 1977

(Board of Trustees — A)

AMERICAN MEDICAL ASSOCIATION

BALANCE SHEET

November 30, 1976 and 1975

ASSETS	1976		1975	
Cash		$ 1,185,621		$ 394,584
Certificates of deposit and commercial paper		5,679,000		6,725,000
Receivables, less allowances of $100,000		2,258,294		2,256,362
Inventories:				
Books and pamphlets	$ 124,706		$ 409,270	
Paper, supplies and editorial material	859,125	983,831	500,694	909,964
Investments:				
Securities (Note 3)	19,183,411		3,884,409	
Real estate, primarily land	4,000,216		5,509,387	
Interest in real estate partnership (Note 4)	2,200,000	25,383,627		9,393,796
Investment in wholly-owned reinsurance company (Note 5)		5,020,620		-
Property and equipment — net (Note 6)		8,351,335		8,445,489
Prepaid expenses and deposits		380,679		722,516
		$49,243,007		$28,847,711
LIABILITIES, DEFERRED REVENUE AND ASSOCIATION EQUITY				
Liabilities:				
Accounts payable		$ 2,134,831		$ 2,126,936
Accrued liabilities —				
Payroll, pensions and other employee benefits (Note 7)	$ 520,818		$ 790,191	
Property taxes	564,914		599,125	
Other	215,414	1,301,146	605,851	1,995,167
Total liabilities		3,435,977		4,122,103
Commitment and contingent liability (Notes 8 and 11)				
Deferred revenue:				
Unearned subscription receipts	1,827,852		3,178,831	
Unearned membership dues	3,181,159	5,009,011	1,520,786	4,699,617
Association equity		40,798,019		20,025,991
		$49,243,007		$28,847,711

See accompanying notes

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(Board of Trustees — A)

AMERICAN MEDICAL ASSOCIATION
STATEMENT OF REVENUE, EXPENSES, AND ASSOCIATION EQUITY

Years ended November 30, 1976 and 1975

	1976	1975
Operating revenues:		
Membership dues earned	$ 36,574,152	17,801,846
Advertising	9,232,212	8,211,403
Subscriptions earned	2,582,799	3,319,173
Royalties	2,245,186	2,184,414
Grants and contracts (primarily governmental)	1,089,385	1,684,391
Book and pamphlet sales	603,791	723,109
Interest and investment income, including gains of $86,525 ($114,208 in 1975)	1,509,845	724,765
Services to Members Retirement Plan, state societies and related organizations	687,435	735,610
Educational programs and association meetings	862,678	732,527
Accreditation Program	403,084	483,206
Other	543,077	601,322
Total operating revenues	56,333,644	37,201,766
Operating expenses:		
Salaries and wages	13,346,224	12,612,443
Employee benefits	2,492,511	2,331,426
Direct publication costs, except salaries and wages	9,870,358	10,543,501
Meetings and travel	3,845,848	3,128,277
Facility costs, including utilities and depreciation	3,168,788	3,095,187
Professional services	2,077,883	2,220,274
Postage and supplies, except publication related	1,342,492	1,100,638
Complimentary films and literature	558,780	459,985
Grants, primarily to related organizations	799,446	696,560
Other operating expenses	1,400,979	1,159,209
Total operating expenses	38,903,309	37,347,500
Operating revenues in excess of (less than) operating expenses before other income	17,430,335	(145,734)
Other income:		
Special membership assessment, less related direct expenses of $19,000 ($162,000 in 1975)	491,105	8,335,825
Gain on sale of real estate (Note 9)	1,410,030	—
Gain on sale of publications (Note 10)	1,419,938	—
Equity in earnings of reinsurance subsidiary	20,620	—
Total other income	3,341,693	8,335,825
Revenues in excess of expenses	20,772,028	8,190,091
Association equity at beginning of year	20,025,991	11,835,900
Association equity at end of year	$ 40,798,019	20,025,991

See accompanying notes

AMERICAN MEDICAL ASSOCIATION

STATEMENT OF CHANGES IN FINANCIAL POSITION

Years ended November 30, 1976 and 1975

	1976	1975
Funds provided by (used for) operations:		
Revenues in excess of expenses	$ 20,772,028	8,190,091
Add (deduct) items not involving use of funds —		
Depreciation	763,535	770,698
Gain on sale of real estate	(1,410,030)	
Gain on sale of publication	(1,419,938)	
Equity in earnings of reinsurance subsidiary	(20,620)	
	18,684,975	8,960,789
Other funds provided by (used for) —		
Receivables	(1,932)	309,515
Inventories	(73,867)	876,586
Prepaid and deferred expenses	341,837	(254,590
Accounts payable and accrued liabilities	(686,126)	(282,863
Deferred revenue	1,729,332	112,539
Net funds provided by operations	19,994,219	9,721,976
Uses (other sources) of funds:		
Net proceeds from real estate sale	(2,919,201)	
Short-term bank notes retired		2,000,000
Cost of securities sold	(2,019,989)	(982,96-
Securities purchased	17,318,991	1,233,83
Real estate purchased		179,39
Investments in real estate partnership and reinsurance company	7,200,000	
Furniture and equipment additions — net	669,381	362,77
Net uses of funds	20,249,182	2,793,04
Increase (decrease) in cash and cash equivalents	(254,963)	6,928,93
Cash and cash equivalents at beginning of year	7,119,584	190,65
Cash and cash equivalents at end of year	$ 6,864,621	7,119,58

See accompanying notes

AMERICAN MEDICAL ASSOCIATION
NOTES TO FINANCIAL STATEMENTS

November 30, 1976 and 1975

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Inventories are valued at the lower of first-in, first-out cost or market except for purchased editorial materials (articles and artwork) expected to be utilized in future publications, which are valued at cost.

Investment in securities are carried at average cost and investments in real estate are carried at the lower of cost or net realizable value.

The Association's investment in its real estate partnership and its investment in its wholly-owned reinsurance subsidiary are carried at equity.

Property and equipment are carried at cost. Depreciation is computed on the straight line method over the estimated useful lives of the assets (five to fifteen years for equipment and thirty years for the building).

Membership dues are recognized as revenue in equal monthly amounts over the membership year which ends on December 31. The special membership assessment has been recorded as received because estimating the actual membership response to the assessment was not possible at the time of the assessment.

Subscriptions to periodicals are recognized in income over the terms of the subscriptions. Advertising revenue and direct publication costs are recognized in the period the related periodical is issued. Other publication costs are included in expense as incurred.

Grants to other organizations are recorded when paid.

The Association's contributory pension plan covers the majority of its employees. Pension expense is computed using the aggregate level cost method with supplemental liability and is accrued annually in amounts equal to the actuarially determined current service costs of the plan plus an amount necessary to accrue past service costs over a forty-year period. Accrued pension costs are funded currently.

2. RELATED ENTITIES

The Association and the American Medical Association Education and Research Foundation (AMA-ERF) are affiliated organizations through common members of their respective Boards of Trustees, who determine the source of funds for program activities common to both organizations. The AMA also provides administrative services and operating support to AMA-ERF, which makes reimbursement for direct expenses incurred.

The Association provides administrative services to the American Medical Association Members Retirement Plan under a contractual arrangement in which the Association receives reimbursement for direct and indirect expenses not to exceed certain amounts. The Association provides administrative services to the American Medical Assurance Company, for which the Association is reimbursed. It also provides administrative services and financial support for several other organizations.

3. INVESTMENTS IN SECURITIES

The cost and approximate market value of security investments as of November 30, 1976 and 1975 are summarized below:

	1976	1975
At cost:		
Corporate stocks	$ 2,676,596	2,828,261
Corporate bonds	11,341,485	987,298
Time deposits and demand notes	5,165,330	68,850
	19,183,411	3,884,409
Market value	19,575,640	3,951,065
Unrealized appreciation	$ 392,229	66,656

4. REAL ESTATE PARTNERSHIP

During 1976, the Association invested $2,200,000 and became a 10 percent limited partner in a new partnership organized to construct and lease a major Chicago hotel. The total cost of the hotel is expected to be approximately $70,000,000. Construction and permanent financing have been obtained. Construction has already begun with 1978 as the scheduled completion date for the project. The terms of the partnership agreement provide for all profit or loss during construction to be borne by one of the general partners.

5. AMERICAN MEDICAL ASSURANCE COMPANY

During 1975, the Board of Trustees approved the incorporation of a reinsurance company, American Medical Assurance Company (AMACO), and the state of Illinois issued a corporate charter. In 1976, the Association capitalized AMACO by investing $2,000,000 to purchase 2,000 shares of capital stock. The Association subsequently invested $3,000,000 to purchase AMACO's 7 percent subordinated debentures, which mature in 1996.

Operations for the nine months ended September 30, 1976 were limited to interest income received on short-term investments and the incurrence of start-up and other administrative expenses.

In October 1976, AMACO began its insurance operations by signing a management contract with a large insurance company. Under the agreement AMACO has acquired through retrocessi medical malpractice insurance from medical-society sponsored/physician-owned companies.

6. PROPERTY AND EQUIPMENT

Association property and equipment used for operations at November 30, 1976 and 1975 consisted of:

	1976	1975
Building	$ 10,142,407	9,630,506
Furniture and office equipment	3,101,292	3,045,345
Data processing equipment	2,163,786	2,109,492
	15,407,485	14,785,343
Less accumulated depreciation	8,181,047	7,464,751
	7,226,438	7,320,592
Land	1,124,897	1,124,897
	$ 8,351,335	8,445,489

7. PENSION AND OTHER DEFERRED COMPENSATION PLANS

The Association has a qualified pension plan providing benefits for most employees, a deferred compensation plan for certain employees not qualified by age to join the pension plan, and a supplemental, discretionary retirement plan (approved by the Board of Trustees in 1975) for key executives. Expenses include $1,333,000 in 1976 and $1,173,000 in 1975 for these plans. Accrued liabilities at November 30, 1976 include $342,000 ($617,000 in 1975) under the deferred compensation and supplemental retirement plans to be held by the Association until employees' retirement or other termination of employment.

8. INCOME TAXES

As an exempt organization, the Association is subject to income taxes only on income determined to be unrelated business taxable income. Advertising income from periodicals (advertising revenue less allowable publication expenses) was defined as unrelated business taxable income by federal income tax regulations, effective for the Association's 1968 fiscal year. The concepts of the revised regulations were substantially incorporated into the Internal Revenue Code by the Tax Reform Act of 1969, and are reflected in the State of Illinois income tax statutes enacted in 1969. The methods of determining advertising income were retroactively amended by federal regulation in December 1975 to require that, in certain circumstances, a portion of membership receipts reduce publication expenses which might otherwise offset advertising revenue.

Prior to 1968, the Association had filed only information returns with the Internal Revenue Service. As a consequence of the 1968 regulation revisions, the Association began filing unrelated business income tax returns. Based on the Association's interpretations of the statutes and regulations applicable to its revenue, the returns filed for all years through 1975 reflect no unrelated business taxable income and, therefore, no tax liability. The Association intends to file its returns for 1976 on a similar basis.

The Internal Revenue Service has been examining the Association's federal returns for 1968 to 1974. Although no reports on the examinations have been issued, the examining agent has indicated an intention to propose tax deficiencies for those years upon the ground that income of the Association from certain sources is subject to tax. Until a report is issued by the Internal Revenue Service, the dollar amount in controversy cannot be determined. The Association recognizes that significant differences in interpretation may exist between itself and the Internal Revenue Service. If federal income tax deficiencies are proposed and eventually sustained, very material income tax liabilities could result for the years 1968 through 1976.

Although the ultimate outcome of the income tax matter described in the preceding paragraph cannot presently be determined, management is of the opinion that the Association's federal tax returns for the years involved have been appropriately filed. Accordingly, the accompanying financial statements do not reflect any provision for income tax.

9. SALE OF REAL ESTATE

In June 1976 the Association sold for $3,000,000 a parcel of land it held for investment. A provision in the contract gives the Association the right of first refusal on repurchase of the property at the then appraised fair market value should the purchaser offer the property for sale or discontinue the use of any building constructed on the property. This right expires after 50 years.

10. GAIN ON SALE OF PUBLICATIONS

The Association during 1976 sold two publications, "Today's Health" and "Environmental Health," and discontinued publication of a third, "Prism," resulting in a net gain of approximately $1,420,000. The proceeds from the two sales consisted of the assumption of the subscription and other liabilities of the publications and, in the "Today's Health" sale, receipt of a ten-year, 8 percent note for $134,000.

To secure the fulfillment of the subscription liability and the payment of the note in the "Today's Health" sale, the Association has obtained the personal guarantees of the purchaser's principal stockholders. In addition, securities having a market value at November 30, 1976 of $1,292,000 are held in escrow as a further guarantee of the fulfillment of the subscription liability of $571,000.

11. COMMITMENT

On September 9, 1976, the Board of Trustees offered to purchase from the American Medical Association Members Retirement Plan (MRP) any one or more of all parcels of real estate presently owned by MRP in the general area of the AMA's present real estate holdings. The terms of the offer establish the purchase price for each parcel at the greater of either the fair market value of such parcel, as determined by an independent appraisal firm, or the cost of acquisition of such parcel by MRP, plus interest at a compound rate of 8 percent per annum from the date of acquisition. The purchase of such real estate is contingent upon MRP receiving by September 30, 1977 an exemption from the provisions of the Employee Retirement Income Security Act of 1974. This offer is valid for six months from the date when the exemptions are issued.

(Board of Trustees – E)

E. SPECIALTY SOCIETY REPRESENTATION
(Reference Committee F, page 307)

HOUSE ACTION: FILED

A variety of forces impact on today's physician. The pressures of an increasingly sophisticated practice, educational requirements, paperwork and public opinion combine to present challenges to which organized medicine must help the physician respond.

At the national level, medicine is structured geographically (AMA) and by type of practice (specialty societies). It is vitally important that these organizational forces coordinate closely and develop the best possible structural relationships to most effectively represent their constituencies, the individual physician member. Mechanisms to accomplish this objective have been under study by the Council on Long Range Planning and Development and the Board of Trustees for several years. The House of Delegates has received regular reports on this activity during its recent meetings.

Direct representation from the national medical specialty societies, as recommended in Report A of the Council on Long Range Planning and Development (A-77), must be given serious consideration at this time. In part, Report A calls for the AMA to endorse the concept of direct specialty society representation in the House of Delegates as a way to strengthen unity within organized medicine.

The present organizational structure of the House of Delegates requires that the delegate from the Scientific Section be elected by the Section Council. Thirteen of the twenty-eight Section Councils receive appointees from more than one society.

In 1976, the Council on Long Range Planning and Development conducted a survey of specialty society officers, Section Council members, and members of the Interspecialty Advisory Board. The survey, while indicating support for the Section Council mechanism, also clearly indicated the desire by the specialty societies for a more direct form of representation in the House of Delegates. Similar opinions were obtained during a March 1977 conference of specialty societies held to discuss specialty society participation in the AMA. Specialty society participants urged the AMA to quickly respond to their support for a stronger direct voice for specialty societies. This approach was also supported by those representatives from societies appointing members to single society Section Councils.

Weaknesses in the present system of specialty delegate selection, as identified by participants in the March 1977 meeting, included nonrepresentation in the House of Delegates for periods of several years as societies on Section Councils alternate in delegate selection, the lack of responsibility for a Section Council delegate to represent the policies of a specialty society and a general absence of close working relationships between the specialty societies and the delegates selected by the Section Councils.

The Board of Trustees recognizes the sense of sincerity and urgency of the specialty societies in urging the AMA toward a more formal mechanism for interaction involving the specialty delegate. The need for a higher level of organizational unity is pressing, and organized medicine must combat the threat of divisive fractionalization.

Report A of the Council on Long Range Planning and Development (A-77) describes a mechanism which would improve the Section Council structure by providing direct selection of the delegate by those societies represented on the Section Council. This would be carried out with minimal impact on existing bodies, at some saving of expense to the AMA, and would more closely align the role of the specialty society delegate with that of the delegates from the state medical societies. It would also be responsive to the interests of the national medical specialty societies in having direct participation in the activities of the House of Delegates.

The Board of Trustees strongly supports the recommendation for direct specialty society representation contained in Report A of the Council on Long Range Planning and Development as being responsive to previous directions of the House of Delegates and leading to strong organizational relationships and unity in all organized medicine.

F. NATIONWIDE PEER REVIEW AS A COMMERCIAL SERVICE
(Reference Committee A, page 248)

HOUSE ACTION: ADOPTED IN LIEU OF RESOLUTION 2 (C-76)

At the 1976 Clinical Convention, the House of Delegates referred Report HH of the Board of Trustees and Resolution 2 to the Board for report at the 1977 Annual Convention. Both dealt with the possibility of AMA involvement in nationwide peer review as a commercial service; Report HH recommended that AMA not involve itself at this time, while Resolution 2 called on the Association to determine the availability of peer review nationwide, and, if available, to enter into negotiations with interested national corporations for the purpose of assisting them in a reduction of employee health care costs through, but not necessarily limited to, peer review.

As pointed out in Report HH (C-76), the American Association of Foundations for Medical Care (AAFMC) and the American Association of Professional Standards Review Organizations (AAPSRO) continue actively to pursue contracts with private-sector national accounts to provide peer review of employees' and dependents' health insurance claims. Such review activities would be accomplished by existing foundations and PSROs, members of AAFMC or AAPSRO.

The Board is very much aware of and concerned with the costs to patients and their employers for medical care in the United States. As stated in Report HH (C-76), if the AMA were to begin direct involvement in efforts toward commercial peer review services it might, in the short run, expect to gain public visibility with an aggressive cost control program for medical care, and gain the acceptance of industry – if the costs were effectively reduced.

However, following a review of this subject (including advice from the Council on Medical Service which met with a representative of the Medical Association of Georgia, sponsors of Resolution 2 (C-76), the Board believes those potential benefits are more than balanced by several inherent problems:

- The Association would be exposed to conflict of interest charges if the AMA, or a company established by the AMA, were to engage in or contract for peer review for fees. The Association essentially would be representing third parties in disputes with AMA members.

V. LEGISLATIVE LIAISON
(RESOLUTIONS 36 AND 56, C-76)
(Reference Committee B, page 271)

HOUSE ACTION: ADOPTED IN LIEU OF RESOLUTIONS 36 AND 56 (C-76) with the request that the Board of Trustees report to the House at the 1977 Interim Meeting on additional activities

At the 1976 Clinical Convention, the House of Delegates referred Resolutions 36 and 56 to the Board of Trustees for report at the 1977 Annual Convention. Resolution 36 urged the Association's officers, staff, council and committee chairmen to undertake discussions with officers and staff representatives of state medical societies to bolster federal legislative relationships through key man legislative programs.

Resolution 56 asked that the Association initiate discussions with state and county medical societies to identify individual physicians or groups of physicians with legislative relationships with national leaders, and that a system be created for dissemination of information on critical national health issues to obtain input from individuals and groups of physicians.

Board of Trustees Report K (C-76), which reported on legislative liaison during 1976, was approved by the House of Delegates. It reported on the establishment of a Special Legislative Group of over 250 individuals with special interest in legislation.

In January 1977, state and county medical societies were resolicited for names of individuals for the Special Legislative Group list, and the list was updated. These individuals receive Legislative Roundup weekly. A Legislative Alert on HR 3816 (FTC Amendments) was sent to the Special Legislative Group in April, as well as to state, county and national specialty societies.

The Council on Legislation meetings are always open to officers or staff of state, county or specialty societies. The May Council meeting in Washington, D.C., was especially for representatives of national specialty societies. The September Council meeting will be especially for representatives of state medical societies in the Southeast and will be in that part of the country.

The fifty state medical societies were divided among the AMA lobbyists in January. The lobbyists report to the designated staff person by mail and telephone and, as Washington duties permit, report in person to appropriate state society meetings. At approximately six-week intervals the Washington Office staff reports via conference call to state societies on current legislative developments and priorities.

Legislative briefings are routinely on the agenda of the Interspecialty Advisory Board and AAMSE Advisory Committee to the Executive Vice President. A legislative seminar was a part of the AMA Leadership Conference in January. A special strategy committee on national health insurance has been formed with state and national specialty society executives and met in April.

The Legislative Department continues to send all AMA statements and comments to state and national specialty societies. More important statements are also sent to county medical societies. The Department also works with staffs of state and specialty societies in developing testimony on legislation of special interest.

The Public Affairs Division has sent information on setting up a "key-man" system to all state medical societies.

GG. DIRECT BILLING FOR AMA MEMBERSHIP.
(Reference Committee F, page 306)

HOUSE ACTION: REFERRED TO BOARD OF TRUSTEES with the instruction that the Board of Trustees work in active cooperation with the American Association of Medical Society Executives (AAMSE) to:

1. **Develop criteria for component county and state societies billing and collecting AMA dues;**
2. **Develop a reimbursement formula and a consistent timetable for compensating component societies billing and collecting AMA dues;**
3. **Develop uniform guidelines and procedures for direct billing of AMA dues by the AMA in areas where the criteria have not been met;**
4. **Permit societies in states with unified membership requirements to be exempt from agreements concerning direct AMA billing; and**
5. **Present a new report containing specific recommendations regarding the directives set forth above to the House of Delegates at its 1977 Interim Meeting.**

Board of Trustees Report Y (C-76) proposed direct billing by the AMA to all eligible, po tential members beginning in 1978. The report was referred to the Board of Trustees for stud and report to the House of Delegates at its 1977 Annual Convention.

In referring Report Y to the Board of Trustees, the House of Delegates recommended:

> "That state and county medical societies which have raised objections to the actions proposed in Report Y communicate their views and their own proposed solutions to the real problems outlined in this report to the Board of Trustees within 60 days so that the Board's deliberations on these issues can be facilitated and advanced."

Nineteen states and 20 county medical societies submitted statements to the Board of Tru tees on the direct billing issue. Of the 39 responses, one state medical society and two coun medical societies favored direct billing; all others opposed it. Nine proposed alternatives we submitted by the respondents. Most suggested that the AMA establish criteria to which state ar county medical societies must conform in dues billing and collection.

The following eleven criteria result from conferences involving staff leadership from state ar county medical societies with AMA staff:

1. Each society that bills for AMA should register with AMA each year. The AMA will publicize the need for registration and establish a deadline date.

2. The billing society should send AMA a sample of each billing form and message, a schedule of all mailings, and a list of the names and addresses of physicians billed, including the total number billed for each mailing.

3. All physicians within the society's boundaries who are eligible for AMA membership should be billed.

4. First billing for AMA by all societies should be between October 1 and December 1. (Present AMA billing by societies encompasses all 12 months.)

5. Each society should bill for AMA dues at least twice, and a uniform delinquency date for AMA and all federation dues will be March 1.

6. Societies should continue to bill their members who are not AMA members.

7. The billing society should send out at least two delinquency notices prior to June 1.

8. Billing societies should place the AMA dues figure in the same column as state and county dues, and the AMA figure should be included in the dues total at the bottom of the bill.

9. Qualifiers to AMA dues statements such as "not required," "optional," "voluntary" or "you need not join the AMA" should be eliminated.

10. Billing societies should include a federation message in each billing and delinquency notice.

11. Each society billing for AMA dues should be responsible for remittance of such dues to AMA within 30 days of receipt.

The AMA will work toward signing formal contracts with each billing society, incorporating the criteria above as the conditions that should be met for the county or state medical society to serve as the billing agent for AMA dues.

The AMA has the authority to direct-bill "as appropriate or desirable" as a result of action taken at the 1973 Annual Convention. Given the failure of a county or state medical society to meet the criteria and move toward formal contract, the AMA will move to direct billing of all potential members in the appropriate county or state.

A pilot project of AMA billing is being carried out in South Carolina for the second year. Both the AMA and the South Carolina Medical Association are satisfied with this arrangement. It has apparently helped membership in both the South Carolina Medical Association and the AMA and other pilot projects will be explored.

The Board recommends that the House adopt the above criteria to which billing medical societies must conform in order to move the present membership billing procedures toward a more businesslike arrangement.

(Board of Trustees — GG)

The Board also recommends four additional actions to state medical associations to improve the total federation membership and billing programs. These recommendations reflect concern about impediments to increased membership at every level of medicine.

The Board recommends that:

1. State and county medical societies adopt more uniform constitution and bylaw provisions to enhance recruitment of new physicians and participation of physicians in all disciplines in organized medicine.

2. State, large county and metropolitan medical societies establish membership committees with representation from hospital medical staffs in order to reach physicians at their hospitals with information on membership and physician activities.

3. State and county medical societies move toward uniform collection and billing procedures. In addition to the criteria already enumerated, state societies are encouraged to move toward handling billing activities for the 650 unstaffed county societies which presently bill for organized medicine.

4. State medical societies consider Leadership Conferences to include county medical society presidents, presidents-elect and top staff, medical school deans and major hospital medical staff presidents.

HH. 1977 MEMBERSHIP OPINION POLL
(Reference Committee G, page 312)

HOUSE ACTION: FILED

The publication "Opinions of AMA Members 1977" presents results from the AMA membership opinion survey conducted in the spring of 1977. These findings are based on response received from 74,989 members of the Association.

The Board of Trustees transmits this report to the House of Delegates.

Following is a summary of the results of the 1977 AMA Membership Opinion Survey. Copies of the complete report can be obtained from the AMA Center for Health Services Research and Development.

SUMMARY OF RESULTS

This report presents the results of the 1977 AMA Membership Opinion Survey on various critical issues affecting the practice of medicine. The 1977 survey is the fourth of its kind conducted in response to the mandate of the AMA House of Delegates that AMA members be polled periodically to ascertain their opinions on critical issues. This year's survey was structured to determine the changing attitudes and opinions of those surveyed.

REPORTS OF COUNCIL ON CONSTITUTION AND BYLAWS

The following reports, A-D, were presented by Carroll L. Witten, M. D., Chairman:

A. AWARDS AND HONORS
(Reference Committee on Amendments to Constitution and Bylaws, page 245)

HOUSE ACTION: ADOPTED AS FOLLOWS:

The House of Delegates approved Board of Trustees Report PP (C-76) at the last meeting of the House of Delegates. That report recommended that the Bylaws be amended to eliminate the requirement that the Distinguished Service Award and the Citation of a Layman for Distinguished Service be given annually, thereby permitting more flexibility in the presentation of the awards.

The Council has reviewed carefully the two chapters in question. It is the Council's opinion that both chapters should be rewritten. Accordingly, the Council recommends that Chapter XVIII and Chapter XIX of the Bylaws be deleted, and a new Chapter XVIII enacted which combines the substantive provisions of the two former chapters and also incorporates the recommendations of Board of Trustees Report PP (C-76). The new Chapter XVIII is as follows, the text is entirely new:

CHAPTER XVIII – Awards and Honors

Section 1. Distinguished Service Award

(A) Award: This award shall consist of a suitable medal and a citation selected and approved by the Board of Trustees.

(B) Eligibility: This award may be made to a member of the Association for meritorious services in the science and art of medicine.

(C) Nominations: Names of prospective nominees, together with a brief statement of their qualification for the award shall be submitted to the Board of Trustees at least two months prior to the Interim Meeting of the House of Delegates. After review, the Board may submit at least three nominees to the House of Delegates at an Interim Meeting.

(D) Selection: If the Board of Trustees submits nominees to the House of Delegates for this award, the House shall select the recipient by a vote of its membership by secret ballot, a majority of the votes cast being necessary to select. In case a nominee fails to receive a majority of the votes cast, the nominee receiving the lowest number of votes shall be eliminated from consideration and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the votes cast.

(E) Presentation: The award shall be presented to the nominee selected by the House of Delegates at the next Annual Convention, or at a time and place designated by the Board of Trustees.

Section 2. Citation of a Layman for Distinguished Service

(A) Award: This award shall consist of a suitable certificate of citation selected and approved by the Board of Trustees.

(B) Eligibility: This award shall be made to a person not of the medical profession who has contributed to the achievement of the ideals of American medicine by aid and cooperation in the advancement of medical science, medical education or medical care.

(C) Nominations: The Board of Trustees may submit not more than three nominees for this award to the House of Delegates at an Interim Meeting.

(D) Selection: If the Board of Trustees submits nominees to the House of Delegates for this award, the House shall select the recipient by a vote of its membership by secret ballot, a majority of the votes cast being necessary to select. In case a nominee fails to receive a majority of the votes cast, the nominee receiving the lowest number of votes shall be eliminated from consideration and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the votes cast.

(E) Presentation: The award shall be presented to the nominee selected by the House of Delegates at the next Annual Convention, or at a time and place designated by the Board of Trustees.

Section 3. Other Awards and Honors

Any other awards and honors conferred by the AMA shall be as authorized and approved by the Board of Trustees.

B. AUTONOMY OF STATE MEDICAL ASSOCIATIONS

(Reference Committee on Amendments to Constitution and Bylaws, page 245)

HOUSE ACTION: ADOPTED AS FOLLOWS:

The independence and autonomy of the state medical associations is well recognized and clearly understood by those within the medical profession. Occasionally, however, those outside of medicine view the state medical associations as "branches" or "chartered chapters" of the American Medical Association. There is no objective statement presently in the AMA Bylaws which articulates the independence and autonomy of the state medical associations. Indeed, none has ever seemed necessary, since historically and traditionally the state medical associations have always been independent and autonomous organizations. However, the Council recommends at this time an amendment by addition to the AMA Bylaws which would state not only that the state medical associations are independent and autonomous organizations, but that the state medical associations do not surrender any of their autonomy by participating in the House of Delegates of the American Medical Association.

Accordingly, the Council recommends that the provision set forth below be inserted as Section 3 of Chapter IX of the AMA Bylaws, and that existing Section 3 and those sections following be re-numbered accordingly.

Section 3. Autonomy of State Medical Associations

The participation of a state medical association in the House of Delegates is voluntary. Policy actions of the Association do not in themselves bind a state medical association or subject it to any obligation that it does not voluntarily assume.

C. DECIMALIZATION OF BYLAWS
(Reference Committee on Amendments to Constitution and Bylaws, page 246)

HOUSE ACTION: FILED

The Council has been working for several years on a project to decimalize the American Medical Association Bylaws. This work is now nearing completion. The Council attaches hereto, for illustration purposes only, a preliminary draft of one chapter of the Bylaws in decimal form.

When this project has been completed, the Council will submit the full Bylaws in decimal form for review and consideration by the House of Delegates.

16.00 BOARD OF TRUSTEES

16.10 COMPOSITION. The Board of Trustees shall consist of fifteen members, twelve elected as provided in Chapter XIV, Section 14.34 of the Bylaws, and the President, President Elect, and Immediate Past President. The Speaker and Vice Speaker of the House of Delegates shall attend all meetings of the Board (including executive sessions) with right of discussion but without the right to vote. Voting members of the Board of Trustees shall resign all other positions held by them in the Association upon their election to the Board of Trustees. No person, while serving as a voting member of the Board of Trustees, shall be a delegate or an alternate delegate to the House of Delegates. Members of the Board of Trustees may serve on Councils or Committees when specifically provided for in the Bylaws.

16.20 ORGANIZATION

16.21 OFFICERS AND COMMITTEES. Immediately following the conclusion of the annual convention, the Board shall organize by electing a chairman, vice chairman, secretary and committees necessary to its needs.

16.22 EXECUTIVE COMMITTEE. The Board of Trustees at its organization meeting, by resolution adopted by a majority of the Trustees in office, may designate three or more Trustees to constitute an executive committee. Members of the committee shall serve until the next organization meeting of the Board and until their successors are elected and qualified. The executive committee shall have such powers and duties as may be defined from time to time by resolution of the Board of Trustees.

REPORTS OF COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

The following reports, A-C, were presented by Dale C. Reynolds, M. D., Chairman:

A. SPECIALTY SOCIETY REPRESENTATION IN AMA
(Reference Committee F, page 307)

HOUSE ACTION: RECOMMENDATION NO. 1 OF REPORT A ADOPTED IN LIEU OF RESOLUTIONS 117, 119, 126, 130, 132, 133 AND 134

RECOMMENDATION NO. 2 OF REPORT A REFERRED TO THE BOARD OF TRUSTEES with instructions that the Board bring together representatives to include members of the Council on Long Range Planning and Development, the Association of Section and Service Delegates, the AMA Interspecialty Advisory Board and members of the Board of Trustees to meet as a steering committee to devise an agenda for a larger meeting that is to be arranged to consider this Recommendation with the objective of achieving an alternative that will enjoy a consensus, and that the Board of Trustees report back to the House at the 1977 Interim Meeting

RECOMMENDATION NO. 3 OF REPORT A ADOPTED, AS AMENDED (deletion of the word "direct") to prevent any administrative confusion with regard to the financial responsibility for all specialty society representation activities until the report is received from the Board of Trustees on the progress relative to Recommendation No. 2 at the 1977 Interim Meeting of the House of Delegates

The Council on Long Range Planning and Development has been involved in a study of AMA-specialty society relationships for several years. At the 1975 Clinical Convention, the Council was asked to conduct a survey on the subject. The survey consisted of a questionnaire that was sent to specialty society officers, Section Council members, and members of the AMA Interspecialty Advisory Board. The results of the survey showed support for the current Section Council mechanism, but it was also clear that the specialty societies felt a need for more direct representation in AMA as well.

In considering these survey results, the Council once again identified the need for a clearer, more definite expression of opinion from the specialty societies. Since the Board had recently announced that it was also looking at the overall question of specialty and specialty society participation in the AMA, the Council suggested to the Board that a conference of the Presidents and Executive Directors of all the major specialty societies be convened. The meeting was held in March 1977 and attendance was excellent. The Council came away from that session with a better understanding of the extent to which the specialty societies want formal input into AMA decision making. The Council's previous communications had indicated that a desire for such representation existed, and the conference strongly underscored the fact that the specialty societies believe that this is indeed a very important question and one which should be addressed with some degree of urgency. The overall message that emerged from the March conference was

that organized medicine as a whole must begin to operate with a greater sense of unity. The pluralism that grew out of the trend toward specialization has tended to result in factionalism, and organized medicine owes it to its collective physician constituency to pull together to help ease the pressures facing the profession. It is critical, therefore, that the AMA and the specialty societies establish a more formal mechanism for interaction. There was a strongly expressed opinion that direct representation in the AMA House of Delegates would provide an important avenue for such interaction.

Recommendation No. 1

That AMA endorse the concept of direct specialty society representation in the House of Delegates as a way to strengthen unity within organized medicine.

The Council believes that it is extremely important for Recommendation No. 1 to be adopted by the House of Delegates as an expression of the AMA's concern for unity throughout all of organized medicine and of the AMA's willingness to take the initiative in this area.

Over the two years that the Council has studied this subject, it has considered many mechanisms through which direct specialty society representation could be accomplished. Of all the variations discussed, the one presented below is, in the Council's opinion, the best because it provides for an orderly means of implementation and minimizes the organizational impact on the Section Councils, the Interspecialty Advisory Board, and other existing mechanisms.

Recommendation No. 2

That specialty societies meeting one of the following conditions each have one delegate in the AMA House of Delegates:

1. Any specialty society currently represented on a Section Council and which has 1,000 or more AMA members.
2. Any specialty society currently represented on a Section Council which has fewer than 1,000 members but which has a primary certifying board in that specialty.
3. In the future, a specialty society would get a seat in the House upon recommendation by the Board of Trustees and approval by the House of Delegates.

In instances where there is only one specialty society represented on a Section Council, the current section delegate would continue to serve until the end of his term and would also be identified as a representative of the specialty society.

In instances where there are two or more specialty societies currently represented on a Section Council, the current section delegate would continue to serve until the end of his term and would also be identified as the representative of one of the specialty societies currently represented on the Section Council. The other societies currently represented on the Section Council would appoint delegates to represent them in the House of Delegates.

Recommendation No. 3

That the convention expenses of all specialty society delegates be borne by the specialty societies just as the state societies financially support their delegations.

	DIRECT SPECIALTY SOCIETY DELEGATES		SECTION COUNCIL DELEGATES		STATE SOCIETY DELEGATES		OTHER: MILITARY GOVT, STUDENT, I & R, MEDICAL SCHOOLS		TOTAL
	No.	%	No.	%	No.	%	No.	%	
CURRENT HOUSE (San Francisco – 1977)	0	0	28	11.2	213	85.5	8	3.2	249
PROPOSED APPROACH	46	17.2	0	0	213	79.8	8	3.0	267

B. AMA FULL-TIME PRESIDENT
(RESOLUTION 8, C-76)
(Reference Committee on Amendments to Constitution and Bylaws, page 246)

HOUSE ACTION: **REFERRED TO BOARD OF TRUSTEES with the proviso that a report be made at the 1977 Interim Meeting, and an expression of the desire of the House to retain control of the election of the presidency**

Resolution 8 (C-76), AMA Full-Time President, was referred through the Board of Trustees to the Council on Long Range Planning and Development for further report at the 1977 Annual Meeting of the House of Delegates.

The concept of a full-time AMA President is not an unfamiliar subject to the Council on Long Range Planning and Development or the House of Delegates. This concept was considered during the Council's study and subsequent Report B (C-75) on the AMA organizational structure.

The Council's current study included the solicitation of comments from the author of the resolution plus comments from both the AMA Chairman of the Board and the AMA Executive Vice President. In addition, the Council had the benefit of comments from various officers of the Association when it previously considered this question as part of its organizational study during 1975. This information confirmed the Council's impression that the concept of a full-time President means different things to different people.

Within the different interpretations and corresponding potential organizational configurations, the following underlying concepts and concerns relating to the efficiency and effectiveness of AMA were consistently raised.

3. What effect would this concept have on the AMA organizational structure?

   The ultimate effect this concept would have on the AMA organizational structure would be to organize the AMA more along the lines of the typical corporate structure. Although this concept would not modify the functional relationships between the House of Delegates, Board of Trustees and the CEO, the concept does raise the question of the makeup of the Board of Trustees and the officer configuration. Currently, the AMA has three presidential-related offices — President, President Elect, and Immediate Past President — represented on the Board of Trustees. If the current CEO position were to become the Presidency of the AMA, the retention of the three presidential-related offices within the organizational structure would appear to be confusing on the basis of a duplication of titles and, more importantly, a duplication of corporate accountabilities and responsibilities as previously outlined. To avoid this duplication, the three presidential-related offices would have to be phased out of the organizational structure and their representation on the Board of Trustees replaced by adding three Trustees.

The foregoing discussion presents the major points that were made by various individuals in discussions of the proposal for a full-time, salaried AMA President. In short, the argument in favor of the proposal in Resolution 8 (C-76) is that it would provide a more efficient and businesslike officer configuration that would result in a more responsive organization.

While the Council recognizes that there are both advantages and disadvantages to any organizational configuration, it is convinced that the advantages of a full-time, salaried President for AMA far outweigh the disadvantages. This belief has been confirmed by representatives of other organizations that have already adopted a full-time, salaried Presidency.

C. MEMBERSHIP STUDY
(Reference Committee F, page 309)

HOUSE ACTION: FILED

In the fall of 1976, the Council on Long Range Planning and Development submitted a progress report (Report A, C-76) on the membership study it was conducting. This report is the follow-up to the progress report.

In an organization in which the very foundation of existence is a constituency following, a membership study should be viewed as an ongoing responsibility of the organization and its governing bodies. It should go without saying that the ability of a membership organization to effectively represent its constituency is directly related to the constituency's support of the organization. Since the AMA is basically a federation of state associations, the subject of membership is a problem that is shared by all levels of the federation and calls for their participation in the solution. This participation might have to include an evaluation of federationwide membership solicitation programs, or even a review of the basic federation structure itself.

As part of the Council's study, background information was requested from the Center for Health Services Research and Development and the Membership Department. Additionally, the

Council conducted a survey of the House of Delegates, seeking opinions as to why physicians do or do not choose to become members of the AMA.* Since the survey questions were purposefully rather open-ended, the tally of responses was summarized into a series of broad categories as follows:

Question 1 – Reasons Physicians Choose to Join AMA

	Percent
1. Educational and insurance benefits	17.1
2. National representation, legislative representation	49.8
3. Tradition, customary to belong, peer pressure	21.0
4. Ethical standards, public health	6.4
5. Other	5.7
	100.0%

Question 2 – Reasons Physicians Choose Not to Join AMA

	Percent
1. Money, financial costs, dues	23.6
2. Disagree with AMA positions and policies	19.4
3. Lack of knowledge about AMA and its activities	23.0
4. AMA doesn't do anything for them	17.2
5. Free ride; get the benefits anyway	2.9
6. Other	13.9
	100.0%

The survey's response rate of 36 percent is adequate to provide valid indications of what factors appear to be important in explaining AMA membership levels. However, the 36 percent response rate also raises the question of why the remaining 64 percent did not choose to respond. This may in itself be an indication of the lack of awareness of interest in AMA's membership problem.

After carefully considering the results of the survey as well as the other information and comments that were provided during the course of the study, the Council determined that one of the major areas that appears central to the success of AMA's membership efforts in the future relates to the federation structure and membership procedures.

Federation-Wide Recruitment Problems – The lack of a cohesive federation-wide membership recruitment program has inhibited AMA membership growth. In 1974, the AMA Department of Membership Development identified a series of problems related to membership recruitment that needed to be addressed before significant progress could be made. Among the more significant problems were:

1. Differences in membership requirements in the Bylaws of state and county societies make uniform recruitment programs difficult.

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* Additional work of the same nature is being done for AMA on a much more sophisticated and comprehensive basis by consultants. Their finding will continue to be reported to the Board of Trustees and taken into consideration as part of the Board's ongoing deliberations on the membership situation. The Council's survey questionnaire was sent to all delegates and alternate delegates. Out of a possible 500 responses, the Council received only 178 questionnaires back for a response rate of 36 percent. In interpreting the survey results, it is important to keep in mind that the respondents were asked to indicate why they feel physicians join and don't join AMA. Hence, the survey results represent the respondents' perceptions of other people's behavior.

2. There are approximately 850 billing units, each using different billing techniques, and 650 of which are unstaffed. Billing procedures and forms in some areas actually discourage physicians from joining AMA by including such things as "you need not join the AMA," "voluntary," or "optional" on the bills.

3. As financial pressures and external issues (professional liability, NHI, etc.) have intensified over the past several years, the willingness to promote membership solidarity throughout all levels of the federation seems to have given way to the "look out for ourselves first" attitude.

4. One of the problems of a voluntary federation structure is that it fosters the "free rider concept." Individuals come to realize that many of the benefits of membership in AMA accrue to the non-member as well as to the member (representation in Washington, accreditation of medical education at all levels etc.). At a time when dues of all medical organizations are increasing to the point where physicians are looking for which ones can be dropped, AMA is one of the most vulnerable due to its position as the third decision point in a three tier decision making process as to whether to join the county society, state society, and AMA. This "last position" in the decision process is one of the real disadvantages in a voluntary federation.

These and other problems have been addressed by AMA. Solutions were developed and programs to achieve the solutions were designed and offered to all units throughout the federation. For example, a set of model bylaws to help standardize membership requirements was developed and promoted. Unfortunately, it is estimated that fewer than 5 of 2,000 societies in the federation have adopted them. It is estimated that only about 20 of 2,000 state and county societies have used the membership promotion materials and programs developed and distributed by AMA. In addition, the practice of holding AMA dues money at the county and state levels in order to earn interest from it continues. When all of these factors are put together, the overall picture that emerges is that the unity and singleness of purpose that is assumed to be the basis of the federation simply is not there to the extent that is necessary to provide the organizational strength the federation needs for the future.

The solutions to this problem are not obvious, nor will they be easy to achieve once they are found. Different aspects of the problem have been and are continuing to be studied by the Board, councils and staff units of AMA. The traditional approach to unity that is generally referred to as "unified membership" is no longer popular in most areas. New approaches to unity are needed. In 1976 the House received a proposal for direct dues billing that was aimed at one part of the problem. In 1975 the Council on Long Range Planning and Development proposed some structural changes to the federation that were aimed at increasing solidarity. These and other efforts will continue until acceptable solutions are found. However, the cooperation of all levels of organized medicine is urgently needed because this federation-wide problem cannot be solved by AMA alone. The delegates in the House are vital links between AMA and the rest of the federation and must serve as the conduit and stimulus for helping to achieve the federation-wide solution.

Other Considerations – In the course of its study, the Council also identified numerous other specific topics that relate to more operational concerns. For example, does the benefit package that AMA offers to prospective members compete favorably with the benefits offered by other medical organizations? What kind of "differentiated" recruitment programs are needed to appeal to the various different segments of the physician population (students, housestaff, FMGs, educators, urban vs. rural, young vs. old, etc.)? These operational concerns are beyond the purview of the Council's responsibility. They have been summarized in a report by the Council and sent to the Board of Trustees for appropriate follow-up at that level and by staff.

No. 111 CO-PAY FOR ALL INSURANCE PROGRAMS
Introduced by Michigan Delegation
(Reference Committee A, page 262)

HOUSE ACTION: REFERRED TO BOARD OF TRUSTEES

RESOLVED, That the American Medical Association urge the application of a deductible provision for each service a patient receives as the most effective means to control rising medical costs both in private and public insurance programs, without arbitrary regulations or restrictions on services, and that deductible provisions be a part of the AMA's program for national health care.

No. 112 ALCOHOLIC AND CHEMICALLY DEPENDENT PATIENTS
Introduced by Minnesota Delegation
(Reference Committee A, page 256)

HOUSE ACTION: ADOPTED

RESOLVED, That the American Medical Association strongly urges that United States governmental agencies responsible for the negotiation of the Federal employee health insurance program include medical treatment for alcoholic and chemically dependent patients as a standard benefit.

No. 113 ADHERENCE TO PROCEDURAL DUE PROCESS BY DISCIPLINARY COMMITTEES
Introduced by Resident Physicians Section
(Reference Committee D, page 292)

HOUSE ACTION: ADOPTED

RESOLVED, That any member of the American Medical Association, acting in any official capacity within the profession or on a committee in any professional setting or disciplinary committee, be it hospital, city, county or state medical society, professional association or organization, governmental medical body or the like, who passes judgment on any other member of the AMA involving any charge or complaint concerning the latter's professional ability, honor, reputation, or right to make a living shall adhere to the principles of procedural due process as promulgated by the Judicial Council of the AMA or the AMA House of Delegates, or the Joint Commission on Accreditation of Hospitals; and be it further

RESOLVED, That in the disciplinary hearing if the adjudging physician is grossly or recklessly negligent in adhering to due process or conducts the hearing with malice or lacking in good faith, shall himself be open and liable to the charge of unethical conduct, such charge to be adjudicated as a complaint related to procedural due process (as distinct and separate from the substance of the charge and complaint) within a reasonable period or interval of time by the county or state society of the AMA consistent with the constitutional principle that a person is entitled to a speedy trial.

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REPORTS OF REFERENCE COMMITTEES
AS PRESENTED TO THE HOUSE OF DELEGATES

The following Reports of Reference Committees DO NOT REPRESENT FINAL HOUSE ACTION. The page number at the end of each item refers to the final action of the House of Delegates.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

W. Scott Hendren, Oklahoma, Chairman
E. Tremain Bradley, Connecticut — O. Emfinger, Alabama
John E. Dettmann, Wisconsin — Ralph M. Schwartz, New York

(1) REPORT A OF COUNCIL ON CONSTITUTION AND BYLAWS AWARDS AND HONORS (BOARD OF TRUSTEES REPORT PP, C-76)

Report A of the Council on Constitution and Bylaws contains Bylaw amendments to the chapters dealing with awards and honors. This report is in response to the action of the House of Delegates at the 1976 Clinical Meeting adopting Board of Trustees Report PP (C-76).

Your Reference Committee, with the concurrence of the Council on Constitution and Bylaws, recommends an amendment by addition to Section 2 (D) by adding the following sentence at the end of Section 2 (D): "This procedure shall be continued until one of the nominees receives a majority of the votes cast."

This brief amendment coincides with the exact language found at Section 1 (D). Since both paragraphs describe the selection process, the language should be the same.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report A of the Council on Constitution and Bylaws, as amended, be adopted, and the Bylaws be amended accordingly. (see page 120)

(2) REPORT B OF COUNCIL ON CONSTITUTION AND BYLAWS AUTONOMY OF STATE MEDICAL ASSOCIATIONS

Report B of the Council on Constitution and Bylaws proposes an amendment by addition to Chapter IX of the Bylaws which describes the autonomy of the state medical associations.

At the open hearing before your Reference Committee, the Council on Constitution and Bylaws modified the language of the proposed amendment. As so modified, the amendment in full now reads as follows:

Section 3. Autonomy of State Medical Associations

"The participation of a State Medical Association in the House of Delegates is voluntary. Policy actions of the Association do not in themselves bind a State Medical Association or subject it to any obligation that it does not voluntarily assume."

While the independence and autonomy of the state medical associations are clearly recognized within the medical profession, there is no objective statement of this principle presently in the Bylaws. Those outside of medicine sometimes erroneously consider the state medical associations to be "branches" of the AMA and controlled by the AMA. Therefore, a provision which articulates the autonomy of state medical associations is necessary.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report B of the Council on Constitution and Bylaws, as amended, be adopted and the Bylaws be amended accordingly. (see page 121)

(3) REPORT C OF COUNCIL ON CONSTITUTION AND BYLAWS
DECIMALIZATION OF BYLAWS

Report C of the Council on Constitution and Bylaws is an interim report on its progress in decimalizing the AMA Bylaws.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report C of the Council on Constitution and Bylaws be filed. (see page 122)

(4) REPORT B OF COUNCIL ON LONG RANGE
PLANNING AND DEVELOPMENT
AMA FULL-TIME PRESIDENT
(RESOLUTION 8, C-76)

Report B of the Council on Long Range Planning and Development proposes that the current position of Chief Executive Officer carry the title of President, be the chief spokesman for AMA, be selected by the Board of Trustees and serve at the pleasure of the Board. The report also proposes the phasing out of the elective office of President Elect, President and Immediate Past President, and adding three additional Trustees to the Board. The report includes a proposal for implementing these actions over a three year period.

Your Reference Committee heard extensive testimony on this report. While most of those discussing this report expressed a desire for some change from the current structure, there was little agreement as to the type of change which would be best for AMA or the reasons for making a change. The elements heard most frequently were that the President of AMA should be a physician elected by the House of Delegates, and that it would be desirable to provide for some continuity in office.

(Committee B)

(12) RESOLUTION 118 — NUCLEAR REGULATORY COMMISSION

This resolution calls on the AMA to recognize the adequacy of regulation of medical use of nuclear materials by the Nuclear Regulatory Commission over the past twenty-five years and to urge that the responsibilities of the NRC be neither expanded nor curtailed.

The only testimony presented to the Committee was from the sponsor of the resolution who urged referral to the Board for further study. The committee is in agreement.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 118 be referred to the Board of Trustees. (see page 240)

(13) REPORT V OF BOARD OF TRUSTEES LEGISLATIVE LIAISON (RESOLUTIONS 36 AND 56, C-76)

Report V of the Board of Trustees responds to Resolutions 36 and 56 (C-76) which were referred by the House of Delegates to the Board of Trustees for report at the 1977 Annual Convention. Resolution 36 urged the Association to undertake discussions with representatives of state medical societies in order to bolster federal legislative relationships through keyman legislative programs. Resolution 56 asked that the AMA initiate discussions with state and county medical societies to identify physicians having legislative relationships with national leaders and that a system be devised for the dissemination of information on critical national health issues to obtain input from individuals and groups of physicians. Report V relates the Association's various activities in maintaining legislative liaison with state and county medical societies.

Your Reference Committee heard testimony in support of the activities of the Association as indicated in the report. However, concern was expressed over the slowness of development of a national program. Association activities in relation to legislative liaison have been underway for a period of time, and the Committee recognizes the difficulty of implementing an effective program quickly. The Committee believes that this program is viewed by component societies as vital to achieving Association goals, and that Association activities should continue to expand rapidly.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report V of the Board of Trustees be adopted in lieu of Resolutions 36 and 56 (C-76) and that the Board of Trustees report to the House at its 1977 Interim Meeting on additional activities. (see page 77)

(14) RESOLUTION 41 — REEVALUATION OF AMA POSITION ON HR 2222 (AMENDMENT TO THE NATIONAL LABOR RELATIONS ACT)
RESOLUTION 51 — STATUS OF RESIDENCY PROGRAMS
RESOLUTION 103 — AMA TESTIMONY ON HR 2222

Resolutions 41, 51 and 103 urge, respectively, that the AMA reevaluate its position in support of HR 2222, that the AMA support the view that employed residents in a medical residency

(Committee D)

(13) RESOLUTION 106 — THE PHYSICIAN AS AN INDEPENDENT CONTRACTOR

Resolution 106 calls for the AMA to define and promote the concept of physicians as independent contractors, particularly in relationship to the Department of Health, Education, and Welfare's regulations for Medicaid and Medicare, "Conditions for Participation of Hospitals: Requirements for Certification and Utilization Review."

Testimony before your Committee disclosed that the intent of Resolution 106 is to reaffirm existing AMA policy that the hospital medical staff is responsible for the quality of care provided to patients in the hospital, exercising authority in medical matters. Therefore, the following Substitute Resolution is offered:

> RESOLVED, That the American Medical Association reaffirm its policy that hospital medical staffs are responsible for the quality of care provided patients in the hospital, exercising authority in medical matters comparable to those exercised by the governing body in performing corporate managerial functions.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 106 be adopted. (see page 236)

(14) RESOLUTION 113 — ADHERENCE TO PROCEDURAL DUE PROCESS BY DISCIPLINARY COMMITTEES

Resolution 113 calls for the adherence to the principle of due process as specified by the AMA and the Joint Commission on Accreditation of Hospitals in any specific instances in which an AMA member passes judgment on any other AMA member concerning the latter's professional ability, honor, reputation, or right to make a living.

Your Reference Committee reviewed the testimony presented and notes that the general area of this resolution falls within the purview of the AMA Judicial Council.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 113 not be adopted. (see page 238)

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(Committee F)

(6) REPORT GG OF BOARD OF TRUSTEES
DIRECT BILLING FOR AMA MEMBERSHIP
(BOARD OF TRUSTEES REPORT Y, C-76)

Report GG of the Board of Trustees proposes that in lieu of direct billing for AMA membership, the AMA seek contracts with constituent societies to formalize their status as AMA billing agents. Such contracts would be consistent with the criteria offered in Report GG to guarantee that AMA interests are appropriately protected. Further, four additional actions are offered for state medical society implementation to improve total federation membership and billing programs. This report was developed from the responses of state and county medical societies to a request for assistance from this House of Delegates. Those societies that participated deserve our thanks.

Yet, the Reference Committee did perceive that the requirement of a legal contract has caused concern among some of the groups that would be affected. Further, we are informed that societies in states with unified memberships would not be affected by implementation of this report since an effective working relation already exists between the AMA and these states. Therefore, while we are in agreement with the intent of the report, the criteria offered, and action programs to improve total federation membership that are proposed, we believe that the report should be amended to include specific exemption of societies in states with unified membership and that the words "agreements consistent with the criteria" should be substituted for "contracts" in the first paragraph following the eleven criteria listed in the report, and in the second paragraph following these criteria substitute "agreement" for "contract."

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report GG of the Board of Trustees be adopted as amended. (see page 100)

(7) REPORT II OF BOARD OF TRUSTEES
REDUCED DUES FOR NEW AMA MEMBERS
RESOLUTION 20 — REDUCED DUES FOR MEMBERS
IN THEIR FIRST YEAR OF PRACTICE
RESOLUTION 107 – AMA RESIDENT MEMBERSHIP

Report II of the Board of Trustees, Resolution 20 and Resolution 107 address similar objectives and were considered together.

Report II of the Board of Trustees acknowledges that advice from many sources recommends a program of reduced dues for new AMA members to encourage the participation of physicians beginning their careers in medicine, and promises to present a coordinated report at the 1977 Interim Meeting. Since your Reference Committee was offered testimony by some young physicians opposing a program of reduced dues based on the philosophy that even new members should pay their own way, we believe that the Board should be allowed the additional time requested to develop a carefully considered proposal for this House of Delegates.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the Board of Trustees Report II be adopted in lieu of Resolution 20 and Resolution 107. (see page 105)

(Committee F)

(8) REPORT A OF COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT — SPECIALTY SOCIETY REPRESENTATION IN AMA
REPORT E OF BOARD OF TRUSTEES SPECIALTY SOCIETY REPRESENTATION
RESOLUTION 117 — SPECIALTY REPRESENTATION IN THE HOUSE OF DELEGATES
RESOLUTION 119 — CONTINUATION OF SPECIALTY SECTION COUNCILS
RESOLUTION 126 — THE MISSION OF THE SECTION COUNCILS
RESOLUTION 130 — CONTINUATION OF SPECIALTY SECTION COUNCILS
RESOLUTION 133 — CONTINUATION OF SPECIALTY SECTION COUNCILS

Report A of the Council on Long Range Planning and Development proposes three recommendations in response to a charge from this House of Delegates to reconsider the Council's Report B (C-75) that was considered in Hawaii. Report A also responds to a recognized need for a greater sense of unity within organized medicine and a desire among specialty societies for direct representation in the House of Delegates. Report E of the Board of Trustees expresses the Board's strong support for Report A and for the direct representation of specialty societies in the House of Delegates that is recommended by the Council on Long Range Planning and Development in its report. Resolutions 117, 119, 126, 130 and 133 offer an alternate approach to improving the representation of specialty societies in the House of Delegates and the sense of unity within medicine. Therefore, your Reference Committee determined that these matters should be considered together.

There was apparent agreement on certain of the Council's recommendations and therefore your Reference Committee considered the Council's recommendations separately.

In Recommendation 1, the Council proposes that the AMA endorse the concept of direct specialty society representation in the House of Delegates as a way to strengthen unity within organized medicine. The Reference Committee heard little testimony in opposition to this principle. The opinion was expressed repeatedly that the present Section Council system provides direct representation.

In Recommendation 2, the Council proposes that specialty societies meeting one of the following conditions each have one delegate in the AMA House of Delegates to implement Recommendation 1:

1. Any specialty society currently represented on a Section Council and which has 1,000 or more AMA members.

2. Any specialty society currently represented on a Section Council which has fewer than 1,000 members but which has a primary certifying board in that specialty.

3. In the future, a specialty society would get a seat in the House upon recommendation by the Board of Trustees and approval by the House of Delegates.

(Committee F)

There was considerable controversy over this recommendation and your Reference Committee is convinced that this proposal requires further study and perhaps revision..

In Recommendation 3, the Council proposes that the convention expenses of all direct specialty society delegates be borne by the specialty societies just as the state societies financially support their delegations.

All members who testified favored this recommendation or expressed a willingness for the fiscal responsibility for specialty society representation to be shifted to the societies.

Mr. Speaker, your Reference Committee believes that the recommendations in Report A of the Council on Long Range Planning and Development should be considered separately.

RECOMMENDATION NO. 1:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of Report A of the Council on Long Range Planning and Development be adopted in lieu of Resolutions 117, 119, 126, 130 and 133. (see page 125)

RECOMMENDATION NO. 2:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 of Report A of the Council on Long Range Planning and Development be referred to the Board of Trustees with instructions that the Board is to bring together representatives to include members of the Council on Long Range Planning and Development, the Association of Section and Service Delegates, the AMA Interspecialty Advisory Board and members of the Board of Trustees to meet as a steering committee to devise an agenda for a larger meeting that is to be arranged to consider this recommendation of the Council with the objective of achieving an alternative that will enjoy a consensus. (see page 125)

RECOMMENDATION NO. 3:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 of Report A of the Council on Long Range Planning and Development be amended by deletion of the word "direct" and that CLRPD Recommendation 3 be adopted as amended to prevent any administrative confusion with regard to the financial responsibility for all specialty society representation activities as we await a report from the Board on the progress relative to CLRPD recommendation 2 at the next Interim Session of the House of Delegates. (see page 125)

RECOMMENDATION NO. 4:

Finally, Mr. Speaker, your Reference Committee recommends that Report E of the Board of Trustees be filed. (see page 52)

(Committee F)

(9) REPORT C OF COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT -- MEMBERSHIP STUDY

Report C of the Council on Long Range Planning and Development reports on a study designed to illuminate the reasons physicians join or refuse to join the Association and reviews recruitment problems that are organizational in nature. The Council proposes no specific action.

While there was no testimony offered on this report, your Reference Committee recommends it to you for careful study.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report C of the Council on Long Range Planning and Development be filed. (see page 130)

(10) RESOLUTION 21 — CLOSED CIRCUIT TV COVERAGE OF HOUSE OF DELEGATES MEETINGS FOR PHYSICIANS ATTENDING SCIENTIFIC SESSIONS

Resolution 21 advocates the broadcast, via closed circuit TV, of the meetings of the House of Delegates to physicians attending the concurrent scientific sessions. Since concurrent sessions are no longer contemplated, the purpose of this resolution has been lost.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 21 be not adopted. (see page 209)

(11) RESOLUTION 25 — PHYSICIAN ON THE AMA DEPARTMENT OF NEGOTIATIONS STAFF

Resolution 25 proposes that one or more physicians be added to the staff of the Association's Department of Negotiations.

Your Reference Committee was advised that the intent of Resolution 25 was to encourage consultation between physicians eminently qualified in negotiations and the expert staff of the AMA Department of Negotiations. There was no intention to add employees to the Department's present staff. Since we are informed that the Department consults with knowledgeable physicians as a matter of routine, the intent of this resolution appears satisfied.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 25 be not adopted. (see page 210)

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ANNUAL REPORTS

JULY 1, 1969 TO JUNE 30, 1970

The House voted to receive the Annual Reports as information

The following Annual Reports were submitted to the House of Delegates by the Board of Trustees. Each Division and Department of the AMA was asked to prepare a comprehensive report of its activities from July 1, 1969 to June 30, 1970. These reports contain detailed information regarding the programs and contributions of the Standing Committees of the House as well as Councils, Committees and Commissions of the Board of Trustees, AMA Education and Research Foundation and the Woman's Auxiliary.

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BOARD OF TRUSTEES

Many subjects of importance in the life of the American Medical Association and its members were considered by the Board of Trustees during the past year. In addition to those summarized below were health care costs, health care of the poor, the Commission on Foreign Medical Graduates, the report of the Citizens Commission on Graduate Medical Education, the AMA Physicians Recognition Award for participation in continuing medical education, the computer in medicine, AMA dues, highway directional signs, current procedural terminology, and position statement on nursing. These and others (totaling 47) were submitted to the House of Delegates and will be found in the Proceedings of the Nov. 30-Dec.), 1969, and the June 21-25, 1970, Conventions.

Liaison and Affiliations: The American Medical Association continues its membership in the Joint Commission on Accreditation of Hospitals, Board of Commissioners of the National Association of Blue Shield Plans, U. S. Chamber of Commerce, World Medical Association, National Health Council, National Better Business Bureau, Conference of National Organizations, World Federation of Mental Health, and Commission on Foreign Medical Graduates. The Board recently voted to accept membership in the Inter-Agency Council on Smoking and Health in view of the strong stand taken by the House of Delegates on the subject of smoking and health.

Previously established liaison committees continued their activities with similar committees of the American Hospital Association, American Bar Association, National Medical Association, American Medical Women's Association, Student American Medical Association, Association of American Medical Colleges, and others. In addition, representatives of the AMA have cooperated with the American Association of Medical Assistants, American Association for the Advancement of Science, the National Research Council, Division of Medical Sciences, National Society for Medical Research, National Fire Protection Association, and the National Council for Homemaker Services. Meetings also have been held between the Board and representatives of the AMA Women's Auxiliary, the American College of Obstetricians and Gynecologists, and others.

Development of New Health Occupations: The subject of health manpower continued to receive particular attention, and the Board's Council on Health Manpower developed Guidelines which specified the desirable steps to be taken and questions to be resolved by any group or institution attempting to develop a new health career. These Guidelines were intended to assist those organizations and institutions contemplating the development and training of individuals in a new health occupation, and considered scope of duties, need, education and training, employment, professional certification, and career, education, and geographic mobility. The Council on Health Manpower also outlined procedures which will be followed in its evaluation of the relevancy to health service needs of specific new health occupations.

AMA Medicredit Bill: One of the major subjects for discussion during the past year related to various forms of national health insurance and particularly to the legislation developed by the AMA, approved by the House of Delegates, which

implemented the plan to encourage individuals and families to obtain comprehensive health insurance through the medium of tax credit incentives. This plan, known as Medicredit, was the basis for the AMA's testimony before the House Ways and Means Committee late in 1969. In the following months because of the government's interest in reducing costs and controlling alleged abuses under Medicare and Medicaid, a structured "peer review" mechanism under the direction of state and local medical societies was added to the Medicredit bill. This provision for a structured peer review organization (PRO) would propose that the Secretary of HEW would contract with a state medical society (or any organization designated by a state medical society to enter into such agreement) for the establishment and operation of a PRO in the state. The agreement could provide for a peer review mechanism established in accordance with certain requirements set out in the bill or under a plan approved by the Secretary and state medical society which is intended to accomplish the same result.

Depending on the course of action chosen, PRO could require the state medical society (or entity it designates) to appoint a Commission to administer the program and an Advisory Council. The Commission would appoint Local Review Panels to review the need for and quality of medical services furnished under federally supported programs and the appropriateness of charges for such services, as well as local Advisory Councils. Each panel would determine, on information obtained, if there is sufficient cause for a hearing. If a hearing is called and the Panel determines that disciplinary action is warranted, it would make such recommendation to the Commission. Upon review, if the Commission agrees that any disciplinary action is warranted, it would so recommend to the Secretary of HEW. The Secretary could accept or reduce (but not increase) the recommended disciplinary action.

Study is continuing on the AMA Medicredit bill so that appropriate refinements can be made as changing circumstances demand.

Professional Liability: The ever-increasing problems of the need for assurances that insurance protection will continue to be available to all professionally competent members of the Association led the AMA to study, in conjunction with appropriate representatives of the insurance industry, a means by which a qualified insurance program could be instituted under joint sponsorship of the AMA and the state medical associations. Late in this reporting year the Board recommended, and the House approved, continuation of negotiations to the end that a professional liability insurance program for members of the AMA might be established to provide long term protection (guaranteed renewable for up to five years), stabilized premium costs, and basic insurance coverage at the level of $100,000/$300,000 with optional excess coverage up to $5,000,000.

Minority Students: In November 1969 the Inter-Association Committee on Expanding Educational Opportunities in Medicine for Black and Other Minority Students was established, with representation from the AMA, the National Medical Association, the Association of American Medical Colleges, and the American Hospital Association. The Committee was planned to coordinate activities related to minorities, to develop new programs, and to develop additional financial support to meet the needs.

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A Task Force was organized with Sloan Foundation support to study the problem and present recommendations to the Committee for increasing the representation of minority students in United States medical schools and in the medical profession. The report of the Task Force was presented to the Inter-Association Committee, was accepted, and was referred to the parent organizations for study and consideration.

The long-term goal is to achieve equality of opportunity by reducing or eliminating inequitable barriers and constraints to access to the medical profession and the short-term goal is to expand minority student enrollments from the current 2.8 per cent to 12 per cent by 1975-1976. The report reached the following conclusions: (1) that major efforts should be focused on the problem of retention of minority students in undergraduate programs, (2) the major barrier for minority students in attending medical schools is the inadequacy of financial aid, (3) that the need for career counseling should be directed so as to increase the motivation of minority students, and (4) that there was a need to increase class size.

The report was accepted in principle by the Board and the AMA is continuing to participate in the deliberations of the Inter-Association Committee.

Communications Program: Many events led the Board of Trustees to embark on an expanded, long-term program of identifying through improved communications techniques the AMA and individual physicians with the legitimate concerns of the nation with respect to the organization, financing and delivery of medical care. As a part of this program the positive contributions of the profession and its quantitative voice - the AMA - will be emphasized. Approval has been given by the Board to the production of documentary programs showing the positive, effective side of medical services to the country, for showing by selected television stations from coast to coast. Other plans envision an educational program to the people through the advertising media, closer relationships between the leaders of the medical profession and the top executives of the communications media, production of special educational materials designed for the education of the disadvantaged, and an expansion of the AMA's audio-visual education and informational programs. The AMA will also work closer with national and regional women's and youth organizations, including school counselors who wish to help students seek careers in medicine or health.

AMA Dues: Faced with an operating deficit of approximately $2,000,000 in the 1970 budget, the Board of Trustees recommended an increase of $80.00 in the annual AMA membership dues, effective January 1, 1971. The Board pointed out that such a substantial increase was necessary to operate new and expanded programs, without which the AMA cannot provide leadership in health affairs, to provide for federal taxes on "unrelated business income"; to maintain the AMA's reserves as directed by the House of Delegates, and to provide for rising operating costs in an inflationary economy. The Board also provided a description of the Association's financial situation and a list of some of the programs and activities demanding priority attention. (Subsequently, the House of Delegates in considering the Board's recommendation amended the Bylaws authorizing the House to prescribe Association annual dues in an amount fixed by the House. The House then proceeded to adopt a dues increase in the amount of $40.00, establishing annual membership dues at $110.00 beginning January 1, 1971.)

Committees of the Board: The following new committees or expansion or revision of existing committees were authorized by the Board:

1 - Advisory Committee on Medical Science: The following missions were approved for this Committee: (1) To be broadly consultative to the Board in matters of basic and clinical medical science; (2) to advise on long-term needs, created by evolving medical science and technology, in education of the medical profession and the public; (3) to assist in preparation of statements of scientific policy that relate to anticipated or existent advances in medical science and technology; (4) to maintain an overview of and offer critiques on the scientific programs of the Association, to the end that such programs will most effectively deploy the resources of the Association in the accomplishment of its basic purpose; (5) to assist in the development of advice to the executive and legislative divisions of the federal government to the end that national resources will be used efficiently in promotion of the health of the American people, and (6) to assist the Board in selection of the most deserving recipients of the scientific awards and citations sponsored by the Association.

2 - Committee on Membership: The Committee was established in May 1970 to study the membership problems to the end that county and state medical society recruitment may be assisted, that other appropriate channels of entry may be considered, and that motivation for membership may be increased.

3 - Committee on Professional Liability: In March 1970 a Committee was established to direct activities in the area of professional liability.

4 - Committee on Community Emergency Services: This Committee was established in February 1970 as a committee of the Board.

Annual and Clinical Conventions: The following places and dates were approved for Annual and Clinical Conventions of the Association:

Annual:	1971	Atlantic City, June 20-24
	1972	San Francisco, June 18-22
	1973	New York, June 24-28
	1974	Chicago, June 23-27
Clinical:	1970	Boston, November 29-December 2
	1971	New Orleans, November 28-December 1
	1972	Cincinnati, November 26-29
	1973	Anaheim, California, November 25-28
	1974	Portland, Oregon, December 1-4

AMERICAN MEDICAL NEWS

American Medical News made its first appearance with the July 7, 1969 issue, succeeding The AMA News which has been published since 1958. The charge to the editors from the Board of Trustees was to report "any news of importance to medicine" in an objective manner.

During the first year, many changes were made in format and content. Emphasis was placed on improving the graphic appearance and on in-depth reporting of issues affecting medicine. Question-and-answer interviews with leading figures in medicine and government, and "Personal Opinion" columns also were additions to the newspaper.

Subjects that were reported in-depth during the year included national health insurance proposals, computers in medicine, professional liability,

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Regional Medical Programs, abortion, foreign medical graduates, profit-making businesses in medicine, the financial plight of medical schools, and physicians' assistants.

DEPARTMENT OF MEDICINE AND RELIGION

The purpose of the Department is to provide opportunities for communication between the physician and the clergyman that will lead to their mutual efforts in giving total care to a patient and his family. To accomplish this task, the Board of Trustees Committee on Medicine and Religion has recommended three major areas of emphasis:

State and County Societies: Through committees already established, various programs are carried on to inform physicians and clergy of existing opportunities for discussion about their concerns for the whole man. These committees encourage county societies to engage in this activity on a county or community basis. In this past year, an increasing number of other organizations have sought the cooperation of medicine in co-sponsoring such programs. Many programs have been planned in cooperation with American Cancer Societies, American Heart Associations, Veterans Administration hospitals, local community hospitals and other institutions.

Theological Education: Priority was given to the Department's efforts to provide consultation and resources to assist county societies in developing seminary courses on medicine and religion. Of 199 responses to a survey of seminaries, 150 or 75% said they would be interested in such assistance from physicians in county medical societies. Several courses have been arranged during the year to help seminarians understand their cooperative role with physicians in caring for patients. A guide is being prepared on this subject.

Medical Education: Hospitals are being encouraged to include medicine and religion as part of their continuing education programs for interns and residents. Medical schools that have held seminars on medicine and religion report good attendance and deep concern on the part of both professions. The Department continues to expand this area of its total program.

The Department held its Eighth Annual Program during the Annual Convention. The subject was "Crises - A Time For Counseling." Four regional workshops were held for state committee chairmen and state society staff members working with these committees. Two films, The One Who Heals and A Storm - A Strife, continue to have a large number of bookings.

DEPARTMENT OF MILITARY MEDICINE

The Department is responsible for the staffing of the Council on National Security. The Committee on Disaster Medical Care was discontinued on January 1, 1970.

A publication entitled Selective Service, Military Service and the Physician was designed to furnish general information to the medical student and the young physician. Approximately 60,000 copies have been distributed to medical students, physicians, libraries and other informational agencies.

The Department's information service, which was begun in 1963, continues to be available to all Armed Forces physicians. The service offers physicians assistance and guidance prior to, during and subsequent to their assignment in active military service.

The Council maintains liaison with the Department of Defense and the Surgeons General of the Armed Forces in formulating and coordinating programs, plans and procedures to improve medical care for members of the Armed Forces through the efficient utilization of medical and allied health personnel.

Problems concerning the supply of physicians for the Armed Forces, a review of the expansion of the physician draft, and other pertinent matters were explored by the Council on April 3, 1970, in Washington, D.C., at a meeting with medical officials of the Department of Defense, the Surgeons General, the Chairman of the Health Resources Advisory Committee, and other federal agencies. Subjects of concern were improved professional programs through academic affiliations, medical facilities planning, medical manpower, supply and operations, medical legislation and status and trends in resources for medical research.

With the current draft law due to expire on June 30, 1971, the Council began a full review of the Military Selective Service Act as it relates to the drafting of physicians and the overall problem of medical officer procurement and retention. Recommendations will be referred to the Board of Trustees prior to the 1970 Clinical Convention.

DEPARTMENT OF SPECIALTY SOCIETY SERVICES

The Department of Specialty Society Services was established January 1, 1970, within the Executive Vice President's Office. Its primary responsibilities are to maintain liaison with the national medical specialty societies and to staff several of the AMA activities related to specialty organizations.

The Department has had three primary functions during this period:

1. To assist with the staffing of the AMA Interspecialty Committee. This Committee was created in 1966 as an advisory body to the AMA Board of Trustees and has representatives from twenty national medical specialty societies. It meets four times each year.

2. To staff the organization and operation of the AMA Section Councils, which become formally operative on January 1, 1972. Twenty-three Section Councils are in the process of being organized and planning is underway for their initial meetings in 1971.

3. To continue liaison with twenty-one specialty groups. This liaison activity provides for an exchange of information and ideas between AMA and specialty organizations and encourages a close working relationship.

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MEDICAL NEWS DEPARTMENT

The Medical News section of JAMA carried 572 news articles and features. Several of the features dealing with such subjects as Russian medicine, medical assistants, the financing of medical research and medical problems associated with air travel which involved extensive interviewing of physicians. The section also devoted special issues to the Annual and Clinical Conventions.

The section also was responsible for 66 articles carried in the "Internal Medicine at Large" section of the Archives of Internal Medicine. This section was started in the January issue. The articles were based on presentations at scientific meetings in the United States and Canada and on interviews.

DIVISION OF SCIENTIFIC PUBLICATIONS

John H. Talbott, M. D., completed his services as Director of the Division and Editor of The Journal at the end of 1969, at which time he became Editor Emeritus. He continued his association with the Division with responsibilities for the JAMA colored cover and other special assignments, including liaison with some of the AMA Specialty Journals. Hugh H. Hussey, M. D., former Director of the Division of Scientific Activities, was appointed Director of the Division and Editor of JAMA effective January 1, 1970.

THE JOURNAL

During the early months of 1970 the format was reviewed and various changes were made to produce a more attractive and readable periodical. A three-column format was adopted for the main scientific sections. Article headings were changed to larger and heavier types. Synopsis-abstracts now have a "ragged right" -- intended to loosen up the appearance of the book. Natural endings are being used for articles, resulting in more white space between articles. The number of fillers has been greatly reduced. Charts are being made more uniform, more readable and more understandable. Various new styles have been adopted for departmental headings.

The Medical News section has been redesigned with a color bar at the edge of right-hand pages, making for easy identification. In addition to "hard science" news, medical feature stories are now being published from time to time.

More illustrations are being used in AMAgrams and a special seven-part series on places of interest in Chicago was published preceding the Annual Convention.

The Clinical Notes section has been renamed Brief Reports, indicating that the length of the articles and concise treatment of the subject are the criteria for allocation to this section rather than strictly clinical subject matter.

A new department entitled The Environment appeared for the first time in the April 6, 1970 issue and now appears regularly in the first and third issues of the month. This department is intended to present interesting facets of today's environmental problems.

The Osler Issue, published December 22, 1969, is believed to be one of the outstanding issues of JAMA during the decade. The annual Book Number was published on April 6, 1970.

SPECIALTY JOURNALS

Three new Chief Editors were named. They are Richard Warren, M.D., Boston, who succeeded J. Garrott Allen, M.D., as Chief Editor of the Archives of Surgery; B.R. Alford, M.D., Houston, who followed George Shambaugh, Jr., M.D., as Chief Editor of the Archives of Otolaryngology; Daniel X. Freedman, M.D., University of Chicago, who followed Roy Grinker, Jr., M.D., as Chief Editor of the Archives of General Psychiatry.

The format of the American Journal of Diseases of Children was changed to the larger 8 x 11" size as used for JAMA, the Archives of Internal Medicine and the Archives of Surgery.

Medical Writing: A two-day workshop in medical writing was held in July under the auspices of the American Medical Writers Association at AMA Headquarters.

DIVISION OF SCIENTIFIC ACTIVITIES

The Division has eight departments which are responsible for staffing six councils and 17 committees. Secretariats are provided for the Advisory Committee on Medical Science, the Committee on Maternal and Child Care, the Committee on Transfusion and Transplantation, the Committee on Computers in Medicine, the CORE Committee on Human Sexuality, and several internal committees of the Board of Trustees and the AMA-ERF. Advertising Evaluation, formerly a separate department, is now a function of the Division office.

Advisory Committee on Medical Science: This Committee advises the Board of Trustees on a wide diversity of scientific problems. It has met to consider problems in medical education and health manpower, the role of research training in medical education and the implications of certain aspects of medical technology.

Committee on Maternal and Child Care: The Committee sponsored two Regional Conferences on Maternal and Child Care (in Denver and in Chicago), each designed to encourage interchange of ideas for effective medical programs to reduce infant and maternal mortality.

Following one year of study, a statement on birth certificates and reporting methods for vital statistics was submitted to the Board of Trustees for transmission to the House of Delegates. In adopting this report, the House requested the Committee to initiate an in-depth study of the methods used nationally and internationally to calculate infant mortality. The Committee also

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prepared a report on abortion and a report on contraceptives for minors which were transmitted to the Board of Trustees and to the House of Delegates.

Committee on Computers in Medicine: The Committee met several times with consultants representing research, insurance companies, professional associations and government. A conference is planned for 1971 to explore the developing role of computers in medicine.

Committee on Transfusion and Transplantation: The Committee, formerly known as the Committee on Blood, was renamed and its charge was broadened to encompass the developing area of organ transplantation. Staffing arrangements for the Committee were transferred from the Department of Environmental Health to the Division office. The Committee sponsored several statements in JAMA and published a revised edition of the booklet Current Principles of Blood Transfusion.

AMA Handbook on Human Sexuality: Written by a professional writer under the supervision of an editorial committee of physicians, this handbook is nearing completion. The book is intended to be a guide for practicing physicians, interns, residents and medical students to enable them to function more effectively as counselors on matters pertaining to human sexuality. A late 1970 or early 1971 publication date is anticipated.

DEPARTMENT OF POSTGRADUATE PROGRAMS

The Department includes the following sections: Impairment Rating, Rehabilitation, Medical Physics, Scientific Exhibit, and Medical Motion Pictures and Television. Staff services were provided to the Council on Scientific Assembly and the Committee on Rating of Mental and Physical Impairment.

On June 30, 1970, the Department of Postgraduate Programs was terminated and two new departments created to begin operation July 1. They are (1) the Department of Medical Instrumentation which will expand activities in the field of medical physics and instrumentation and continue the programs in rehabilitation and impairment rating; and (2) the Department of Scientific Assembly which will continue activities in connection with the Annual Scientific Assembly, the Clinical Convention scientific programs, medical motion pictures and television and the scientific exhibit.

Publications: More than 28,000 copies of 18 different publications, including impairment rating guides, film catalogs, rehabilitation literature, ionizing radiation regulations, medical instrumentation information and special exhibit pamphlets were distributed.

Annual and Clinical Convention Scientific Sessions: The educational scientific programs of the Clinical Convention in Denver and the Annual Convention in Chicago were prepared. The Denver Convention attracted 2,986 physicians and the Scientific Assembly of the Annual Convention was attended by 8,100 physicians. More than 2,300 physicians and other scientists participated in the preparation and presentation of the scientific sessions, exhibits and motion picture programs of the two Conventions. A television program was produced by the University of Colorado School of Medicine and presented at the 1970 Clinical Convention on an experimental basis. During the Scientific Awards

Dinner at the Annual Convention, Henry L. Bockus, M. D., received the Distinguished Service Award; Choh Hao Li, Ph. D., received the Scientific Achievement Award; and John S. Mills, Ph. D., received the Citation of a Layman for Distinguished Service.

Services to Physicians: More than 23,900 motion pictures were loaned from the AMA Film Library. The total number of film titles is now 428, of which there are 3,000 prints. Film reviews were prepared for publication in JAMA and the 1969 reviews were published in booklet form. The third edition of the Medical & Surgical Motion Pictures Catalog of Selected Films was released and approximately 4,000 catalogs have been distributed. The AMA Medical-Health Film Library Catalog was revised. Consultation was provided for the CINE Gold Eagle Film Awards.

Exhibits: Two exhibits, "Evaluation of Impairment" and "Engineering-Medicine-Physics," were shown at the Conventions and medical specialty society meetings. A new exhibit on resuscitation was included in the Scientific Assembly.

Liaison: Liaison was maintained with organizations concerned with biomedical engineering, ionizing radiation, and medical apparatus and instrumentation. Included was the Committee on the Interplay of Engineering with Medicine and Biology of the National Academy of Engineering. Liaison was maintained with various state medical and other organizations concerned with rehabilitation. The Department participated in the activities of the Committee on Hospitals of the National Fire Protection Association, a series of lectures to school and engineering research groups, and the activities of the President's Task Force on the Physically Handicapped. Liaison was maintained with the Joint Commission on Accreditation of Hospitals in the development of Fire and Safety Standards and Rehabilitative Service Standards.

In cooperation with the American College of Obstetricians and Gynecologists, the AMA produced a motion picture entitled Modern Obstetrics: Postpartum Hemorrhage. This is the second in a series of films carrying the overall title of Modern Obstetrics.

Council on Scientific Assembly: In cooperation with the Section Secretaries and national medical organizations, the Council arranged the Scientific Program of the Annual Convention in Chicago. In cooperation with the local Scientific Program Committee in Denver, the Council arranged the program for the Clinical Convention. The Council gave particular attention to means of continuing improvement of the Convention scientific programs and the role of television in the Convention programs.

Exhibits at both Conventions were selected and awards were presented to outstanding exhibits. The award-winning exhibits at the Student American Medical Association meeting and the International Science Fair were also shown at the Annual Convention.

A petition for the creation of a Section on Neurological Surgery was approved by the Board of Trustees and the House of Delegates. Petitions were received for the creation of a Provisional Section on Cardiovascular Disease and a Provisional Section on Plastic & Reconstructive Surgery.

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Committee on Rating of Mental and Physical Impairment: The Committee concluded work on a guide to the evaluation of impairment of the skin which was later published in JAMA. A guide on impairment of the hematopoietic system was completed and submitted for publication. The publication of this guide, the thirteenth in the series will complete the Committee work. The guides will be published later in book form. Twenty thousand copies of 12 different guides were distributed during the year.

DEPARTMENT OF ENVIRONMENTAL HEALTH

The Department provided staff services for the Council on Environmental and Public Health. Prior to January 1970, staffing also was provided for the Joint American Institute of Architects-American Medical Association Committee on Environmental Health, the Committee on Medical Aspects of Automotive Safety and the Committee on Transfusion and Transplantation.

In January, for the purpose of concentrating attention on environmental health, the following organizational changes were made: The AIA-AMA joint committee was dissolved; the CMAAS staff activities were transferred to the Department of Health Education; staff functions of the COIT were transferred to the Office of the Division of Scientific Activities, and staff activities involving fluoridation of public water supplies were moved to the Department of Foods and Nutrition.

The AMA Councils on Medical Service and Environmental and Public Health met with public health representatives prior to the Annual and Clinical Conventions. This exchange of viewpoints strengthened liaison between the medical profession and public health agencies. Briefing sessions for the Council and staff were held by the Consumer Protection and Environmental Health Service in Washington, D.C., and the National Institute of Environmental Health Sciences at Research Triangle Park, North Carolina.

A Council statement on the use of rubella vaccine was distributed to state and county medical societies. The Council approved a proposal to revise the AMA Statement on Fluoridation of Public Water Supplies. The Council recommended support of S. 2162, the Poison Prevention Packaging Act of 1969. Efforts were made to develop closer liaison between the AMA and the National Fire Protection Association and the Information Council on Fabric Flammability. State and county societies were urged to include fire protection subjects in future meetings and to obtain NFPA speakers.

The first in a series of regional meetings between the Council and representatives of state medical societies, state public health departments and state agencies was held January 9 in Scottsdale, Arizona. Representatives from New Mexico, Arizona, California, Colorado, the Consumer Protection and Environmental Health Service of HEW, the National Communicable Disease Center of HEW, the Woman's Auxiliary to the American Medical Association and the Student American Medical Association reported on problems, activities and goals. There was general emphasis on the need for cooperation and participation by physicians on all levels. Similar regional meetings during the next two years will cover all sections of the country.

A letter was sent to President Nixon offering AMA cooperation in policy and programming under any reorganization of the government's programs in environmental quality. Council members and staff also met with the new Council on Environmental Quality, reiterating the AMA's concern over environmental health hazards and offering the services and resources of the Association.

The 1970 Congress on Environmental Health was held May 4-5 at the Statler Hilton Hotel, Washington, D.C. Theme of the Congress was "The Population Problem and the Physician." The 1971 Congress, to be held April 26-27 in New York City, will focus on the subject of Solid Waste Management.

The Council Chairman, appearing before a House Committee, presented an AMA statement on H.R. 12934 and H.R. 15848, and the Council on Legislation presented the AMA position on S. 3229 and S. 3466. The AMA supported these proposals to extend and amend the Clean Air Act and went on record as favoring national ambient air quality standards.

A program to develop guides, pamphlets and other informational materials on environmental health was approved by the Council. A statement on abortion, declaring that it should be a medical matter removed from the area of law, was presented to the AMA Review Committee.

In accord with the action of the House of Delegates at the 1969 Clinical Convention, the Department is working on plans to expand programs and services.

OFFICE OF CURRENT MEDICAL TERMINOLOGY

Current Procedural Terminology (CPT), Second Edition, was published in April 1970. Additions include approximately 1,000 new procedures or revised terms for old procedures, and a special index of terms arranged according to body systems. CPT is computer oriented for statistical studies or peer review.

The manuscript of Current Medical Information and Terminology (CMIT), Fourth Edition, has been completed and computerized for publication in November 1970. Approximately 500 new terms and definitions have been added. Preciseness and specificity of terminology have been cultivated throughout the text. A special section of preferred names of diseases and conditions in French, German and Spanish with cross references has been added and the format has been enlarged.

The manuscript of Current Medical Information and Terminology Spanish (CMITS) has been completed. Publication date has not been determined.

Thesaurus of Medical Descriptors (TMD) is under development. Source material for the new edition of CMIT will be correlated with vocabularies derived from the scanning of standard textbooks.

DEPARTMENT OF FOODS AND NUTRITION

Jonathan Rhoads, M.D., and Stanley Dudrick, M.D., received the Joseph Goldberger Award in Clinical Nutrition for 1970. They were honored for their work in the nutritional management of the surgical patient and for development

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of the techniques of parenteral hyperosmolaralimentation. The Goldberger Lecture was presented jointly at the Annual Convention.

Fourteen medical students received Goldberger Research Fellowships to support three months' research experience in clinical nutrition. Nine of the students studied overseas.

The AMA Lectures in Medical Science were given on 55 college campuses by nine medical scientists. This program has been expanded so that 300 colleges can be visited in three years.

A core symposium, "The Role of Malnutrition in the Etiology of a Slum," was held at the University of Alabama Medical Center, Birmingham, February 11-12, 1970. The Symposium explored the cyclic nature of factors creating and perpetuating urban slums.

The Council, with the AMA Food Industry Liaison Committee, worked on many aspects of food composition and standards of nutritional quality. Special attention has been given to the composition of new or fabricated foods and to meal replacers. On behalf of the AMA, testimony was given at public hearings on proposed revision of the Food, Drug, and Cosmetic Act--Section on Foods for Special Dietary Use.

DEPARTMENT OF MENTAL HEALTH

Council on Mental Health: The 16th Annual Conference of State Medical Society Mental Health Representatives was held in March in Chicago. The theme of this conference, co-sponsored with the AMA Committee on Health Care of the Poor, was "Mental Health Services for the Poor." Recommendations for AMA and state society action were referred to the appropriate AMA departments for consideration and development.

The Council presented its evaluation of the "Report of the Joint Commission on Mental Health of Children." The Council sponsored a symposium on "Mental Health Dynamics in the Pre-School Child" at the 1969 Annual Convention in New York and a symposium on Suicide at the 1970 Annual Convention in Chicago.

Two members of the Council testified before a Congressional subcommittee which was conducting "a careful review of the state of the law governing those who are subject to loss of their liberty and to hospitalization because of mental illness."

The Council prepared a statement recommending that the AMA support the concept that the decision to interrupt pregnancy should lie solely with the woman and her physician. At the request of the Commission on Obscenity and Pornography, a statement was prepared on the effects of obscenity and pornography on the public and the adequacy of existing laws. The Council issued a brief statement on sensitivity training and is continuing its consideration of that type of activity. A revision of the Handbook on Mental Retardation was undertaken. Two members of the Council and staff participated in the development of an AMA Handbook on Human Sexuality. In support of testimony by the National Institute of Mental Health, the Council and its Committee on Alcoholism and Drug Dependence reaffirmed their stand for flexibility in judicial handling of drug abuse offenders and against mandatory penalties.

Committee on Alcoholism and Drug Dependence: Committee members testified on several drug and alcoholism bills under consideration by Congressional Committees.

The Committee's statement, "Guidelines for Admission of Alcohol-Dependent Patients to General Hospitals," was published in the October 6, 1969, issue of JAMA. Another statement, "Recovery from Drug Dependence," has been accepted for publication in JAMA. A statement on "Medical Principles for Alcoholism Laws" was prepared as a guide in the development of model or state legislation and was forwarded to the American Bar Association. A similar guide, "Medical Principles for Drug Abuse Legislation," was referred to the AEA. The book Drug Dependence: A Guide for Physicians is undergoing revision.

Department of Mental Health: Staff met with 12 mental health, alcoholism and drug abuse committees of state medical societies to exchange ideas and information. The Department initiated the formation of a National Liaison Committee on Alcoholism, an informal association of representatives from several groups working in the field of alcoholism. Two department exhibits, one on alcoholism and one on drug dependence, have been sent to various state medical association meetings and to other large medical meetings.

DEPARTMENT OF DRUGS

Council on Drugs: The Council met three times with representatives of government, industry and medical specialty groups to discuss current concepts, policies and practices of pharmaceutical advertising and promotion. The Executive Committee met twice to discuss governmental activities in matters of drug therapy, and the Ad Hoc Review Committee for AMA Drug Evaluations met eight times to review sections of the book. The Committee on Drug Utilization and the Committee on Cutaneous Health cosponsored a symposium on adverse reactions at the AMA Annual Convention, and the Council also sponsored a symposium on drug interactions at this Convention.

The Study Group for a National Drug Commission met in Washington, D.C., on January 21, 1970, to determine the need for the existence of such a commission. An ad hoc committee is to be appointed from the study group to discuss the feasibility of establishing panels of experts to consult with the FDA Commissioner.

Articles in JAMA included two evaluations of new drugs, 11 listings of new nonproprietary names adopted by the USAN Council, one report on adverse reactions, one review and one editorial. Two new editions of the nomenclature printout were published.

Committee on Cutaneous Health and Cosmetics: The Committee met twice to discuss cosmetic legislation, a symposium and exhibit programs. The Committee also cosponsored a symposium at the Twelfth National Conference on Physicians and Schools in Chicago and a conference at the annual meeting of the Southern Medical Association in Atlanta. Articles were published in GP, Journal of the Society of Toxicology and Applied Pharmacology, Oral Surgery, Oral Medicine and Oral Pathology, Today's Health, JAMA, Cutis, and Journal of School Health. Four revised pamphlets were issued during the year.

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In addition to providing support for the activities of the Council on Drugs and the Committee on Cutaneous Health and Cosmetics, the Department maintained liaison with many governmental agencies and medical and scientific associations, answered 7,856 inquiries from physicians and the public, mailed 29,066 reprints and 32,700 pamphlets, generated 4,762 abstracts on new drugs and drug reactions, and developed and staffed five exhibits that were shown at 13 meetings.

DEPARTMENT OF OCCUPATIONAL HEALTH

This department staffs the Council on Occupational Health, Committee on Aerospace Medicine, Committee on Occupational Toxicology and the Joint Committee on Mental Health in Industry. The department handled more than 2,000 requests and furnished 100,000 pamphlets and guides to physicians and nurses. The second edition of "The Physician's Career" was published in January 1970. Staff assisted government agencies in plans for administering the new Coal Miners' Occupational Safety and Health Act of 1969.

Council on Occupational Health: The 29th Annual Congress on Occupational Health, sponsored by the Council, featured symposia on aviation medicine, agricultural occupational hazards, the nurses' role in pre-placement examinations, and measurement of permanent partial impairment in workmen's compensation. During the Congress, Melvin T. Johnson, M. D., Medical Director of the U. S. Civil Service Commission, was presented with the Physician's Award for his promotion of employment of handicapped people in the federal service.

Council representatives testified before Congressional Committees on the proposed Occupational Safety and Health bills. A new guide, "The Role of Medicine Within a Business Organization," was published in JAMA.

Committee on Aerospace Medicine: The Committee, in cooperation with the Committee on Disaster Medical Care, presented a symposium on aircraft disasters at the 1969 AMA Annual Convention. Four of the papers will be published in the Archives of Environmental Health.

A statement on stress electrocardiogram testing of commercial pilots was produced in response to proposals of the Federal Aviation Administration. The Committee is preparing a health advisory statement for aircraft passengers traveling through many time zones, another on medical spin-offs from the space program, and papers for a symposium at one of the 1972 AMA Conventions.

Committee on Occupational Toxicology: A Committee statement, "Evaluation of the Present Status of DDT With Respect to Man," was published in JAMA, and an article on "Potential Health Hazards of Materials Used in Boating" has been accepted for publication.

The Committee sponsored a symposium on occupational diseases in the Section on Special Topics of the 1970 AMA Annual Convention. It is at work on studies in microwave exposures, on revision of the pneumoconioses guide, and on revision of the three pamphlets on industrial dermatoses. Work continues on the Committee's Registry on Adverse Reactions Due to Occupational Exposures.

Joint Committee on Mental Health in Industry: A guide on behavioral aspects of accidents is nearing completion. The Committee is developing a statement on cooperation between psychiatrists and occupational physicians. It plans to sponsor a symposium at the 1971 AMA Annual Convention on mental health in industry from the viewpoints of management, unions and the medical profession. Studies are continuing on drug abuse in industry and on sensitivity training.

DIVISION OF MEDICAL EDUCATION

Two new medical schools opened for the 1969-70 academic year, increasing the number of medical schools with students enrolled to 101. At least a dozen additional schools are in development. During the past year, the number of allied health occupations for which AMA has responsibility and accreditation increased from nine to fifteen. The number of continuing education courses offered by institutions across the United States increased by 15 percent. The number of physicians in internship and residency programs has more than doubled since 1950. The expansion of the Division, authorized during the previous year, has gone forward steadily. In addition, the Department of International Health was converted to a Department of International Medicine and was added to the Division. Further expansion is contemplated to meet increasing demands during the next two years.

Publications and Reports: The Division has for many years published four major reports annually. Three of these are regular issues of JAMA: the Education Number, the Medical Licensure Number and the Continuing Education Number. The fourth report is the Directory of Approved Internships and Residencies which appeared in the fall of 1969 as the 43rd annual report on graduate medical education in the United States. A new publication, the Directory of Accredited Medical Education Programs, appeared during the year. It is planned that this directory will b published annually.

Annual Congress on Medical Education: The 66th Annual Congress on Medical Education was held in Chicago in February 1970. It was attended by 1,525 physicians, educators, hospital and medical administrators and representatives of state licensing bodies. Many of the papers were published in JAMA and are being assembled as "Selected Papers from the 66th Annual Congress on Medical Education."

Committees of the Council on Medical Education: Each of the four standing advisory committees met at least four times. The membership of each committee was increased from five to ten. The Liaison Committee on Medical Education of the AMA and the AAMC met serveral times, as did the Liaison Comittee for Specialty Boards of the AMA and the Advisory Board for Medical Specialties (now the American Board of Medical Specialties). The Committee on Family Practice continued implementation of the recommendations of the Ad Hoc Committee on Education for Family Practice as directed by the House of Delegates.

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DEPARTMENT OF ALLIED MEDICAL PROFESSIONS AND SERVICES

The House of Delegates adopted the "Essentials" of approved educational programs for Nuclear Technologists and Technicians, Medical Assistants, and Orthopedic Assistants, and Histologic Technicians. This brings to a total of 15 the number of allied medical programs approved by the AMA in collaboration with 14 national professional associations.

The Panel of Consultants, which includes representatives appointed by each of the 14 collaborating national professional associations, met twice in conjunction with meetings of the Allied Health Advisory Committee. The Panel of Consultants has become a valuable mechanism for improving relationships with the collaborating associations.

Circulation of the Allied Medical Education Newsletter increased to more than 2,400. A total of 198 educational programs were given new or continued approval by the Council on Medical Education. This brings the number of approved allied medical education programs to 2,499.

Educational Programs in Allied Medical Fields

July 1, 1960 - June 30, 1970

	No. of Approved Programs	Student Capacity	Enrollment	Graduates
Certified Laboratory Assistant	210	2,224	2,004	1,570
Cytotechnologist	118	765	511	416
Histologic Technician	0	0	0	0
Inhalation Therapy Technician	56	800	395	256
Medical Assistant	6	340	220	70
Medical Record Librarian	26	501	256	250*
Medical Record Technician	18	411	219	175*
Medical Technologist	793	8,387	5,008	4,408
Nuclear Medicine Technician	0	0	0	0
Nuclear Medicine Technologist	1	2	0	0
Occupational Therapist	36	1,015	563	492
Orthopedic Assistant	0	0	0	0
Physical Therapist	52	1,575	1,469	1,362
Radiation Therapy Technologist	8	41	18	8
Radiologic Technologist	1,177	18,511	11,387	5,188
*Estimated Totals:	2,499	34,594	22,630	14,393

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Thirty institutions or organizations were granted accreditation by the Council on Medical Education after review by the Advisory Committee on Continuing Medical Education. On June 30, 1970, there were 81 accredited institutions, including 33 medical schools, 22 hospitals, 15 specialty societies and 6 others including medical societies, voluntary health and governmental agencies. There was a 15 percent growth in the number of courses in the listing of "Continuing Education Courses for Physicians." The listing now includes 2,319 courses offered by 611 institutions and organizations.

At the 1970 Annual Convention, the House of Delegates approved for the first time a formal statement of "Essentials of Continuing Medical Education Programs." As a result of the 1968 National Conference of State Medical Association Representatives on Continuing Medical Education, considerable activity has been generated in various state medical associations to coordinate and plan more suitable continuing education for their members.

The AMA Physician's Recognition Award was established at the 1968 Clinical Convention. It was expected that 10,000 physicians would qualify for the Award during its first year, but, as of June 30, 1970, almost 14,500 physicians had qualified. From physicians in residency training programs, approximately 9,500 applications were received and 6,730 qualified for the Award. From practicing physicians, 10,647 applications were received and 7,770 qualified for the Award. A second mailing of application forms was made to residents in the Spring of 1970, and returns from this mailing are being processed. A second mailing to all other physicians will be made in the Fall of 1970.

The Continuing Medical Education Newsletter is now received by 1,450 physicians and educators.

New Activities: Proposals have been prepared for the development of continuing education programs in community hospitals, the encouragement and promotion of self-assessment programs for physicians, the promotion of house officer observer programs or clinical traineeships, and the possible development of a national biomedical communications network for continuing education.

DEPARTMENT OF GRADUATE MEDICAL EDUCATION

Internship Requirements and Matching Procedures: By June 30, 1970, five specialty boards had indicated that they did not require candidates for certification to have served an internship. These were the American Boards in the following fields: Obstetrics-Gynecology, Ophthalmology, Pathology, Psychiatry and Neurology, and Surgery. Because of changing requirements, the National Intern and Resident Matching Program announced that candidates would be matched to first-year residencies in the specialty fields of these boards as a part of the intern matching procedure. These residencies will therefore be listed in a special section of the 1970-71 Directory of Approved Internships and Residencies. Candidates for Family Practice Programs were also included in the March Intern Matching Program. In the March 1970 Intern Matching Program, graduates of osteopathic schools, for the first time, were permitted to participate.

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Appointments of Osteopaths to Residency Programs: Several examining boards in the medical specialties revised their requirements so that qualified osteopaths could apply for certification. In conformity with the December 1968 action of the AMA House of Delegates, the residencies in these fields were declared open to qualified osteopaths who had served in AMA-approved internships. The following approved examining boards now accept osteopaths for examination: Anesthesiology, Dermatology, Internal Medicine, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Preventive Medicine, Psychiatry and Neurology, and Radiology.

Report of the Citizens Commission on Graduate Medical Education: As a further implementation of the Report of the Citizens Commission on Graduate Medical Education, the House of Delegates approved at its 1970 Annual Convention the following revisions of policy:

1. After July 1, 1971, a new internship program shall be approved only when the application contains convincing evidence that the internship and the related residency years will be organized and conducted as a unified and coordinated whole;

2. After July 1, 1975, no internship program will be approved which is not integrated with residency training to form a unified program of graduate medical education.

The Citizens Commission proposal of "institutional approval" rather than individual program approval for graduate training programs was implemented on a pilot basis by including in the surveys of four medical schools a simultaneous evaluation of their internship and residency programs. The surveys are being made available to the residency review committees for their evaluation.

Two new sections were added to the "Essentials of an Approved Internship" and "Essentials of Approved Residencies," one pertaining to employment relationships of house officers and the other relating to the importance of socio-economics in the education of the young physician. A revision of the statement in these "Essentials" on part-time residencies for men and women was also approved by the House of Delegates. The House also approved revisions in the "Essentials of Approved Residencies" in the special requirements for the following fields: Child Psychiatry, Internal Medicine, Neurological Surgery, and Pathology. At the 1970 Annual Convention, a revision of "Essentials of Approved examining boards in Medical Specialties" was approved, thus making available a procedure for the processing of applications for conjoint boards.

DEPARTMENT OF UNDERGRADUATE MEDICAL EDUCATION

Accreditation of medical schools continued to account for a major portion of the activities of the Department. Thirty-four accreditation surveys were carried out. Twelve of these visits involved schools under development. Five of the schools visited were Canadian schools. Four of the visits involved surveys in which the graduate as well as the undergraduate programs of the schools were reviewed, although approval of the residency programs continued to be the responsibility of residency review committees. The Liaison Committee agreed that during the 1970-71 academic year the number of surveys of this type would be increased.

A function of the Liaison Committee is the issuance of letters of "reasonable assurance" indicating that a new school is expected to attain accreditation status or that in an existing school a contemplated major increase in enrollment does not jeopardize the school's accreditation. During the year, 24 letters of reasonable assurance were issued, 17 relating to established schools and seven to new schools.

The Liaison Committee on Medical Education: Consideration was given to the role of the Liaison Committee in relation to the proposed Commission on Medical Education. It was agreed to move toward the goal of a single "central deliberative body for medical education in the United States" through expansion of the Liaison Committee. Expansion of the membership of the Committee was initiated by appointment of a representative of the Federal government and a representative of the public. Task forces on Graduate Medical Education and on the Physician's Assistant are being appointed.

A policy statement encouraged medical schools to develop extramural programs to bring their students into the community, recognized the existence of extramural programs developed outside the aegis of the medical schools, and specified that guidelines for programs developed by such organizations as SAMA did not imply approval by official accrediting agencies. The development of programs through which an osteopathic physician might qualify for the M. D. degree was suggested to medical school deans.

American Students in Foreign Medical Schools: Staff visited several foreign medical schools in which large numbers of American students are enrolled. These included schools in Mexico, Spain, Italy, Switzerland and Belgium. The Advisory Committee on Undergraduate Medical Education studied the means by which the return of these students to the United States and their integration into American medical practice might be facilitated.

Advisory Committee on Undergraduate Medical Education: The Committee devoted itself to such subjects as recent developments in medical education and the accreditation problems they present, medical school enrollments and the production of physicians, externships, American students in foreign medical schools, particularly the Universidad Autonoma de Guadalajara, and Federal legislation relating to financial support of medical schools.

The Department participated in numerous informal consultations with groups and individuals contemplating the establishment of new medical schools. Over 70 such institutions have been identified as potential for future years. Project Talent, a research study of the careers of 440,000 high school students who indicated an interest in medicine in 1960, continued during the year.

DEPARTMENT OF INTERNATIONAL MEDICINE

The Department of International Health was renamed the Department of International Medicine on January 1, 1970, and transferred from the Office of the Executive Vice President to the Division of Medical Education. All international activities of the AMA were grouped within the Department. Expansion of the AMA's program in international medicine was emphasized and a task force was appointed to define an innovative role.

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Vietnam Medical School: The AMA has completed three years of support to the Faculty of Medicine, University of Saigon, in a contract arrangement with the U. S. Agency for International Development. A new contract was signed in April 1970.

In addition to the counterpart relationships listed in the last annual report, sub-contracts have now been signed with University of Colorado (Dermatology), University of Oklahoma (Medicine), University of Hawaii (Microbiology). Informal support is being provided by Yale for Neurosurgery. Emphasis has shifted progressively from basic toward clinical sciences, as the supporting programs have matured and opportunities for clinical counterpart relationships developed. A major policy decision was made to place emphasis primarily upon graduate education. The thrust has been to develop graduate programs in the basic sciences and indigenous residency program in clinical departments in Saigon, and to select promising individuals from among graduate students for supplementary training in the counterpart departments in the United States. During the year, the outpatient departments of the Nguyen Van Hoc Hospital were opened. The inpatient services are being prepared. A contract has been signed by AID and the government of Vietnam with an American architectural firm to write the program and draw the plans for a new teaching hospital which will be built adjacent to the basic science buildings of the medical school.

Volunteer Physicians for Vietnam Program: This program operates under a contract with AID and has been continued for a period of two years from March 31, 1970. This project furnishes service to provincial hospitals in Vietnam by American physicians who contribute two months without pay. Travel expense and a minimal per diem allowance are provided.

World Medical Association: Direct financial subsidy from AMA to WMA ended in this year. Efforts are being made to increase American participation in WMA through associate membership and to enlarge the distribution of World Medical Journal, the official publication of WMA. Promotion includes an exhibit for WMA at the Annual Convention and editorial support and advertising in JAMA.

Medical Missionary Program: Complimentary subscriptions of AMA publications are provided for American missionary physicians serving overseas; 401 physicians are receiving approximately 1,200 journals. The textbook program for missionaries has been continued with arrangement by AMA for donation of medical texts from publishers. During the year, 1,186 textbooks were sent overseas. The market value of this contribution is approximately $24,000.

Doctor-to-Doctor Program: Approximately 650 American physicians are contributing about 1,500 medical periodicals to more than 600 colleagues in countries of Africa, Asia, Latin America and Europe. This program, which had been sponsored as a joint effort with the WMA, is now operated by the AMA alone.

Liaison Activities: Liaison continued with international organizations, international agencies of the government, religious and secular voluntary agencies, other national medical associations, and many visiting foreign physicians. The International Health Bulletin has a distribution of 3,000.

During the Annual Convention, the Department served as host to distinguished guests to whom honorary memberships were given, provided a hospitality center for international visitors, and gave a reception for American missionary physicians.

OFFICE OF THE GENERAL COUNSEL

This report covers the activities of the Office of the General Counsel, the departments under its jurisdiction and the following Councils and Committees staffed by the Office and the departments: Council on Constitution and Bylaws, Judicial Council, Committee on Quackery, Committee on Medicolegal Problems, Committee on Professional Liability and the AMA Liaison Committee to the American Bar Association.

The Office of the General Counsel continued to function as a central source of information on state legislative proposals and enactments in the medicolegal field. A "State Legislative Roundup" of new laws of interest to medicine enacted during 1969 was distributed to state medical society executive offices. Since January 1, 1970, about half of the state legislators have been in session and five reports on "Current State Legislation" have been distributed. In addition, there has been a distribution of laws and proposals relating to malpractice, abortion and chiropractic. Probably the most controversial laws enacted were the liberalized abortion laws of Alaska, Hawaii and New York. A number of memoranda were prepared for the Board of Trustees, the Executive Vice President, the Divisions and various Councils and Committees.

Council on Constitution and Bylaws: The Council held five meetings during the period and reports were submitted to the House of Delegates at the Annual and Clinical Conventions.

CORPORATE LAW DEPARTMENT

This Department handles the business law matters of the AMA and AMA-ERF, such as contracts, leases and insurance. Among other activities, the Department negotiated contracts with the U. S. Agency for International Development for the Volunteer Physicians and Viet Nam Medical Education porjects, Temple University regarding an "urban core" health care project, and several paper suppliers and printing companies for AMA publications; negotiated leases for the 1971 Clinical Convention at Anaheim, California, and for two field offices; filed an annual Registration Statement with the Securities Exchange Commission for the Members Retirement (Keogh) Plan and exempt tax returns for AMA-ERF and the members' and employees' pension trusts. The Department researched the Tax Reform Act of 1969 in depth for tax planning purposes, especially under the "aid-tax" provisions of the Unrelated Business Income Tax.

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DEPARTMENT OF INVESTIGATION

The Department continued its activities in combatting health quackery in general and chiropractic in particular.

Chiropractic: Despite chiropractic's most intensive lobbying efforts, Congress continued to exclude chiropractic from services covered under Medicare. In cooperation with state medical societies, members of both the House and Senate were supplied AMA materials on chiropractic, along with a list of statements and resolutions by organizations outside medicine condemning chiropractic. Among such organizations were AFL-CIO, ACPA, AHA and AANC. The Health Insurance Association of America issued a statement cautioning the public on "Limited Practitioners" and the HEW Task Force on Medicaid and Related Programs supported the continued exclusion of chiropractic under Medicare. Earlier, an independent HEW study resulted in the (1966) report to Congress recommending chiropractic exclusion from Medicare and the National Advisory Commission on Health Manpower reported (1967) that chiropractic "constitutes a significant hazard to the public."

All of these reports have been given wide distribution by this Department, including distribution of 50,000 copies of the HEW report in paperback. Distribution of the independently-published book At Your Own Risk: The Case Against Chiropractic, by Ralph Lee Smith, continued. A new AMA film, Health Quackery: Chiropractic, was made by the Committee on Quackery.

To obtain a closer relationship with state medical societies in dealing with chiropractic problems, the Committee on Quackery began a series of five Regional Conferences on Health Quackery-Chiropractic. In addition, state medical societies were furnished copies of all bills introduced in state legislatures involving chiropractic. Several state medical societies were supplied specific staff assistance in connection with chiropractic legislative situations.

Other Areas: The treatment of obese persons by the use of dangerous drugs, various quack diet schemes and devices continued to be a major problem. The Department supplied extensive information to counteract a new surge of promotion of copper bracelets for arthritis sufferers. Several "directory" schemes, called to the attention of the Chief Postal Inspector, were prosecuted successfully. Information on the so-called cult of Scientology was furnished federal and state mental health agencies and others, including foreign governments, that are investigating its operations.

Meetings: The Department continued to represent the AMA in the Coordinating Conference on Health Information, a group composed of representatives of government and voluntary professional organizations. It provided AMA representation on the American Cancer Society's Committee on New or Unproved Methods of Treatment and on the Subpanel on Deception and Misinformation of the White House Conference on Food, Nutrition and Health.

Committee on Quackery: The Committee met four times to consider such major topics as attempts by chiropractors to be covered by federal health

legislation and to obtain federal recognition of their schools, to have their services covered by the insurance industry, to obtain coverage under workmen's compensation laws and to expand their scope of practice in certain states. The Committee continued to emphasize the necessity for state medical societies to take the legislative initiative away from chiropractic.

DEPARTMENT OF MEDICAL ETHICS

This Department provides staff assistance to the Judicial Council and acts as liaison between the Council and members of the Association and its headquarters staff.

The Department prepared a script for a closed circuit television program on "Physician Press Relations" at the 1969 Annual Convention. A discussion on the ethical principles involved in drug repackaging was taped for CBS. Articles were prepared for American Medical News and the "Law and Medicine" page in JAMA. The Department presented a program at the Annual Meeting of the Federation of State Medical Boards of the United States and participated in various state medical association programs on medical ethics.

Opinions and Reports of the Judicial Council was revised and distributed to state medical societies and senior medical students. A manual of current problems in medical ethics for the information of the members of the Council was also prepared. The ethical aspects of physician-ownership of hospitals operated for profit were researched in order to provide information for the Judicial Council's report to the House of Delegates. The ethical aspects of multiphasic screening operations were also investigated for the Council, and the 1969 Medical Disciplinary Survey was conducted. Applications for affiliate membership in the AMA were reviewed and processed for consideration by the Council.

Judicial Council: Five regular business meetings and one regional meeting with the chairmen of ethics committees of state medical societies were held.

The Council's "Review of Ethical Considerations Relating to Clinical Laboratories" was disseminated to component and constituent medical societies and other appropriate medical organizations. On October 5, 1969, the Council held a regional meeting on medical ethics in Chicago with representatives of the state medical societies of Iowa, Illinois, Missouri, Michigan, Minnesota, Wisconsin and Indiana. Among the subjects discussed were advertising by clinical laboratories, programs for financing medical care, relations with the communications media, professional corporations, physician dispensing and various disciplinary problems.

LEGAL RESEARCH DEPARTMENT

The Department developed and made available to members of the Association and to state and county medical societies a variety of informational and instructional material on medicolegal matters. It published 24 issues of The Citation, the newsletter of the General Counsel's Office covering current court decisions and other legal developments of interest to the medical profession.

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Several articles were written for the "Law and Medicine" page of JAMA. Three packets of materials concerning professional liability insurance were sent to state medical societies.

The Department conducted two meetings with representatives of the liability insurance industry to discuss the possibility of medical accident insurance, loss-control programs and medical society sponsorship of liability insurance programs. It submitted to a Senate Subcommittee a detailed response to inquiries concerning problems of professional liability and liability insurance. Staff assistance was provided for the Board of Trustees' Committee on Professional Liability in the development of a proposed program to provide liability insurance to members under the joint sponsorship of the AMA and the state medical societies. Responses to the 1970 Professional Liability Survey were analyzed and a report on findings was prepared. A loss-control program, including a National Congress on Patient Safety to be jointly sponsored by the American Hospital Association, and a program to develop model state legislation were initiated.

Liaison Committee to the American Bar Association: The Committee met three times. It assisted in the preparation and distribution of the Proceedings of the 1969 National Medicolegal Symposium and, with the ABA Committee, it developed the program for the 1971 National Medicolegal Symposium. The Committee began development of a Handbook of Interprofessional Relations for local medical societies and bar associations. The Committee also considered (1) minimum fee schedules for medical witnesses; (2) physicians liens; (3) the collateral source rule; and (4) medicolegal aspects of the prolongation of life. Action was initiated to oppose a proposal for the abolition of the physician-patient privilege under the Rules of Evidence for U. S. District Courts.

Committee on Medicolegal Problems: The Committee met twice. It initiated several programs aimed at loss-control in the field of professional liability. It studied patient-safety workshops as a method of reducing the incidence of adverse occurrences during medical care, a critical-incident technique to identify and minimize sources of patient injuries in hospitals, and patient safety activities which can be undertaken by medical specialty organizations. The Committee made a survey of insurance companies that handle professional liability to serve as a basis for loss-control programs. It also made surveys of state and county medical societies to determine what procedures were followed in handling interprofessional grievances with the bar associations and whether minimum fee schedules for medicolegal services had been established. It also surveyed national health organizations and national scientific medical societies to determine their interests and activities in the medicolegal field.

PUBLIC AFFAIRS DIVISION

The Public Affairs Division is charged with the responsibility of representing the Association on matters dealing with legislation, political education and liaison with constituent and component medical societies and other medical groups. The Division also works with all organizational levels of the Association to establish appropriate programs of public affairs value.

DEPARTMENT OF FIELD SERVICE

The twelve AMA Field Offices continued to offer an effective interface between the AMA and state and local medical societies, individual AMA members and the general public. The Department functions in the areas of political education, legislative activity and general service.

Political Education: The AMA-AMPAC Workshop was held during May in Washington, D. C. A series of state-wide programs were patterned after the Workshop. Ten states last year presented such programs. The year 1969 showed a record number of physician and physician wives participating in AMPAC and state PACs, and participation will be even higher in 1970.

Legislative Activity: As the AMA develops its forward legislative thrust, the need to motivate local action becomes increased. AMA legislative proposals were introduced into the 91st Congress with well liaisoned activity among the Departments of Legislation and Field Service in concert with the AMA's Washington staff. In addition, there were numerous legislative proposals introduced which required immediate reaction from local physicians. This activity typically involves the cooperation of state and local medical society members in direct communication with their congressman or senator.

Here is a partial list of such activity:

--Professional Service Corporations - The Senate Finance Committee in October 1969 issued a press release calling for serious limitations on the Professional Service Corporation. A nationally coordinated plan aimed at the Senate Finance Committee membership and later at the entire Senate resulted in the defeat of such a limitation on the Senate floor. The mechanism was an amendment introduced by Senator Fannin (R-Arizona), and the vote in support of his amendment was 65 to 35.

--Title XVIII, Chiropractic Inclusion - In January 1970, an intensive legislative contact campaign was implemented to thwart efforts to include chiropractic services in the Social Security Amendments of 1970. This same effort became necessary again in May for the Senate. At the time of this report, the issue is not resolved, but the House-passed version (HR 17550) does not include chiropractice. The Senate is still considering the matter.

--Part C, Health Maintenance Organization - The original HMO legislative proposal resulted in considerable confusion because of the hastily drawn provisions and the lack of public hearings. As a result, an intensive campaign to inform legislators through local physicians was undertaken. The issue is not yet resolved in the Senate.

A partial list of the subjects of other legislative activity includes: reporting of physician receipts by insurance carriers, unrelated income provisions of the IRS Code, Hill-Burton amendments, medical education appropriations, drug abuse and drug regulation.

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General Service: Activities in the area are intended to strengthen liaison between the AMA and constituent and component associations. During the reporting period, the Department held regional meetings of state medical societies for round-table discussion of mutual problems, promoted the New Medical Executives School, participated in AMA Auxiliary Regional Workshops, and assisted in the "Professional Liability Survey Report."

The Department prepared state association annual meeting reports for national distribution. It assisted other Divisions in gathering state and local information on such subjects as continuing medical education, student loan programs, delivery of health care to disadvantaged areas, emergency medical facilities and effective health education programs.

LEGISLATIVE DEPARTMENT

In January 1970, the Council name was formally changed from the Council on Legislative Activities to the Council on Legislation. The primary assignment of the Council and staff is to attend to the national needs and interests of the medical profession. This was accomplished, in large part, by reviewing legislation of medical interest which had been introduced in the Congress, and recommending to the Board of Trustees an AMA position on such legislation. In addition, the Council and staff undertook a major program of writing draft legislation supporting the principles and policies of the AMA.

Staff analyses were made of all bills of interest to medicine which were introduced in the Congress and they were distributed for comments to appropriate committees, councils and departments of the AMA, state medical associations, and certain specialty societies in order to provide the Council with information upon which to base decisions.

Council on Legislation: The Council met seven times. Specialty society representatives were invited to attend one meeting and state medical associations in the New England area were invited to attend another meeting.

The distribution of the Legislative Roundup has been expanded. Regulations and other information on Medicare, Medicaid, Partnership for Health and Regional Programs for Heart Disease, Cancer and Stroke, and FDA directives were disseminated with comments to the profession. The Congressional Record, the Federal Register, and a number of other publications were reviewed and pertinent material was reproduced and distributed to appropriate staff members.

Development of Proposed Legislation: The AMA has undertaken an accelerated program of developing draft legislation which incorporates medicine's policies, recommendations, and goals. Staff conducted interviews with the staffs of other AMA councils and committees to determine what changes were needed in existing programs, which new programs were needed, and which programs should be eliminated. The suggestions were considered by the Council and were subsequently approved by the Board of Trustees. Draft bills were then

prepared and forwarded to the Washington Office for implementation. During the 91st Congress, 16 draft bills were prepared. These are:

--An amendment to the antitrust laws to provide that the refusal of nonprofit blood banks and of hospitals and physicians to obtain blood and blood plasma from other blood banks shall not be deemed to be acts in restraint of trade, introduced as HR 13888;

--The creation of a national advisory commission to study qualified controls and manufacturing procedures of medical devices, surgical instruments, artificial organs and limbs, therapeutic instruments and devices, and other medical and hospital equipment so as to determine the need for and the extent of Federal regulation, and to establish methods for determining minimum design and manufacture standards for devices, and for determining their medical value;

--An amendment to the Social Security Act to eliminate certification requirements for certain inpatient hospital services under Title XVIII;

--An amendment to the Social Security Act concerning psychiatric benefits available under Title XVIII and XIX, which was introduced as HR 14377;

--An amendment to the Social Security Act to permit payment to Title XIX recipients for certain medical and dental services which became HR 13695;

--An amendment to enable Title XIX beneficiaries in Puerto Rico, the Virgin Islands, and Guam to obtain medical assistance from providers of services of their choice, introduced as HR 16625;

--An amendment which would provide veterans with an option to receive hospital care in private community facilities rather than Veterans' Administration facilities, introduced as HR 13568;

--An amendment to the Military Selective Service Act as it pertains to calls for physicians, dentists and allied medical specialists, to provide for the allocation of health personnel among the Armed Forces, other government agencies, and the civilian population, and to reestablish the position of Assistant Secretary of Defense for Health Affairs, which was offered as HR 13486;

--The creation of a cabinet level U.S. Department of Health, introduced as HR 14238;

--An amendment excluding federal authorization for chiropractic services under state Title XIX programs;

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--An amendment to the federal income tax law to allow medical and drug expenses of persons 65 and over as a full deduction which was introduced as HR 14273;

--An amendment to provide that, for the purposes of federal income taxes, professional corporations shall be considered as "corporations";

--An amendment to provide for Congressional review of regulations promulgated by federal regulatory agencies;

--An amendment to the Immigration and Nationality Act as it relates to foreign-trained physicians was introduced as HR 14384;

--An amendment to the Federal Food, Drug and Cosmetic Act to require that the label of drug containers dispensed to the patient bear the established or trade name, the quantity and strength of the drug dispensed became HR 15604 and HR 15630;

--The establishment of a national program of tax credits and vouchers for the purchase of voluntary health insurance (Medicredit) which was introduced as HR 18567.

Medical Bills Enacted Into Law: During the period covered by this report, over 25,000 legislative proposals were introduced in the 91st Congress. Many of these were of particular interest to medicine. Among those enacted into law were: Public Law 91-51, National Commission on Product Safety, PL 91-87, National Family Health Week; PL 91-95, Higher Education Student Loans; PL 91-113, Child Protection Act; PL 91-137, Air Quality Act; PL 91-190, Council on Environmental Quality; PL 91-222, Cigarette Smoking Health Act; PL 91-224, Water Pollution Control Act; PL 91-268, District of Columbia Anatomical Gift Act; and PL 91-296, Hill-Burton Medical Facilities Extension Act.

AMA Testimony: The AMA was called upon by the Congress to present its views on pending legislation and on other matters. Testimony on the following was presented in the House: HR 445, Cultural Exchange Visitors Program Amendments relating to the immigration status of foreign physicians in American training programs; HR 9312, Drug Abuse Education Act; HR 11701, Comprehensive Drug Abuse Control Act and HR 13743, Controlled Depressant and Stimulant Drug Act; HR 12934 and HR 15643, Clean Air Act Amendments; HR 13270, Amendments to the Internal Revenue Code relating to the taxability of income derived from advertising relating to the taxability of income which is received by a non-profit organization through advertising purchased in its journals; HR 13373, Occupational Safety and Health Act; HR 13432, Migrant Health Service Amendments; and HR 14284, and other bills, concerned with the extension and amendment of the Regional Medical Programs and the Comprehensive Health Planning and Public Health Service Program.

In the Senate, the Association presented its views on: S 1622, Vaccination Assistance Act Amendments and S 2264, Communicable Disease Control

Amendments; S 2108, Family Planning and Population Research Act; S 2559, Medical Library Assistance Act Amendments; S 2608, Comprehensive Narcotic Addiction and Drug Abuse Care and Control Act; S 2637, Controlled Dangerous Substances Act; S 1895, Omnibus Narcotic and Dangerous Drugs and Addict Rehabilitation Act and S 2590, Commission on Marihuana; S 2640, Migrant Health Service Act; S 2788, Occupational Safety and Health Act; S 2898, Health Organization Act; S 3071, District of Columbia Comprehensive Drug Abuse and Narcotics Crime Control Act; S 3096 and other bills, concerned with drug labeling and identification; S 3229 and S 3466 concerned with amendments to the Clean Air Act; S 3355, extension of Regional Medical Programs; S 3418, grants for Family Practice programs, S 3967, Federal Drug Abuse and Drug Dependence Prevention, Treatment, and Rehabilitation Act; and S 3835, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act.

Informational Statements: In addition to presenting testimony, the AMA presented statements on: Drug Abuse and Drug Dependence, before the Senate Labor and Public Welfare Committee; Health Aspects of the Economics of Aging, before the Senate Committee on Aging; Funds for the Medical Education for National Defense Program before the House Appropriations Committee; Nutrition and Human Needs, before the Senate Select Committee on Nutrition and Human Needs; Advertising Revenue of Tax Exempt Organizations, before the House Ways and Means Committee; and Trends in Long-Term Care, before the Senate Special Committee on Aging.

Informational statements were also given on: Advertising of Drugs, before the Senate Select Committee on Small Business; Constitutional Rights of the Mentally Ill, before the Senate Judiciary Committee; Proposal to provide a Voluntary Health Care Program for the Nation, and the Proposed Health Cost Effectiveness Amendments, before the House Ways and Means Committee; Loans for Medical Students, before the Senate Appropriations Committee; Medicare And Medicredit, before the House Ways and Means Committee; Postal Reform, before the House and the Senate Post Office and Civil Service Committees; Appropriations for Medical Schools, before the House and the Senate Appropriations Committees; and Medicare and Medicaid, before the Senate Finance Committee.

Other Statements: Each year the AMA is called upon to submit formal comments on regulatory proposals and other matters to governmental agencies. During the past year, the AMA offered comments to: Department of HEW concerning proposed regulations on "Conditions for Investigational Use of Methadone for Maintenance Programs for Narcotic Addicts"; Secretary of Labor concerning certificates of the Educational Council for Foreign Medical Graduates; Commissioner of FDA concerning certain combination drugs; Social and Rehabilitation Service, Department of HEW concerning interim policies relating to reasonable charges for individual practitioner services in the administration of medical assistance programs.

Other statements were sent to: National Highway Safety Bureau concerning seat and shoulder belts; Department of HEW concerning Medicare regulations for physical therapists; Commissioner of Social Security concerning a proposed rule on the composition of hospitals and extended care facility utilization review committees; Commissioner of Social Security on

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proposed regulations concerning post-hospital extended care under Medicare; Social and Rehabilitation Service of the Department of HEW concerning a proposed inclusion of an "anti-fraud" statement on physician's report of Medicaid services; Social and Rehabilitation Service of the Department of HEW relating to information reporting requirements under state plans for Medicaid; Department of HEW on a proposed statement of Policy Concerning Oral Contraceptive Labeling Directed to Laymen.

AMA WASHINGTON OFFICE

The increasing involvement of the Federal Government in programs affecting the nation's health has required an enlargement of the AMA Washington staff. In turn, this necessitated that the offices be moved in July 1969 from One Farragut Square, South, to 1776 "K" Street, N. W. To inaugurate the opening of the new offices, a two-day open house reception was held. Some 600 members of Congress, key people in the Executive Branch of government and their staffs attended. The AMA Office in Washington continues to collect and evaluate information about proposed legislation and regulation; provide services to Congressmen and government officials; and inform media representatives, para-medical organizations, those in the Legislative and Executive branches of government, and allied groups of the AMA's position and policies.

Department of Congressional Relations: Of the 27,000 bills introduced in Congress during the period under review, approximately ten percent affect health or medical care. Of particular interest to the AMA were:

—The Amendments to Medicare and Medicaid. Committee hearings in both the House and Senate have been extensive. Although final legislation is delayed pending Senate action, the House bill includes such new concepts as peer review and the use of Health Maintenance Organizations as additional providers of health services.

--The Tax Bill. One provision of this measure, having to do with unrelated income, was vigorously but unsuccessfully opposed by the AMA. The result of its inclusion is to subject the advertising income of JAMA to taxation.

--Health Manpower. The AMA worked successfully to increase Federal appropriations for health manpower.

--Chiropractic. Despite heavy pressure by the chiropractors on Congress, efforts to include chiropractic services under Medicare were successfully resisted.

--Drug Control. Working with the Department of Governmental Relations, the Department of Congressional Relations was able to modify this measure substantially in the House Interstate and Foreign Commerce Committee. As originally written in the Senate, the proposal--among other things--gave the Department of Justice the authority to classify drugs subject

to abuse and regulate medical research involving their use. The AMA position, that this authority should be vested in the Department of HEW, will probably be accepted.

As in the past, the Department assisted AMA witnesses, attended Congressional Committee hearings, helped brief visiting state delegations of physicians, addressed medical audiences on request and furnished liaison on legislative matters with appropriate AMA councils and headquarters staff.

Department of Governmental Relations: The Department's relations with the Executive Branch have improved steadily and are now better than at any point in the AMA's history. During the past several months, liaison has been close and mutually cooperative, and contacts have been made that range from counsellors to the President, through the Department of HEW's new secretary and staff, to the mid-level civil servants in the operating agencies.

A major accomplishment has been the development of a procedure for participating in the nominations of qualified persons for appointment to the many governmental advisory bodies which function in the area of health. Information was developed on hundreds of committees, their memberships, terms of office and assigned functions. This work required close cooperation with many elements of government. Assistance has also been provided to recruitment officials in obtaining qualified persons for full-time employment in government.

The Department of Governmental Relations works closely with the Department of Congressional Relations on many occasions. As an example, numerous meetings were held with Justice Department officials during the development of drug abuse legislation. The Attorney General has modified his position on several key aspects of the Administration-supported bill and has accepted as valid certain modifications suggested by the AMA.

The Department has worked with medical societies and HEW on regulations requiring agreements by physicians in order to participate in the Medicaid program; with the Office on Education and the Bureau of Health Professions Education and Manpower Training on the financial assistance available for medical students; with the White House Conference on Children and Youth, to assist with planning; with the General Accounting Office in its investigation of the use of physicians in the military departments; with the Food and Drug Administration to develop more rapid communication of FDA actions to physicians through AMA media; with the Health Resources Advisory Council and the Selective Service System on new regulations for student deferments; and with a variety of other government groups and agencies on a wide assortment of other matters.

Washington Library: Prior to the move to new quarters, the Washington Library was housed in two separate office buildings. It has now been consolidated and needed reference works have been added. This has made possible an improvement in the library's ability to service requests promptly. The staff works actively with more than forty governmental and non-governmental libraries in the Washington area, and maintains contacts with professional staffs in more than a dozen governmental agencies to obtain information. It

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serviced more than 7,000 inquiries last year from congressmen and their staffs, from administrative agency personnel, and from the general public. One major effort by the library has been to assembly a representative collection of AMA publications for use by congressmen in responding to their constituents. A catalog of these publications was prepared and distributed.

Communications: Three staff members in Washington serve the local press corps and cover news of interest to physicians for American Medical News and JAMA. A series of lunches with members of the Washington medical press was instituted, and a program was undertaken to distribute, on a regular basis, a legislative roundup of medical measures. Washington reporting for the AMA Newsletter was placed on a more formal basis, with written reports prepared weekly. Major hearings and events were covered with daily reports; AMA publications were serviced with medical, political and scientific news from Washington and elsewhere; and more than 5,000 inquiries from the press and the public were handled. Staff distributed news releases prepared in Washington and Chicago to the Washington news media and arranged news conferences and television appearances for AMA officials.

PROGRAM DEVELOPMENT DEPARTMENT

This Department was established to serve all departments and the various aspects of political education. Specific programs and projects were developed for the Department of Field Service and the AMA Office in Washington. The primary emphasis was on the creation of new and improved communication tools and technique.

Slide-Sound Programs: The Department tested a new audio-visual device which was subsequently accepted for use by the Department of Field Service and the Washington Office. The hardware consists of a 35-mm. slide projector which can be programmed to advance slides and provide audio. Four separate slide-sound programs were prepared during the year dealing with overall public affairs programming for the Association and political education. In addition, state medical associations have purchased the equipment and, through Field Service, states were given assistance in the development of their own presentations.

AMA-AMPAC Public Affairs Workshop: On February 28 and March 1, 1970, the AMA-AMPAC Public Affairs Workshop was held in Washington, D.C., for a national audience of over 600 medical leaders. The Workshop concentrated on political education in anticipation of the Congressional election in November. Many of the program materials developed for the meeting have become available for use by medical groups throughout the country. An audio-visual review of the Workshop was produced for the sound-slide equipment.

General Service Materials: Newsletters, speeches, pamphlets and a specific public affairs program for the Woman's Auxiliary to the AMA became the responsibility of this Department.

Conference for Senior Medical Executives: As a new and joint venture of the Public Affairs Division and the American Association of Medical Society Executives, this conference was held in Chicago on January 28 and 29, 1970.

It was designed to identify the priority programs and activities that depend on the constituent and component societies and/or medical specialty organizations for involvement and success.

COMMUNICATIONS DIVISION

A comprehensive ongoing media relations program to improve public understanding of the profession and the problems of assuring the availability of quality medical care in our changing society was the most significant development in the Communications Division during the year. A new Department of Communications Services was created and a number of departments were grouped under the Media Relations umbrella. Towards the end of the year the position of editorial director was re-established, with responsibility for editorial content of Today's Health magazine and for articles transmitted through the Magazine Relations Department. An extension of the Division's activities in New York was achieved when the Myers-Infoplan International, Inc., public relations counsel was retained. Transferred from the Division to the Executive Vice President's Office were American Medical News and the Medical News Department.

COMMUNICATIONS SERVICES DEPARTMENT

Since beginning operations in January 1970, this Department has developed and distributed to medical societies a public relations plan of action and three sets of resource materials (Operation Grassroots) on the Senate Finance Committee's staff report. It also developed a roundup of medical society actions on the CBS television health reports, and a roundup of positive medical society activities for possible use in future television news features. Two appearances were arranged for NBC's Today Show.

Public Relations counseling service was provided for four medical societies and three state society public relations chairmen. The Department staffed the press room at the annual meeting of the American Academy of Neurology. The AMA Tour Guide Handbook was revised and classes were held for new guides. Tours for more than 700 visitors to AMA headquarters were provided.

DEPARTMENT OF HEALTH EDUCATION

Dissemination of health information and promotion of health education programs are the goals of this Department. Its concerns are divided into six major areas: exercise and physical fitness, health education of the public, medical aspects of automotive safety, medical aspects of sports, school and college health, and voluntary health agencies.

The Physicians' Placement Service was transferred from this Department to the Department of Health Care Organization in December 1969. Medical Aspects of Automotive Safety was transferred from the Department of Environmental Health to the Department of Health Education in January 1970.

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New publications include Fit For Fun, a booklet to encourage children to exercise regularly; Tips on Athletic Training XI; posters entitled "Give Blood--Give Life" and "Emergency Medical I.D. Symbol"; the pamphlet What To Do Before Your Baby Comes, and the poster "Food Power For Your Family." Three new Timely Tips were added to the series: Noise--The New Pollution, Waging War On German Measles, and Beware the Brown Recluse. In progress are the following: Air Pollution, Water Pollution, The Sun and Your Skin, The Aging Skin, Spanish editions of Amphetamines, Barbiturates, Marihuana, LSD, and Glue Sniffing, and a paperback edition of Today's Health Guide.

Requests from the public totalled 45,595 as against 29,470 last year, including 2,615 Question & Answer letters, 7,115 teacher, student and health kits, 5,264 catalogs of health education materials, 27,555 automatic replies, and 3,046 telephone inquiries. The majority of inquiries concerned drug use and abuse, sex education, environmental pollution, sports and physical fitness, automotive safety, personal health problems and curriculum in health education.

The Twelfth National Conference on Physicians and Schools was conducted in October 1969, and the Twelfth Annual AMA-American School Health Association Joint Session on School Health was presented in June 1970.

Distribution of the bulletins, Health Education Service for Schools and Colleges and More Life for Your Years (circulation 20,000 and 30,000, respectively), increased during 1969-1970. The Today's Health column "That's A Good Question" was continued.

The Department staffs the Council on Voluntary Health Agencies, Committee on Exercise and Physical Fitness, Committee on the Medical Aspects of Automotive Safety, Committee on the Medical Aspects of Sports, Committee on Continuing Professional Education Programs of Voluntary Health Agencies, Joint Committee on Health Problems in Education of the National Education Association and the AMA, and AMA/American College Health Association Liaison Committee.

Council on Voluntary Health Agencies: A suggested policy statement on "Relationships between Voluntary Health Agencies and Government Medical Programs" was sent to all national voluntary health agencies listed in the AMA Directory of National Voluntary Health Organizations for review and reaction. Revision of the Directory is underway. Two meetings were held with representatives of national voluntary health organizations. The Council sponsored a Regional Conference of Midwest State Medical Associations on Relationships with Voluntary Health Agencies in Indianapolis in October 1969 and the Third National Voluntary Health Conference in Washington, D. C., in May 1970. The Council's Committee on Continuing Professional Education Programs of Voluntary Health Agencies held two meetings. Revision of the 1967 summary report, "Continuing Professional Education Programs of Voluntary Agencies, was initiated.

Committee on Exercise and Physical Fitness: The Committee sponsored a meeting on physical fitness at which more than 20 national organizations were represented. A joint statement, "Evaluation of the Apparently Healthy Candidate for Participation in an Exercise Program," in conjunction with the American Heart Association and the President's Council on Physical Fitness and Sports, is being prepared.

The third "Symposium on Exercise and the Heart," was conducted in Detroit in September 1970 in cooperation with the Michigan State Medical Association, the President's Council on Physical Fitness and Sports, and the Michigan Heart Association. The Committee is sponsoring joint programs on physical fitness in industry with the AMA Council on Occupational Health, and on family fitness with the Woman's Auxiliary to the American Medical Association.

Questions and Answers On Physical Fitness and Sports, a joint publication with the AMA Committee on the Medical Aspects of Sports, has been completed.

Committee on the Medical Aspects of Automotive Safety: The Committee's uniform injury severity rating system has aided efforts to make automotive crash investigation more productive. An Abbreviated Injury Scale and comprehensive scales in some medical specialties have been completed. A new AMA rating system and the "pilot" collision investigation training course sponsored by the Committee at UCLA for physician-police teams make it possible to gather comprehensive and scientifically accurate data.

"Visual Factors in Automobile Driving, and Provisional Standards" was published as a supplement to the "Physician's Guide for Determining Driver Limitation." In progress are "The Problem of Alcohol and Accidents," in conjunction with the AMA Committee on Alcoholism and Drug Dependence, and "Medical Evaluation of the Older Driver," in conjunction with the AMA Committee on Aging.

Support was given to National Highway Safety Bureau programs, particularly the attack on the abuse of alcohol and the inflatable occupant restraint system. Also supported was the program called STATES, organized by national agencies for the promotion of highway safety standards. Liaison has been set up with the American Academy of Pediatrics Committee on Accident Prevention.

Committee on the Medical Aspects of Sports: Tips on Athletic Training XI has been published and has had wide distribution. Tips on Athletic Training XII and JAMA Questions and Answers on Sports and Physical Fitness 1965-1969 have been prepared for the printer. Work is continuing on the Manual for Athletic Trainers in cooperation with the National Athletic Trainers Association and the Athletic Institute.

The film The Team Physician was awarded top honors in the National Committee on Films for Safety contest. It has had some 1,200 bookings, and more than 3,000 showings before audiences totalling 110,000 and was used on 75 telecasts with an estimated total audience of more than 2,200,000 since its release a year ago.

The 11th National Conference on the Medical Aspects of Sports was held in Denver in November 1969. Statements on health and safety in sports were forwarded to the National Federation of State High School Athletic Associations for publication.

Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association: Some 700,000 copies of the five pamphlets in the sex education series were distributed. A paperback

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edition of the book Healthful School Environment, one of the three volumes in the school health series, was published. The pamphlet Parents Responsibility, one of the booklets in the sex education series, was revised.

Resolutions were distributed to state medical associations and state educational associations on the use of scientifically accurate materials in drug abuse education, the need to utilize only professionally accredited leaders in conducting voluntary sensitivity groups, the importance of requiring professional courses in health education for all teachers, and the need for emphasis on human ecology in health education programs.

Liaison Committee of the American Medical Association and the American College Health Association: The American College Health Association's accreditation program is being implemented by survey teams composed of members of varying disciplines. To date, 32 schools have been surveyed and 17 have been certified. The Committee served in an advisory capacity in development of plans for the Fifth National Conference on Health in College Communities and it has been active in encouraging utilization of the ACHA uniform health record forms.

MAGAZINE RELATIONS DEPARTMENT

Staff continued to serve an ever-increasing number of magazine free-lance writers, editors and editorial researchers. The Department serviced requests for research material to prepare articles and more than 2,000 received manuscripts for review, authentication, checking and comment. Interviews were arranged for editors and writers. Requests from magazine editors for articles by AMA officials were serviced. The Department expanded its efforts to place medically oriented ideas for articles with all major consumer publications.

MEDIA RELATIONS

In an effort to streamline some of the functions of the Division, a number of activities were grouped under the umbrella of "Media Relations," as follows:

The Press News Department was established in February 1970. It develops recognition of the Association as the spokesman for medicine in socioeconomic affairs by disseminating information to and answering queries from wire services, newspapers, radio-TV news desks, news magazines, as well as the profession. Pressrooms were staffed for the Annual and Clinical Conventions and for 11 other AMA conferences during the period covered by this report. A comprehensive media relations program to improve public understanding and opinion of the profession was developed.

The Science News Department was reconstituted as a separate department in April 1970. It serves as the point of contact with the lay press and the public with regard to the scientific programs of the Association. In the three months of this report period that the Department operated as a new entity, 60 press releases were issued, press kits were prepared and pressrooms were staffed for the Annual Convention and several smaller meetings, more than 600 queries were answered from writers and editors, liaison was re-established between the AMA and the leading science writers who regularly report on medical science.

The Department of Youth Activities, also newly formed, established liaison with youth groups such as 4-H, Lee Clubs of Iowa, Inc., Science Clubs of America, and the National Committee for Children and Youth. Staff provided press assistance to the Woman's Auxiliary to the American Medical Association. Working with the Auxiliary, staff revised the Health Careers-Health Manpower package program and developed the EXPLO '70's (Explore the Exploding Health Industries of the 1970's) program, a joint venture of the Auxiliary and the Woman's Auxiliary to the Student American Medical Association.

OFFICERS SERVICES DEPARTMENT

Assisting Officers and Trustees of the AMA is the major responsibility of this Department. Staff members serve as administrative and press aides to the President, President-Elect, Past President and Trustees. The staff replies to correspondence addressed to officers, assists officers in preparing speeches and published articles, assists in arranging speaking engagements and planning travel itineraries. Interviews were arranged in cities visited by the President and President-Elect. Special attention was given to medical students, medical education, manpower and comprehensive health insurance.

PROGRAM SERVICES DEPARTMENT

Consolidation of art and layout services for all regular AMA publications was achieved by formation of a new Art and Layout Section. New formats were designed for several publications. Services continued to be provided for design, layout and illustration and advertisements, books, brochures, direct mail pieces, posters and slides.

Numerous public service publications and kits were completely rewritten and reprinted. These included Horizons Unlimited, An Informational Booklet on the AMA, Your AMA Membership ... Make the Most of It, the Drug Abuse Information Packet and lists of films on health careers and medical assistants. The Community Health Week Kit was produced.

In the area of health careers recruitment, another 100,000 copies of Horizons Unlimited were distributed. Letters were sent to over 7,000 National Merit Scholarship semi-finalists encouraging them to enter medicine or allied careers. Awards were presented to the 21st International Science Fair Winners and the two high school students attended the Annual Convention with their exhibits.

Twenty new exhibits were developed and six were remodeled by the Exhibit Section. A total of 317 exhibit showings in 147 cities were scheduled. Staff assisted in the design and development of the new AMA Museum and in planning numerous health fairs.

Demand for photographic services continued to increase. More than 4,700 photographs were taken, over 11,000 prints made and 5,200 slides produced.

RADIO, TELEVISION AND MOTION PICTURES DEPARTMENT

Staff programed the AMA's closed circuit television network at the Annual and Clinical Conventions and transferred several of the programs to film for

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distribution. Staff assists in the development of lectured and programmed audio-visual presentations. It is responsible for programming of the Audio News Journal and public service commercials for virtually every commercial television station and 2,500 radio stations. Three films, A Matter of Opportunity, Medicare-Medicaid, and The Patient Care Committee, were produced.

SPEAKERS PROGRAM DEPARTMENT

The Department conducted 18 speakers training seminars for state and county medical societies in Illinois, Indiana, Kentucky, Maryland, Minnesota, New Mexico, New York, North Carolina, Ohio, Pennsylvania and Rhode Island. Special seminars were conducted for the AMA Board of Trustees, the American Association of Medical Society Executives and the AMA Public Affairs Division. As of June 30, 1970, more than 2,700 speakers had been trained under this Program.

Approximately 170 physician and staff speakers were placed before national lay audiences and on broadcast shows. A total of 1,000 speakers kits were distributed in seminars and to fill individual requests. A new leadership training seminar format was developed for medical societies.

SPEAKERS SERVICES DEPARTMENT

Staff researched and wrote 55 speeches for officers, trustees and executives of the Association and completed 37 other assignments, including Senate testimony and summaries of House actions at the 1969 Annual and Clinical Conventions.

TODAY'S HEALTH

In its 48th year of publication, Today's Health reached an estimated 4,500,000 Americans monthly. Two special series -- one on malnutrition, the other on ecology -- drew thousands of reader reponses. A forum on drug abuse elicited more than 3,600 responses.

The magazine's readership is increasingly the young, middle-class parent. Median age of a 1970 subscriber was about 36, with 72 percent having children under age 18. Emphasis of material therefore was on such contemporary issues as sensitivity training, sex education, abortion laws, male contraception. Articles specifically relating to AMA programs featured the family physician, national health insurance, ghetto medical care, quackery, immunizations, cancer and smoking.

The regular feature "Growing Pains" was issued as a paperback book and over 44,000 copies distributed in cooperation with the American Academy of Pediatrics. The entire ecology series is being reprinted for public distribution, as are a number of other articles.

The magazine received the National Safety Council Public Service Award for distinguished service by a consumer magazine to accident prevention. Wider distribution of articles was obtained by granting 225 reprint permissions to newspapers, magazines, book publishers and public health agencies. These

included publications in Brazil, Australia and Holland, as well as such U. S. publications as Reader's Digest, Pageant, Science Digest and Catholic Digest. Large distributions of reprints were made by such agencies as the U. S. Information Agency, National Cancer Society, Arthritis Foundation and the National Braille Press.

WOMEN'S INTERESTS/ACTIVITIES

A working relationship with national women's organizations was established with staff utilizing resources of several departments to provide interested groups with health education materials, workshop planning, convention speakers and to promote sustained interest in good health with club and organization leaders. This Department arranged newspaper, radio-TV interviews for the Vice President and the wives of the President and President-Elect. Staff maintained liaison with the American Association of Medical Assistants, and provided public relations counsel and publicity to AAMA.

DIVISION OF HEALTH SERVICE

The six departments of the Division studied and developed programs on health care costs, medical care delivery systems, health manpower, relations of medicine to government medical programs, methods for improving medical care standards, and practice management. The Division also provided staff services and conducted research for more than a score of AMA councils and committees.

With heightened interest in new delivery systems, departmental activities related to such systems mushrooned. A staff task force on neighborhood health centers was established to coordinate these activities, make site visits, and analyze data on the functions, methods of financing, costs, utilization, and characteristics of the population to be served by such centers. Among those where the Division has either been involved or has given special impetus are the Temple University Center for Health Services Research and Development in Philadelphia, the East Harlem Triangle Project in New York and a proposed pilot rural health demonstration project in the state of Washington. The task force is developing guidelines for state and local societies concerned with such experimental programs.

The Division and Council on Medical Service sponsored the Fourth National Congress on the Socio-Economics of Health Care, "Systems of Health Care Delivery: Appraisals, and Projections."

Council on Medical Service: Three new committees were created under the aegis of the Council -- the Committee on Private Practice, the Ad Hoc Committee on Foundations for Medical Care, and the Subcommittee on Aging. Council representatives met with key personnel of the Department of Health, Education, and Welfare, the most frequent contact being with the Bureau of Health Insurance on provisions under P. 89-79. The Council reported to the Board of

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Trustees on such subjects as the Sears Community Medical Assistance Program, automation in medicine, physicians fees, peer review, and Medicare payments for physicians' services in teaching institutions.

Committee on Community Health Care: The Committee's responsibilities for physician-hospital relations were transferred to the new Committee on Private Practice. Another change in responsibility involved reactivation of programs for aging. The Subcommittee on Aging was created and assigned to the Committee on Community Health Care.

The Committee developed reports to the House of Delegates on medical staff representation on hospital governing boards and off-hour elective or semi-elective care and participated in developing reports on comprehensive health planning and utilization review. Under Committee guidance a survey on medical staff organization was conducted. The Committee continued its study of the problems of providing medical care in communities lacking adequate facilities or personnel. Site visits were made in Atlanta, Louisville and Chicago. A staff task force is investigating and evaluating neighborhood health centers and other mechanisms for delivering health care.

The Committee maintains formal liaison with the Association for Hospital Medical Education and the Association of Nursing Home Administrators. It maintains informal liaison with Community Health, Inc. and with appropriate agencies of the federal government.

Subcommittee on Aging: A current goal of the Subcommittee is ensuring that the Association's policies and programs are represented at the November 1971 White House Conference on Aging. The AMA has been asked by the U.S. Administration on Aging to make nominations for the committee that will be preparing background papers.

An ad hoc committee is developing recommendations on content and format of orientation programs for physicians serving patients in long-term care facilities. Planning has begun on a national conference for medical directors of long-term care facilities.

An exhibit on "Comprehensive Health Appraisal" was presented at the Annual Convention.

The Subcommittee maintains liaison with many private and governmental groups. Among these are the American Geriatrics Society, National Council on Aging, National Advisory Council on Nursing Home Administration, National Council for Homemakers Services, and several agencies within the U.S. Department of HEW.

Committee on Government Medical Services: The Committee met with representatives of the Indian Health Service and Indian tribal councils to review health care delivery experiments and health aide training programs and also met with SAMA representatives to discuss a proposed SAMA summer project for working with Indian health programs. The Committee considered--with staff of the Office of Civilian Health and Medical Program, Uniformed Services--developments in civilian care for uniformed services dependents and

retirees. Medicaid developments were reviewed with Medical Services Administration staff. The Committee studied, with Veterans Administration representatives, medical and hospital care programs and the status of disability benefit programs for veterans and the relation of such programs to physicians in private practice. With staff of the Social Security Administration's Bureau of Disability Insurance, the Committee reviewed proposals in regard to disability benefits and the new program of benefits for underground coal miners with pneumoconiosis.

Committee on Health Care Financing: The Committee reviewed two drafts of the Medicredit bill. This bill, prepared by the Legislative Department, is based on conclusions reached during the joint meetings of the Committees on Health Care Financing of the Board of Trustees and the Council on Medical Service.

The Committee reviewed the progress being made by local medical societies to develop peer review programs. The Committee studied foundations for medical care and met with representatives of the Hennepin County Medical Society, Minneapolis, Minnesota, to discuss the progress being made toward the establishment of the Hennepin County Health Care Foundation.

Committee on Private Practice: The Committee on Private Practice was established by the House of Delegates at the 1969 Clinical Convention as a standing committee of the Council on Medical Service. The Committee is composed of eleven members, two of whom are members of the Council on Medical Service. Since January 1970, the Committee has held two meetings.

The Committee has established liaison with the AMA Council on Health Manpower and plans liaison with the AMA Council on Medical Education and with the Student American Medical Association. State medical associations are being surveyed to determine the incidence of similar committees at the state level. A study of the effectiveness of private practice as compared with other forms of health care delivery is contemplated.

The Committee is revising the 1964 Report on Physician-Hospital Relations, reviewing for possible revision the General Principles of Medical Staff Organization and repeating a 1960 study of physicians not-in-private practice.

Joint Liaison Committee of the American Association of Medical Clinics, American Medical Association and the Medical Group Management Association: Liaison was maintained with the National Association of Blue Shield Plans, Health Insurance Council, Group Health Association of America, Incorporated, Blue Cross Association, and HEW's Office of Group Practice Development. The major project during this period was the preparation of a revised edition of Group Practice: Guidelines to Forming or Joining a Medical Group.

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DEPARTMENT OF SURVEY RESEARCH

A census of the physician population was conducted to gather information on professional activities, specialties, and employment of physicians. Data from this and a similar census conducted in 1968 were tabulated and published in the 1968 and 1969 volumes of the Distribution of Physicians, Hospitals, and Hospital Beds in the U. S. An explanation of methodology used in the 1968 and 1969 census was presented in the Reclassification of Physicians, 1968.

Other surveys conducted include the 1969 Survey of Group Practice, and the Fifth Periodic Survey of Physicians, whereby data was collected on utilization of physicians' services, physicians' income and expenses, and fees for selected procedures. Results of these surveys will be published. Other activities include development of an outline and bibliography for a course on the socioeconomics of health for medical students and physicians, and the establishment of a permanent group practice records system.

DEPARTMENT OF ECONOMIC RESEARCH

In January 1970, the Department of Economic Research was established. Its objective is to apply economic concepts and theory to the analysis of health services. Specific studies focus upon the health care production function, cost function, system relationships, and special topics such as the analysis of innovative health care delivery systems.

The Department has been active in the economic analysis of some legislative proposals, and it played a major role in evaluating the Report of the Senate Finance Committee on Medicare and Medicaid.

The Department is collaborating with a university research team to aid in the program planning, development, and evaluation efforts of a neighborhood health center and to facilitate the development of a data base that would possibly allow comparative analyses among alternative modes of delivery. Staff has consulted with and may provide technical support to a research group for a comparative economic study of group practice and solo fee-for-service practice. A socioeconomic course for physicians is being developed in cooperation with the Department of Survey Research.

The Department provided consultation and technical assistance to other AMA departments. Staff prepared discussion papers on the economics of health services and critiqued technical reports, publications, and working papers. Working relationships with various university, government, and private research organizations are being strengthened.

DEPARTMENT OF HEALTH MANPOWER

Council on Health Manpower: Two special meetings were held with project directors of operational physician's assistant programs. Project directors serve as a consultant group to the Council's Committee on Emerging Health

Manpower. An Informational Conference on Physician Support Personnel was held and a listing, a comparative analysis, and a compilation of numbers enrolled and graduated from physician's assistant projects were prepared. "Issues in Developing Physician Support Personnel" was prepared and published in JAMA.

Plans were made for a National Congress on Health Manpower to be held October 22-24, 1970 in Chicago. Work continued with the American Academy of Orthopaedic Surgeons in a study of task reallocation in the orthopaedic health team, and plans were made for a workshop in 1971 to analyze study results.

With the formal establishment of a Commission on Foreign Medical Graduates in January 1970, the Council's Committee on Foreign Medical Graduates completed its mission and was discharged.

A program resource kit was developed to assist state medical associations concerned with channeling discharged military medical corpsmen into civilian health occupations. In preparation are a position statement and program recommendations on continued competence of physicians; a proposal for a manpower information clearing-house program; a health manpower bibliography; and research proposals for collection of basic source data on medical, allied and emerging manpower categories and for assessing the impact of increased biomedical instrumentation on health manpower requirements and planning.

Committee on Nursing: The Committee met four times. One of these meetings was with its Panel of Nurse Consultants to discuss the role of the nurse in the 1970's; another was with representatives of medical specialty societies to learn of their activities in utilizing nurses in an expanded role.

The Committee continued its effort to provide services to state medical societies in developing physician-nurse conferences. A report of the Second National Conference for Representatives of State Medical Societies Liaison Committee with Nursing was published, and a follow-up questionnaire was distributed to participants to determine the amount of activity initiated as a result of their attendance. Three meetings were held with representatives of the American Nurses' Association and National League for Nursing to discuss mutual areas of concern and the possibility of developing an inter-organizational liaison committee. Meetings were also held with representatives of the Association of Operating Room Nurses and the American Association of Industrial Nurses.

The Committee's film, A Patient Care Committee in Action, was premiered during the Annual Convention via closed circuit television.

DEPARTMENT OF HEALTH CARE ORGANIZATION

The range of functions and the number of staff members have greatly expanded since July 1969. At that time, only two staff members were in the Department and only one committee was staffed by the Department. By the end of 1969, the staff had grown to a full complement of 17 and the Department

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has been assigned full responsibility for five committees and shares responsibility for another. These include two groups under the Board of Trustees -- the Committee on Health Care of the Poor and the Committee of AMA Commissioners to the Joint Commission on Accreditation of Hospitals -- and three groups under the Council on Medical Service -- the Committee on Private Practice, the Joint Liaison Committee of the American Association of Medical Clinics, American Medical Association and Medical Group Management Association, and the Subcommittee on Aging of the Committee on Community Health Care. Responsibility for staffing the Committee on Community Health Care has been shared with the Department of Community Health.

Technical assistance in planning, initiating, operating, and evaluating health service programs is provided by the Department. Site visits have been made to projects in Atlanta, Chicago, Louisville, Morganton, North Carolina, New York, Philadelphia and to a number of areas where centers have been built under sponsorship of the Community Medical Assistance Program of the Sears Roebuck Foundation.

Physicians' Placement Service: This service was transferred to the Department of Health Care Organization from the Department of Health Education in December 1969. A total of 5,398 registrations were processed in 1969. Of these, 2,531 were physicians seeking new locations and 2,867 were job or practice opportunities. In addition, the international section had 307 physicians seeking positions in other countries, and 38 agencies listed overseas positions. The two-year pilot program for urology residents was completed. During the two years 107 physicians and 10 hospitals utilized the service.

Exhibits were staffed at both AMA Conventions and at several specialty society meetings. Liaison and coordination with the Sears Roebuck Foundation have been increased to provide maximum assistance in staffing clinics built under the Sears program.

Committee on Health Care of the Poor: The Committee held eight meetings for all members and several supplementary meetings for a few of the members during the report period. Participants included representatives of the wide range of organizations, groups, and individuals concerned with health care of the poor. Committee members and staff participated in meetings of a number of organizations. The Committee also participated in conferences on rural health, maternal and child care, and the National Congress on the Socio-Economics of Health Care, and co-sponsored, with the Council on Mental Health, a conference on Mental Health Services for the Poor.

The Committee is implementing the recommendations in its reports to the House at the 1969 Annual and Clinical Conventions.

Committee of AMA Commissioners to the Joint Commission on Accreditation of Hospitals: The Board of Commissioners of the JCAH adopted revised Standards for Hospital Accreditation to become effective no earlier than January 1, 1971. A total of 13 resolutions and reports adopted by the House of Delegates were considered and a number were implemented.

A new Accreditation Council for Psychiatric Facilities was formed. Prospective transfer of the Long-Term Care Facility Accreditation Program to Accreditation Council status was approved. The provision of educational externships in U. S. hospitals for students of foreign medical schools was sanctioned. Establishment of an Advisory Council of Consumer Groups was approved. The development of new "Model Medical Staff Bylaws, Rules and Regulations" was initiated.

During 1969, accreditation surveys were conducted in 1,855 hospitals and 301 long-term care facilities. Of the hospitals surveyed, 1,564 were granted full 3-year accreditation; 266 were provisionally accredited for one year; and 65 were not accredited. Of the 301 long-term care facilities surveyed, 216 received full accreditation, 62 provisional accreditation and 23 non-accreditation. As of December 31, 1969, there were 5,093 accredited hospitals and 1,416 accredited long-term care facilities. This represents an increase of 79 accredited hospitals and 278 accredited long-term care facilities since December 1968.

DEPARTMENT OF HEALTH CARE FINANCING

Focal points of activity included promotion of peer review, patterns of change in health care expenditures, evaluation of government programs for financing health care, changing patterns of health care delivery, and new procedures for the business side of medical practice.

Committees staffed included the Committee on Health Care Financing and Committee on Government Medical Services of the Council on Medical Service; the Committee of AMA Representatives of the Board of Directors of the National Association of Blue Shield Plans; the Joint Conference Committee of the American Medical Association and the National Association of Blue Shield Plans; and the Joint Commission for the Promotion of Voluntary Non-Profit Prepayment Health Plans.

The Department assumed responsibility for a regional meeting on peer review. Later, the 1969 Medical Services Conference on Peer Review stressed peer review as a valuable force in enabling the best use of manpower, facilities, and money to provide quality health care. The Department conducted a survey of medical society peer review activities to determine the existence and extent of peer review programs, the scope of services they provided, and the manner in which they were organized.

The Department, in staffing the Committee on Health Care Financing, is accumulating and distributing information on foundations for medical care.

Committee of AMA Representatives on the NABSP Board of Directors: Three members of the Board of Trustees and two of the Council on Medical Service serve as AMA representatives on the National Association of Blue Shield Plans' Board of Directors. Three meetings were held, and items discussed that were of particular interest to the AMA were the revised Blue Shield coding system and its relation to the second edition of AMA's Current Procedural Terminology;

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implementation of the Comprehensive Benefit Program; development of more effective review programs and authorization of a pilot project to establish uniform bases of supporting data; the establishment of improved mechanisms for an ongoing analysis of health care costs; and the adoption of a report which urged increased and improved lines of communication among the national health organizations.

Joint Conference Committee of the American Medical Association and National Association of Blue Shield Plans: In its continuing efforts to seek resolution of differences which occur between medical societies and Blue Shield, the Committee met with representatives of Blue Shield Plans and/or medical associations from two areas and reviewed progress being made by the Blue Shield Plans and the medical societies in two other locations.

DEPARTMENT OF COMMUNITY HEALTH

The Department provided staffing for the Committee on Community Health Care, the Commission on Emergency Medical Services, the Committee on Emergency Medical Services, and the Council on Rural Health.

The Department assisted in planning and staffing a one-day Conference on Peer Review held prior to the Clinical Convention. In staffing the Committee on Community Health Care, the Department continued to review activities in the field of comprehensive health planning and to maintain information on hospital emergency facilities. It compiled information on regional medical programs and maintained files on utilization review committees. A staff report on "More Effective Utilization of Physicians" dealt with the possibility of draft-eligible physicians voluntarily locating in areas of medical manpower need.

The Department publishes two bimonthly newsletters, Medical Staff-Interns and PERSPECTIVES . . . In Long-Term Care. The latter was started January 1, 1970, in lieu of the Homemaker-Home Health Aide Bulletin (published in cooperation with the National Council for Homemaker Services) and the Chronic Illness Newsletter. Circulation is approximately 8,000. The Department prepared approximately 8,000 kits of resource materials on emergency medical services, 5,500 of which were distributed to all JAYCEE chapters and to every state and county medical society.

Commission on Emergency Medical Services: The following organizations are represented on the Commission: American Academy of General Practice, American Academy of Orthopaedic Surgeons, American Academy of Pediatrics, American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association, American Public Health Association, American Society of Anesthesiologists, National Academy of Sciences - National Research Council, and the U. S. Public Health Service.

The Commission fostered the Registry of Emergency Medical Technicians - Ambulance, through a Task Force on Registry, reviewed proposals for categorization of hospitals and a national workshop; initiated a joint project with the JAYCEES to promote community councils on emergency medical services; established a recommended standard for uniform highway signs to designate emergency medical facilities; conferred with the American Association of Junior Colleges to establish a degree program for emergency medical technicians; and continued to investigate the recruitment of discharged medical corpsmen as emergency medical technicians.

Committee on Community Emergency Services: The Board of Trustees created a Committee on Emergency Medical Services during this report period. (The name was changed to Committee on Community Emergency Services in September 1970.) It charged the Committee to (1) maintain effective liaison with state medical societies in the establishment and implementation of programs designed to improve the quality of emergency medical services rendered at the community level; (2) in addition to planning for the handling of day-to-day emergencies, develop and implement programs for the immediate and efficient handling of casualties resulting from local, regional or nationwide disasters; and (3) develop and maintain appropriate liaison with government. The first official meeting of the Committee was scheduled for July 30, 1970.

Council on Rural Health: A pamphlet, Health Care Delivery in Rural Areas -- Selected Models, was published. Within six-months, nearly 10,000 copies were distributed in response to requests. A report on the Council survey of non-metropolitan physicians appeared in Public Health Reports. Resolutions on "Comprehensive Health Planning in Rural Communities" and "Highway Directional Signs for Emergency Medical Facilities" were suggested by the Council for use by state medical associations.

More than a third of the state medical associations have approved the Council's first aid training and rural emergency medical services plan. With continued communication from the Council, the Boy Scouts of America, FFA Chapters, and 4-H Clubs are actively engaged in promoting first aid training programs among their members. A meeting with the Council on Public Health and Regulatory Veterinary Medicine of the American Veterinary Medical Association resulted in a joint statement on "Concern with Pollution."

The 24th annual meeting of the Council and its Advisory Committee considered the subject of "Delivery of Rural Health Services." the Council held three meetings in Milwaukee, April 8-11, 1970; the Seventh Seminar for Extension Specialists in Health and Related Fields; a meeting for state medical associations' rural health committee chairmen with 23 states represented; and the 23rd National Conference on Rural Health, which used as its theme, "Let's Put You in Comm-U-nity Health."

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AMA EDUCATION AND RESEARCH FOUNDATION

During the period covered by this report, contributions designated for medical schools totaled $1,003,955 and contributions for the Loan Guarantee Fund totaled $125,758. Unrestricted contributions to the AMA-ERF totaled $169,579. During the year, $956,909 was distributed to medical schools in the United States and Canada.

The Foundation guaranteed 7,784 loans worth $3,129,000 to medical students, interns and residents. Since the Loan Guarantee Program began in 1962, the Foundation has guaranteed 42,561 loans worth $47,137,909. At the end of this report period, 23,575 loans worth $37,871,000 (including interest) were outstanding.

INSTITUTE FOR BIOMEDICAL RESEARCH

The House of Delegates voted at the Clinical Convention to discontinue the Institute, and during the last six months of the period covered by this report, the operations of the Institute were phased out. The Association assisted personnel in their relocation. Senior scientists were provided with more than $1,000,000 worth of laboratory equipment and approximately $500,000 for interim support in their new locations. The date set for the official closing of the Institute was July 31, 1970. The Institute was dedicated at AMA Headquarters on October 11, 1965.

PROJECT FOR RESEARCH ON TOBACCO AND HEALTH

The project is supporting 74 different scientific investigations at 50 institutions in the United States and five foreign countries. During the past year, 61 applications for support were considered by the Committee for Research on Tobacco and Health. Of these, the Committee advised the Board of Directors of the Education and Research Foundation to support 23. The Committee meets three to four times a year in order to consider new applications. The Committee has also met on several occasions with representatives of the National Institutes of Health and with representatives of the Scientific Board of the Tobacco Research Council in order to determine the direction that research in this area should take, as well as to provide advice for the Secretary of HEW on the direction of such research and on delineating such gaps in our knowledge as may exist.

WOMAN'S AUXILIARY TO THE AMA

At the 1969 annual meeting of the Woman's Auxiliary to the AMA, delegates were give a tried and true formula for becoming a leader -- "Find a group of people who are going somewhere and get in front of them." The 88,097 members of the Auxiliary have indeed gone places during 1969-1970 and most of this report will summarize the work of the state and county auxiliaries to give an overall view of the program that is occurring nationwide.

Realizing that the increase in national dues from $2.00 to $4.00, voted by the 1968 House of Delegates to take effect with fiscal year 1969-70, might result in some loss of membership, the membership committee early in the year compiled "Blueprints for Building Membership," containing practical suggestions for both state and county membership chairmen. Subsequently, certain chapters were duplicated for distribution to counties on request.

Through combined efforts of hundreds of members at all levels of Auxiliary organization, the membership loss was kept to 3-1/3 percent, or 3,070 members, and 14 state auxiliaries equalled or exceeded their total membership for the previous year. With the increased interest engendered by additional services now possible through sounder financing, the present lag in membership should be quickly overcome and Auxiliary leaders are optimistic about the future.

During 1969-70, several items of new material were developed for use by state and county leaders. The revised "Leaders Handbook" was published in the fall and is available from Auxiliary headquarters for $1.00.

The use of package programs as a tool for health education of the public has increased but still has not reached full potential. A new package program on smoking, designed to educate young people as to the reasons they should not begin to smoke and to help adults conquer the habit, was compiled during the year. In addition, the already existing programs on health careers-health manpower, immunization, sex education and alcoholism were updated. All these, plus six others, remain available free on request of Auxiliaries and members-at-large.

An information kit on medicine and religion programs for local auxiliaries was prepared by the AMA Department of Medicine and Religion with the cooperation and approval of the Auxiliary Board of Directors. The Public Affairs Division of AMA prepared for Auxiliary use a packet titled, "One Dozen Days," which outlines a project for recording and recognizing the activities of individual Auxiliary members in public affairs. The use of this packet at the county level on a voluntary basis was approved by the Board of Directors and the first printing of 500 packets was exhausted within a few months, indicating the keen interest of Auxiliary members in public affairs activities.

This year the Auxiliary's unofficial national slogan has been "Active leadership in Community Health with the Accent on Youth." A brief resume of the reports of the nine national program extension committees will give an idea of the calibre of leadership offered locally, where the action is:

AMA-ERF: Since the Auxiliary's first year of participation, 1951-52, more than $5 million have been contributed and each year the total has been larger than the previous year. It took ten years to reach the first million, four years to reach the second million, three years to reach the third million, and only two years to reach the fourth million. In 1969-70, $698,950.69 was raised and contributed by Auxiliary members, representing an increase of $70,000 (16.3%) over the amount collected the previous year. Nine state auxiliaries gave more than $10 per capita and 38 states showed an increase over their total contributions for the previous year. Eight states have been asked by their respective medical associations to be responsible for all state AMA-ERF contributions, both from Auxiliary members and from physicians.

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Health Careers: State chairmen report $607,237.63 available for loans and scholarships in the health fields, about 75 percent of this amount being administered at the county level. Over $250,000 is available for nursing, about $65,000 for medicine, and almost $135,000 for other health careers. In addition to raising and administering funds for loans and scholarships, the county and state auxiliaries have helped in sponsoring more than 2,000 health career and future nurse clubs and have participated in 664 health career days, tours, workshops, etc., often in cooperation with other organizations, such as hospital auxiliaries, medical societies, public health departments, nursing associations and health careers councils. The national chairman for health careers regularly attends meetings of the AMA Council on Health Manpower to assure coordination of efforts, and the chairman, president and president elect have conferred with officials of the Department of HEW concerning activities of mutual benefit in combatting the shortage of health manpower.

Community Health, Children and Youth, Mental Health: There has been some overlapping in the objectives and activities of these three committees, but this has served to underscore the more generally acknowledged areas of concern and interest common to these committees. The mental health committee concentrated on educational programs on drug abuse and alcoholism and on the mental health of young people. There has also been continuing activity on the part of both individual members and county and state auxiliaries in support of mental health associations, organizations for retarded children, state institutions, etc. The national Auxiliary chairman of mental health meets regularly with the AMA Council on Mental Health.

Although this was the first year that the national Auxiliary had children and youth as a regular program extension committee, 20 states had corresponding chairmen, indicating an interest in this work, while 13 other states combined the committee with either community or mental health. More than 500 programs were presented by county auxiliaries, many of them for the public, dealing with problems of young people and their families. Most states had some activity in antiviolence campaigns, in accordance with a resolution adopted by the 1969 House of Delegates. The national Auxiliary joined the Conference of National Organizations on Children and Youth, one of whose functions is assisting in planning the 1970 and 1971 White House Conferences on Children and Youth. The state auxiliaries are also well represented in the planning process, although it still remains to be seen how many members will be invited to participate in the national and regional conferences.

In community health, notable work has been done in the areas of sex education, immunization (especially against rubella), blood donor recruitment, preschool vision and hearing screening, nutrition, antismoking and alcohol campaigns and assistance with heart disease, tuberculosis, diabetes and cancer detection programs. Package programs, films and other health education materials were used in almost every state, the most frequent subject being drug abuse. The national chairman of community health has served as liaison between the Auxiliary and the AMA Council on Rural Health, serving on its advisory committee and keeping in close touch with other organizations concerned with the health of our rural population.

Legislation: At least half the state auxiliaries are now invited to send representatives to meetings of medical association legislation committees, and

15 states have been given definite assignments by their sponsoring medical associations to assist in the passage -- or defeat -- of health related bills. The national chairman of legislation attends meetings of the AMA Council on Legislation.

Safety-Disaster Preparedness: For the second consecutive year an auxiliary, Washington State, has been cited for an award of honor by the National Safety Council, with Queens County, New York, and Gage County, Nebraska, receiving lesser recognition by the same organization. Twenty-five states conducted CDMS or similar training programs in child care, 24 worked on home safety, 28 on highway safety, 14 implemented the Block Mother Plan for safety of school children, and 13 sponsored medical self-help programs.

International Health Activities: One hundred and forty tons of materials were sent overseas to missionaries, hospitals, etc. In addition, auxiliaries conducted service projects at home, such as international guest days, making layer bandages, johnny coats, children's toys, etc. Other units supported Project HOPE and Project Concern with fund-raising events as well as individual donations and informative meeting programs. Funds remaining in the Viet Nam Student Aid project were donated by the national Auxiliary to assist the sons of the late Dr. Tran Anh of the University of Saigon Faculty of Medicine, through a special trust account administered by AMA.

Home-Centered Health Care: This committee operates in three general areas -- homemaker service, meals service and volunteer friendly visitor training. It continues to serve as a catalyst in starting needed services and in giving support on a continuing basis in those areas where projects are already underway. Twenty-three states reported some sort of activity under the leadership of this committee. As one state chairman said in her report, "We have tried to meet the needs of the community and in so doing have fostered a great deal of good will between local agencies and the medical profession."

The relationship between the AMA Auxiliary and the auxiliary to NAMA has perhaps been closer this year than ever before. Representatives of NAMA were invited to attend an AMA Auxiliary Board meeting to discuss mutual problems and interests. As a result of that discussion, a joint project was developed, "Explo 70's - Exploring the Expanding Health Fields of the 70's." The project envisions "Tour and See Days" at medical centers under the direction of NAMA chapters, with the cooperation of NAMA chapters, under the theory that young people appeal to other young people. The AMA Auxiliary health careers committee prepared a kit for NAMA use in carrying out this project, which was introduced at the national NAMA convention in May. Also during this convention which was attended by several representatives of the AMA Auxiliary, a plan was developed whereby information will be forwarded to both the county and state auxiliary presidents when a former NAMA member is ready to locate permanently so that she can be listed as a NAMA member without delay.

The two regular Auxiliary publications continue to improve as a means of communication between the national Auxiliary and the states, counties and individual members. MD's Wife, published six times a year, goes to all members. An article from this magazine has been quoted in the Congressional Record and reprints from another issue were distributed at a national convention of

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another organization. Further evidence of the constant improvement of the magazine is found in an increased interest in the purchase of advertising space, which in turn increases funds available to make the publication still more attractive.

Direct Line, published three times a year, is a newsletter for leaders of county and state auxiliaries. It carries pertinent information which assists local units in carrying out projects, planning programs, etc.

Other important means of communication with and training for leaders of state auxiliaries are the annual fall conference, regional workshops and convention. The fall conference is planned to acquaint state auxiliary presidents and presidents-elect with national issues, plans and projects. Since the idea of informal discussion groups, used at regional workshops, had proved so successful, the 1969 conference features "mini-workshops" for those program extension committees not included in the program of the regional workshops.

The regional workshops were made possible in 1969 through a loan from AMA which has since been repaid. Included in the participants were six leaders from each state auxiliary -- president-elect and chairmen for AMA-ERF, children and youth, health careers, legislation and membership. Both attendance and enthusiasm were higher than ever and many states followed up the regional workshops with state workshops to disseminate the information gathered.

The annual convention program emphasized "Women in the 70's," giving delegates a challenge for future planning as well as an opportunity to conduct routine business.

Cooperation and coordination remains good between the national Auxiliary and the constituent state auxiliaries, the Auxiliary and other women's and health-related organizations, and the Auxiliary and the AMA. National representatives were sent to each state auxiliary during the year with the state being given the privilege of choosing which national officer or chairman they wished to have. Auxiliary representatives attended meetings of 18 other organizations during the year and representatives of many of these groups also attended the Auxiliary convention.

Auxiliary representatives participated in 12 AMA-sponsored meetings as well as attending meetings of appropriate councils and committees. To set the tone of coordination of activities, representatives of the Auxiliary conferred early in the year with the executive committee of the AMA Board of Trustees, which serves as the advisory committee for the Auxiliary. At that meeting, the programs and projects of the Auxiliary were reviewed and guidance received as to future activities. With continued support by AMA leaders, the Auxiliary will flourish as a valuable adjunct to the American Medical Association.

(Mrs. John A. Chenault, President)

Reports of Board of Trustees

The following reports, A-U, were presented by Max H. Parrott, M. D., Chairman, Board of Trustees. Reports on the Distinguished Service Award and Citation of a Layman for Distinguished Service appear on pages 14 and 16.

A. SCOPE, OBJECTIVES, AND FUNCTIONS OF OCCUPATIONAL HEALTH PROGRAMS
(Reference Committee E, page 200)

HOUSE ACTION: REFERRED TO BOARD OF TRUSTEES for clarification and report at the 1971 Annual Convention

In June 1957, and again in June 1960, the House of Delegates approved a statement on the "Scope, Objectives, and Functions of Occupational Health Programs."

The Council on Occupational Health recommends approval of a revised version (additions underscored; deletions lined out) which it believes will make possible innovative methods for delivery of medical care by industrial medical departments for nonoccupational injuries or diseases of employees in areas where medical care is not otherwise available. These revisions also recognize modern developments in supplementary health screening procedures now widely utilized in industry.

The Board of Trustees concurs with the recommendation of its Council on Occupational Health and submits the following statement to the House of Delegates for its consideration and approval.

Scope, Objectives, and Functions of Occupational Health Programs

Introduction

The term "occupational health program," as used in this statement, means a program, provided usually by management, to deal constructively with the health of employees in relation to their work.

The term "occupational medicine" means that branch of medicine practiced by physicians in meeting medical problems and needs under within occupational health programs.

Some employers, in the middle of the 19th century, established medical services for their employees in areas where satisfactory medical services were not readily available. Since 1911, workmen's compensation laws requiring employers to compensate employees or their heirs for occupational disability or death and to provide medical care for occupationally injured employees have been enacted in all states. In addition to injury, most of these laws require employers to provide medical care for employees with occupational disease. These and other

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DALLAS, TEXAS

JUNE 27 - JULY 1, 1976

125th Annual Convention

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AMERICAN MEDICAL ASSOCIATION
PROCEEDINGS OF THE HOUSE OF DELEGATES

125th ANNUAL CONVENTION
DALLAS, TEXAS
JUNE 27 – JULY 1, 1976

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(Dr. Parrott)

APPROVAL OF MINUTES: The Proceedings of the 29th Clinical Convention, held in Honolulu, Hawaii, November 30-December 3, 1975, were approved.

ADDRESS OF THE PRESIDENT: The following address was presented by Max H. Parrott, M. D., on Sunday, June 27:

HOUSE ACTION: RECOMMENDATIONS FOR SPECIFIC ACTION REFERRED TO BOARD OF TRUSTEES, REMAINDER OF ADDRESS FILED, AND DOCTOR PARROTT COMMENDED FOR HIS THOUGHTFUL COMMENTS AND RECOMMENDATIONS
(Reference Committee F, page 382)

"Swan Song of Parrott":
PREVAILING AGAINST THE NIGHT

To all of you, the representative body of this great federation, as its President, I am saying good-bye at a time when the American Medical Association, and our profession, are doing more for the American people than ever before and yet are being attacked more savagely, and more concertedly, than ever before in the name of the people. I have been directly involved in the American Medical Association's affairs at this level for more than ten years so I've had a good vantage point in time and experience from which to watch the mounting fury.

I've heard the same stories told and retold about us and circulated with new twists each time like bad locker room jokes. I've seen the image of our federation cast in false notions repeated so often, and so hard, that they are taken for truth, like the Great Lies of all totalitarian beginnings.

You all know, all too well, these cliches: That the AMA is nothing but a self-serving union; that it runs the biggest, most costly lobby in Washington; that it controls the production of physicians; that it is responsible for the high cost of health care; that it is closely aligned with the drug industry and the pricing of brand-name drugs, that it produces and protects incompetent physicians; that it fixes prices and exercises a control in restraint of trade; that it opposes and has opposed everything progressive in health care; that it has no heart for the poor, the helpless, and the unhelped; and that it is run by nine to twelve ancient, doddering old men, perhaps like me.

In addition, the federation, i.e., the American Medical Association, and the profession are presently the victims of an extended syllogism which goes something like this: Most practicing physicians seem to be "good guys." But most belong to the AMA, which is bad. So in reality, most doctors are also bad. Since the AMA is composed of those doctors, it is even "badder" than bad. Therefore, the only way to have goodness, sweetness, and light in the medical world is to governmentalize it. For many it has become a conditioned knee-jerk reaction based on all these tools, tricks and techniques of propaganda, slanted statistics, erroneous extrapolations, fallacious reasoning, preconceived conclusions, repetitive prevarication, mindless interpretive reporting, cliches, innuendo, ad infinitum, ad nausem.

There are other reasons, of course, for the widespread trust in the magic of governmentalized medicine in the face of the growing public distrust of government. One reason is that the concept is fashionable which tends to mean doing things the English way or the Swedish way, or some other way. What's wrong with the American way?

(Dr. Parrott)

George Bernard Shaw in a lengthy Preface to a short play said, "The social solution of the medical problem ... depends on that large, slowly advancing, pettishly resisted integration of society called Socialism."

The gradual socialism preached by Shaw, Beatrice Webb, and other members of the Fabian Society became the stadium cheer in Britain for a while. Many American planners are still tuned to that cheer despite the fact that the goalposts of Britain's National Health Service are lost in a financial and bureaucratic haze that it is a failed experiment and that the footballs in that game are, in fact, tattered and torn.

Another basis for the belief in federalized medicine is the assumption that health care in America is a $118 billion a year industry, too big and too important for managerial dispersion. The fact that this so-called industry ranges from eyeglasses to aspirin tablets, from dentures to organ transplants, from nursing homes to radioisotopic facilities, the fact that it is a gigantic miscellany in contrast with the integrated functions of airlines or public utilities means little to the planners. They see it as one big lump, amenable to slide rules and cast-iron molds.

Once federal medicine becomes the goal, it is easy for its advocates to select or imagine the facts that fit the goal instead of letting the objectives fit the true facts. They revive all the irony of the old Roman phrase, "Post hoc ergo propter hoc" — "After it, therefore because of it." Thus, they turn their backs on the scientific method which is the very essence of rational medicine and of what the science of medicine can technically do for those it serves.

We have seen the clash between the scientific method and unscientific motives in the adjudication of professional liability suits. Judges and juries often fail to understand that in medical practice, the conclusion is tailored to the facts while in law the facts often are tailored to the conclusion. We have seen similar conclusions drawn by the Food and Drug Administration based not only on the same fallacious reasoning, but originating in data as soft as powder snow.

We have seen the misuse of facts and thinking in a Congressional subcommittee's estimate of undefined unnecessary surgery which was simply a blowup of situations in which a second doctor did not confirm or agree with the first physician's findings. In addition, the committee staff used some figures it had to know were dead wrong.

We are constantly confronted by the apples-and-oranges comparisons such as cost-of-living comparisons that fail to allow for the dynamic nature of hospital services as opposed to the static nature of such strange comparisons. All in all, we can easily feel that we are struggling against an Alice-in-Wonderland world of illogic, a world, furthermore, where government seems to ape the words of old Fury: "I'll be judge, I'll be jury," said cunning old Fury. "I'll try the whole cause, and condemn you all to death."

The threat of governmentalization is abetted by the unity of purpose, and even of personnel, that exists among many segments of the federal structure. In recent months, dozens of individuals have left Health, Education, and Welfare to join Congressional staffs. Now the possibilities for cross-fertilization of ideas and attitudes here are obvious. Meanwhile, our own profession is handicapped by disunifying influences, by allegiances to different branches of medicine, different organizations, different concerns. And any disunity on our part makes us all the more vulnerable to the concerted actions of government and to the age-old whipsaw techniques for exploiting factionalism: One faction against the other to the detriment of both.

But while my remarks today are the swan song of Parrott, if you'll forgive the avian reference, they are certainly not for the birds and in no way are they intended as a swan song for the profession.

(Dr. Parrott)

I have apprehensions about what can happen to us, yes. But I also have great confidence in what we can enable to happen. Just what are some of the things I would like to see our federation do in the context of what it already is doing, and doing so well? My prescription is going to consist of extramural endeavors, intramural endeavors, and a combination of the two.

By extramural, I mean activities directed at our profession and at the general public. Those two directions have to be seen as a two-lane highway with one destination. For unless it is truly responsive to the needs of the public, the American Medical Association cannot be fully responsive to the needs of our profession and our members or even to survive.

You and I know the countless ways in which the AMA has manifested concern for the people at large. I could tick off our essentially private-sector National Health Insurance bill with its avoidance of the hazards of the Social Security Administration or our rural-health-care-delivery bill or our input into the emergency care law, our health proposals for Indians and migratory workers, our guarantee of more than $66 million in loans to disadvantaged and other medical students over the years through AMA-ERF or our efforts to ensure the quality of drugs. This is a good list but it is only a starter.

To that list I would promptly add our court actions against the original Utilization Review regulations, the Maximum Allowable (Drug) Cost rules, and the Health Planning Act of 1974 because all such efforts to protect the quality of care are primarily public-minded. The State of North Carolina initiated the suit against the Health Planning Act for the sake of the five million people that live in that state, not the 7,000 physicians who practice there. For the same reasons, for people at large, we of the American Medical Association initiated an amicus curiae brief in the same suit as co-plaintiffs.

But manifest as our public concern is, let us never feel complacent about it. In the first place, we must recognize that the public has legitimate worries about the cost and distribution of care and about the quality of care and about the competence of the people rendering care. In the second place, we must recognize our obstacles, as an organization and as a profession, in getting our message to the people. The stereotyped notions of the AMA — interacting with the impaired image of the profession — have impounded us in an echo chamber. Some of the media, some of the public, and a number of public leaders echo the stereotype and echo each other. The combined sound is deafening and it is hard getting out of that chamber.

So how do we get out? How do we respond when we are targets of an ambush and shootout at the OK Corral against the faceless men of government? Well, we have no magic bullets. But we do have great ammunition: the Truth. And we have great weapons: the true grit of our professional dignity and honor, and the individualistic and responsible nature of the doctor/patient relationship.

We fired the truth against the unnecessary-surgery fabrications and extrapolations at a well-attended, well-publicized press conference and at other vantage points. We publicly fired the truth against the UR and MAC regulations, conveying the essential message that government has giant eyes for regulation but pygmy eyes when it comes to planning. For there is pygmy vision in any rules that would make the elderly, and the poor, the shorn lambs of false economy. The hard truth is that government does not know how to plan, whether for energy, for housing, for transportation, or for health resources. It merely knows how to regulate in the name of planning.

This is the kind of truth we are gradually getting across against the roar of the echo chamber. It is the kind of truth we must continue getting across wherever and however we can and with all of our ardor. But we also need to make damn sure that our public commitment, on all issues, is as strong as our public words. That commitment, as I asserted earlier, is akin to our professional commitment.

We need to hit back at the cliche-ridden punditry about rising medical costs. But we must also work for savings that would not mar the quality and availability of care. Thus, it must be understood that open access, improved technology, and quality maintenance can only persist with an increase in cost. This could be doubled in spades during times of inflation and the capricious interspersion by government of additional administrative overheads can only compound the total problem. We must put these cost questions and the answers we have in a perspective the public can comprehend. This is intended by our National Commission on the Cost of Medical Care.

We need to hit back at the canard that the AMA inhibits the training and distribution of physicians. But we must also keep supporting and stimulating the growth of medical education, of primary medical care, of family practice, and of new modes of distribution all within the framework of medical freedom, within the framework of flexibility and individualization, and within the framework of pluralism of method in the delivery of medical care.

We need to point out that we are concerned about the incompetent physician; that the AMA is a professional body, not a catch-all like some unions; that it has drafted model state legislation for handling the disabled doctor, that almost thirty states have such legislation, that some twenty state medical societies have programs or plans for identifying and rehabilitating the physician who is in the throes of emotional illness.

In addition, we need to point to the ways in which the AMA has given support and shape to continuing medical education, by accrediting the institutions that give it, by honoring the 55,000 physicians with enough credit hours in it, and by holding regional courses in it to make it more accessible. Nonetheless, we cannot consider the job well done until continuing medical education is universalized. We must work as hard as we can to see that it is. After all, continuing education was an almost pure innovation of the medical profession. PRO, for instance, itself was an invention of the medical profession at the hospital staff level.

We must see everything we do in the light of its full and ultimate significance to our professionalism and to the public. This includes the intramural activities I now want to recommend. They would be carried out for our constituency as well as within our organization. But they would likewise serve our entire profession and the public we serve.

I recommend that we keep producing and updating the "AMA Drug Evaluations" book. It has helped guide and protect the prescribing physician. It is the best guide in its field in stark contrast with any proposed federal drug formulary that would arbitrarily favor generic products. Emphatically, however, "AMA Drug Evaluations" is no brand-name sales catalog. In its latest edition, it criticized in a rational manner some twenty percent of the drugs it considered.

Next, I recommend that our "Current Procedural Terminology," CPT, be constantly updated after its coming fourth edition. Regardless of governmental reservations about this book, the evidence shows that its five-digit system is the only efficient key to procedural designation. And contrary to accusations that procedures cost more if well described by physicians, it has curbed costs where properly used.

(Dr. Parrott)

I further recommend overhaul and refinement of our "Current Medical Information and Terminology," CMIT, also known as "Current Medical Terminology," CMT. The World Health Organization's ICDA is inadequate as a diagnostic-record system yet it has preferred status under PSRO. The AMA should offer, and is entitled to offer, an improved informational system that can prevail and better integrate with the procedural descriptors now in use. This will be expensive but well worthwhile in my opinion in this wonder world of mechanistic integration.

I recommend that the "American Medical Directory" and its accompanying tapes be kept up-to-date. They are invaluable as an indicator of physician distribution and as a mainstay of professional communication. No one, including the government, has anything comparable to it nor has anyone the base or capability short of stealing to reproduce it.

I fervently recommend reestablishment of the "Home Health Guide" and I stand far from being alone in urging this. The guide enabled the AMA Auxiliary to get easy-to-understand, factual and rational information into the schools and the schools' libraries and homes alike. With our development of new councils that could contribute their knowledge to this project, it might be less costly to produce than in the past yet just as effective. It must be good, it must be rational, and it must carry the AMA label in bold relief. After all, what more direct and intimate way is there to assure the public — adults and young people alike — that we have its health interests at heart?

Lastly, I come to the combined intramural-extramural part of my prescription. This consists of improving the professional relationships of the American Medical Association and its component societies with other sectors of medicine. I want to see a greater community of spirit between our federation and the medical schools. The academicians must be given to understand our solid dedication to the cause of medical education and continued support for such federal funding as capitation grants or project grants, as the case may be, minus any federal restrictions on academic and medical freedom.

I reiterate a plea I made at our Clinical Convention in Honolulu: That we give the medical specialty societies a more precise and responsible means of input into the federation which will bring about a more effective output on public issues that concern us all. As I said then, I am not as concerned about the anatomy as to how this is to be accomplished as I am about its being brought into functional existence. Our Council on Long Range Planning and Development is studying the possibilities whereby such input can be formally achieved. I wish the Council well in this and I wish for sympathetic and thorough understanding of this question from our future officers and from the future delegates of the organization.

In addition, I want to see a more formalized relationship between county medical societies and hospital medical staffs. Certainly they need a coordination of outlook and effort in the face of such challenges as peer review. The hospital staff is the firing line along with the doctors' offices. This is where the peers live. This is the arena wherein is established the genesis of medical discipline.

Strong as we are and as resolute as our steps are, this federation cannot walk alone. We need beside us our natural companions: physicians from the other sectors of medicine and lay people from all walks of life.

In substantially the words of the old hymn: The night is dark, and we are far from home. I know we can prevail against the night. I know we can reach a future in which medicine lives not in the guardhouse of government, but in a home for all of us.

(Dr. Parrott)

Now I would like to finish off with a quote from Carr in his most recent book, "Energy and the Earth Machine," in which he tells of a modern parable related by a sophisticated Lebanese: A frog was about to swim across the Nile River when he was accosted by a scorpion who begged to be carried along. "Oh no!" objected the frog, "You'll sting me and I'll die." The scorpion said, "Why would I be so foolish? If I stung you, I'd drown." After thinking this over, the frog agreed to ferry the scorpion across. In the middle of the river the scorpion stung the frog. "Look what you've done, you damn fool," mourned the dying frog, "now we'll both perish." The scorpion replied, "I know, I know, but don't forget, this is the Middle East."

Now one could, with equal justice, apply the parable to the doctors of the United States versus the government — it's full of frogs and scorpions. If we don't quit ripping up ourselves we'll die or drown in a sea of regulation with great detriment to the profession and to the public alike.

To avoid the age-old whipsaw, the pleading is for a unified profession to face any force that would or tend to deteriorate quality medical and health care. The American Medical Association is the only logical organizational unit to encompass the whole profession in the effort for the total concept. It is that home for all of us. Have your friends and colleagues join it, nurture it, support it, and direct and hold it to its primary purpose: the production and maintenance of quality care for all who need it.

REMARKS OF THE SPEAKER: The following remarks were presented by Tom E. Nesbitt, M. D., on Sunday, June 27:

Once again, it is my privilege to bring to your attention a few items of concern as we begin our deliberations at the 1976 Annual Convention. The past eighteen months have witnessed significant changes in the organizational structure of the AMA which need not be recounted. At this meeting, you will have the opportunity to place a final stamp of approval on recommendations that will strengthen the Association's council and committee structure. These proposals are a result of extensive deliberations and those of us who have participated in their development believe that they will help to initiate a new and stronger role for our Association for the decades ahead.

No doubt, you have become aware that this meeting will also mark the 75th Anniversary of the establishment of this House of Delegates and our federation in much the same form as they presently exist. It is our hope that you will take time to read the editorial which pertains to this historic event, by Hugh H. Hussey, M. D., in the June 21, 1976 issue of JAMA. Relative to that, it was our belief that you would appreciate having a copy of the Report of the Committee on Organization that led to the establishment of the House as a memento of this occasion, and this has been prepared in booklet form and distributed.

As you have an opportunity to read this description of the reorganization of the American Medical Association which occurred in 1900-1901, you will no doubt be struck by the similarity between those days of reorganization and the recent events of our history which relate to the current organizational studies. It has been surprising to us to note the remarkable similarity of concerns which the physicians of 1900 addressed in the light of the concerns of the physicians of 1975 and 1976. Truly it would seem that some things never change, and that we should all become more acutely aware of the significance contained in the admonition that those of us who fail to become students of history are destined to relive the same events.

disappointed. The Auxiliary wishes to make a presentation and it is with great pleasure that I invite Mrs. Erle E. Wilkinson, President of the Auxiliary, to join me at the podium

Ladies and gentlemen, thank you for your attention and your continuing and generous support for the American Medical Association Education and Research Foundation. It has brought me personal satisfaction to serve the Foundation over the years, and I thank you for the privilege.

(The following contributions were made to the AMA Education and Research Foundation in Dallas, Texas: American Medical Association Auxiliary $1,434,564; Audio Digest Foundation $50,000; Fifty Year Club of American Medicine $5,000.)

AMERICAN MEDICAL POLITICAL ACTION COMMITTEE: The following address was presented by James C. MacLaggan, M. D., Chairman, Board of Directors:

Two hundred years ago today a group of men, not too dissimilar from this group, sat in Philadelphia in solemn contemplation knowing that in one week's time they would be called upon to make a daring and momentous decision for themselves and for all posterity. Four of our colleagues sat with them. Within their group, Richard Henry Lee of Virginia had risen to offer a resolution "that these United Colonies are and of right ought to be free and independent states." Thomas Jefferson and a few others were in a side room drafting a final resolution for their consideration.

These men were educated, they had come from every settled portion of the Colonies, they were mostly men of means. They were selected because of their high moral character, their ability to reason and their sense of vision, responsibility and dedicated purpose. They did not have electric lights, air conditioning, or running water. Nor did they come conveniently, on modern aircraft, to spend a few days to accomplish their mission. Two hundred years ago on this date they had already made a commitment to their nation. They had already sacrificed their comfort and much of their means. Some had sacrificed their livelihoods to meet together to decide an issue of more over-riding importance than anything that had been contemplated by them thus far — government -- self-government.

The signers of the Declaration of Independence and the drafters of the Constitution believed in some rather basic precepts — precepts, which, in some quarters today, are held up to ridicule. They believed that government should be the servant of the people — that government which governs least, governs best. They believed in equality of opportunity. They believed that diligence and work should be rewarded. They had respect for law and believed their transgressors should be punished.

They held in high esteem the concepts of honor, loyalty, decency and morality. They put their trust in their belief in the existence of a Supreme Being. Their word was as good as their bond. They knew compassion, practiced courtesy, valued tradition and revered time-honored customs. One word describes them — leaders. Using their intellect, their reason, their compassion, and their sense of justice, they produced and signed documents which have been models for freedom and self-government for the world.

As they contemplated, they evaluated the personal risk and the grave danger for their families. When the test came, when the decision had to be made, they made the final commitment of leadership when, as one, they pledged their lives, their fortunes, and their sacred honor.

(AMPAC)

While two hundred years have elapsed since these men sat in contemplation of the way they would be governed, we are in no less need of courageous leaders than we were then. None of us is called upon to make the same personal sacrifices as were the members of the Continental Congress. Nonetheless, we are called upon to demonstrate the moral fiber to cherish and protect the heritage which they left us.

I am happy to report to you that the medical profession has not reneged its responsibility to preserve this heritage. Politics is the modern word for the lubricant which makes the machinery of government work. Physicians have become more political than ever before. The vehicle they have chosen is the PAC movement.

When I reported to you near the end of last year, I told you that AMPAC had achieved its all-time high membership record. In this Bicentennial year we did it again, and we did it in half of the time. As of last Thursday, we have broken our all-time high membership record. AMPAC has more members in this half year than it has had in any other preceding whole year. All-time high AMPAC membership records have been broken in fourteen states also. And these membership breakers are just part of the thirty-five states that are ahead in membership at this point. Further, there are more sustaining members in AMPAC at this half-year point than we have ever had before in a full year.

The growth of the PAC movement is fantastic in this year of political cynicism. The PAC movement is not being eroded by apathy. The medical profession has shown that it is concerned and that it is willing to do something about its concerns. This phenomenal membership growth is due to leadership — your leadership. You can be justifiably proud of your efforts since AMPAC could not be a success if it did not have the approval and support of this body.

It has been AMPAC's practice to present awards to those states who have shown membership growth in several areas. It has been a way for us to publicly acknowledge and thank physicians at the grassroots level for their work in the PAC movement. Until this time we have not had an opportunity to give similar awards in the area of leadership. When the AMPAC Board met yesterday, it was decided that your essential leadership should also be acknowledged. When this House meets next June it will be our pleasure to present an award to each state in which all the delegates, alternate delegates, president and president-elect are 1977 sustaining members of AMPAC. It is my sincere hope that we will be able to present fifty-four awards. It will be our opportunity to salute the leadership at the highest levels in the medical profession.

There has been another notable change in the PAC movement this year which reflects the growing political sophistication of physicians. With the encouragement of the AMPAC Board, state political action committees are moving earlier and faster than they have in previous years and are participating in more primaries than ever before. We welcome this added dimension of political activity.

Just as two hundred years ago, the writing of the Declaration of Independence and the adoption of our Constitution gave man, for the first time, the guidelines and the machinery to create a government based on man's dignity so, today, we have the opportunity to keep that machinery in order by our voluntary participation in the electoral process.

BICENTENNIAL COMMEMORATIVE STAMPED ENVELOPE PRESENTATION: On Wednesday, June 30, The Honorable Paul M. Carlin, Assistant Postmaster General of the United States, made the following presentation regarding the issuance by the United States Postal Service of a Bicentennial envelope honoring the American doctor:

(Board of Trustees — A)

REPORTS OF BOARD OF TRUSTEES

The following Reports, A—GG, were presented by Raymond T. Holden, M. D., Chairman, Board of Trustees:

A. AMA COUNCILS
(Reference Committee on Amendments to Constitution and Bylaws, page 315)

HOUSE ACTION: ACTIONS TAKEN REGARDING AMA COUNCILS ARE ON PAGE 185, REPORT F OF THE COUNCIL ON CONSTITUTION AND BYLAWS

Following is Report A of the Board of Trustees as submitted to the House of Delegates:

METHOD OF STUDY

During the 1975 Clinical Convention, the House of Delegates took action on the twenty-one separate recommendations listed in Report B of the Council on Long Range Planning and Development, "AMA Organizational Structure."

Recommendation 19 of Report B suggested that the AMA function with eight Councils and provided names and charges for each. The House referred this recommendation to the Board of Trustees with the request:

> "That the Board of Trustees prepare for the approval of the House at the 1976 Annual Convention an official charge for each of the eight AMA Councils (Councils on Medical Education, Medical Service, Long Range Planning and Development, Continuing Medical Studies, Scientific Affairs, Constitution and Bylaws, Legislation and Judicial); the number of members each council should have on its roster; a less confusing name for the recommended Council on Continuing Medical Studies that would replace the present Council on Scientific Assembly; and suitable candidates for positions on the councils."

Immediately following the Clinical Convention, the Board of Trustees named an Ad Hoc Committee on Councils and Committees to respond to this referral. The members of the Ad Hoc Committee are: Raymond T. Holden, M. D., Chairman, Jere W. Annis, M. D., Max H. Parrott, M. D., Richard E. Palmer, M. D., Tom E. Nesbitt, M. D., and William Y. Rial, M. D.

The Ad Hoc Committee's charge was primarily contained in Recommendation 19 of Report B of the Council on Long Range Planning and Development (C-75); but this Committee also reviewed the House actions on Recommendations 14-21, all of which relate to the AMA's council and committee structure, and the transcript of the House of Delegates debate on these recommendations. It met with the Chairmen, several of the Vice Chairmen, and the staff secretaries of the seven existing councils that are to be continued. Written recommendations were received from each Council, and recommendations related to the proposed Council on Scientific Affairs were drafted.

Meetings were also held with representatives of the AMA Auxiliary and the Interns and Residents and Medical Students Business Meetings to receive their views on the structure of each council, inasmuch as the Board has in the past approved resident and non-voting medical student and Auxiliary representation on some of the AMA Councils. The Board strongly supports continued resident and student participation and Auxiliary representation on several councils, with the students to be named by the Board from nominees submitted by the Medical Students Business Session, state medical associations, and other appropriate sources, and the Auxiliary representatives to be nominated by the Auxiliary.

ACTIONS OF BOARD

In addition to submitting its recommendations regarding the eight councils, the Board wishes to report, as requested by the House, on its actions on the following other matters related to the AMA's council and committee structure:

COMMITTEE ON HEALTH FRAUD

The House adopted the following Substitute Resolution 24 during the 1975 Clinical Convention:

> RESOLVED, That the House of Delegates requests the Board of Trustees to give high priority to the establishment of a Committee on Health Fraud in order that the AMA may forcefully act to protect the public from health quackery in all its forms.

After discussion of the substitute resolution and a review of the Association's existing efforts in dealing with health fraud and quackery, the Board directed the Executive Vice President to develop an appropriate charge and related data necessary for an ad hoc committee reporting to the Board on this subject.

INTERSPECIALTY COUNCIL

At the 1975 Clinical Convention, the House voted:

> That the AMA continue the Interspecialty Council concept and that the manner of choosing representatives to the Interspecialty Council be referred to the Council on Long Range Planning and Development for discussion with the Board of Trustees.

The Board, in consultation with the Chairman of the Interspecialty Council, is continuing the Council as an ad hoc body reporting to the Board with a change in name to "AMA Interspecialty Advisory Board" and a new charge, and will discuss the manner of its appointment with the Council on Long Range Planning and Development.

DISPOSITION OF COUNCILS AND COMMITTEES

Recommendation 21 of Report B of the Council on Long Range Planning and Development provided:

> That all currently existing councils and committees, except Section Councils, be phased out within six months following affirmative action by the House of Delegates to the proposals of the Board of Trustees in its report in response to Council on Long Range Planning and Development Recommendation No. 19 except as provided in the recommendations above. (Recommendations 14-21)

In keeping with this recommendation, the Board has examined the existing council and committee list to determine the necessity of retaining any in the form of short-duration ad hoc committees as suggested in Recommendation 20 of Report B, which was adopted in amended form by the House. The Board has directed staff to review with the Chairmen the activities of these councils and committees which will be phased out in accordance with House action and to complete any pending matters before the end of the year. In addition, the Board is reviewing the AMA's current priorities to determine whether any are appropriate for study by the type of ad hoc committee suggested in Recommendation 20.

Recommendation 20 of Report B also provided that the appointment of committees established under the eight proposed councils be made "in conjunction with the Speaker of the House of Delegates." In response, the Board has amended its standing rules to add the Speaker as a voting member of its Nominating Committee at such times as the appointments to committees of councils are under consideration.

REPORTING

A portion of Recommendation 15 of Report B of the Council on Long Range Planning and Development, as adopted by the House, provided that:

> Councils, with the exception of the Judicial Council, shall report to the House of Delegates through the Board of Trustees which is expected to maintain its fiduciary and corporate responsibilities in the transmission of reports to the House of Delegates in keeping with zero-based and program budgeting according to the AMA mission plan already adopted by the House of Delegates.

This reporting relationship was discussed by the Ad Hoc Committee with representatives of each of the seven existing Councils. It was agreed that reports, which will continue to carry Council designations, will be submitted to the Board for review prior to their transmittal to the House. In the event of a disagreement, representatives of the Board and the Council involved will attempt to resolve the issue before the report is transmitted. If agreement cannot be reached, the Board will transmit the Council's report and will submit an additional report containing its own comments.

The Board believes that this reporting relationship should work in the same manner in the opposite direction, i.e., matters that the House wishes to refer to one of the eight AMA Councils should either be referred to the Board for appropriate action or be referred to the Board for consideration by a council or councils. In the past, the House has referred items directly to the councils of the House or to a council of the Board. On occasion, more than one council in the AMA structure should be involved with the same issue. If in the future the House of Delegates refers items to the Board or to the councils through the Board, the Board will ensure that, without undue delay, all of the appropriate organizational elements dealing with a particular issue will be involved in its disposition. In this connection, the Board has not included in the proposed charges to the various councils specific language which would indicate they should report to the Board of Trustees or to the House through the Board on all matters pertaining to their areas of study, inasmuch as all AMA councils, except the Judicial Council, have an obligation to submit recommendations to the Board or to the House of Delegates through the Board of Trustees on policy matters and to provide information on subjects within these areas.

The Council on Constitution and Bylaws, therefore, has been requested to prepare Bylaw language which will assure appropriate referral of matters among the House of Delegates, the Board of Trustees and the Councils of the Association consistent with the above discussion.

RECOMMENDATIONS OF BOARD

As requested by the House and after careful consideration of all the information and data presented, the Board submits the following background information and nine recommendations on the charge, membership, term of service and tenure of the eight proposed AMA councils.

A. COUNCIL ON MEDICAL EDUCATION

The Council on Medical Education recommended some revisions in its charge, and further revisions were made by the Board with the concurrence of the Council's representatives. The Council also recommended that the provision that one of its members be a private practitioner of medicine who is not a faculty member of a medical school nor a member of the staff of a hospital associated with a medical school or university be deleted from the Bylaws. Many physicians otherwise well qualified for service on this Council hold appointments which are in conflict with this provision; indeed, with so many hospitals involved in some kind of training, educational, or teaching programs, it is a rarity to find a physician who does not have a faculty appointment or who is not on the medical staff of a hospital which is not associated with a medical school or university. The Council and the Board agree that the continuation of this provision is no longer appropriate, and the Board has not included it in its recommendations for membership on the Council.

The Board and Council representatives agreed that this Council's composition, term of service, and maximum tenure should remain the same and that a non-voting student should continue as a member of this Council, with his or her selection to be made by the Board.

The Council and the Board also agreed that the Council's Advisory Committees on Graduate Medical Education, Undergraduate Medical Education, Continuing Medical Education, and Education for the Allied Health Professions and Services should be continued on an ad hoc basis. This decision is based on the Committee's operational duties, their involvement in the accreditation procedures, and their relationship with the Liaison Committees of the Coordinating Council on Medical Education. They will, however, be subject to the provision of Recommendation 20, which calls for a review at two-year intervals.

RECOMMENDATION 1

The Board recommends that the Council on Medical Education be continued with the following characteristics:

(a) Charge

The functions of the Council on Medical Education shall be:

(1) To study and evaluate all phases of medical education, including the development of programs approved by the House of Delegates for the provision of a continuing supply of well-qualified physicians to meet the medical manpower needs of the public;

(2) To study and evaluate health manpower and education needs in the allied health professions and services, including the development of programs approved by the House of Delegates, to ensure the provision of a continuing supply of well-qualified allied health personnel;

(3) To review and recommend sound policies for medical and allied health education, whereby the AMA may provide the highest educational service to both the public and the profession;

(4) To consider and recommend the means by which the AMA may, on behalf of the public and the medical profession at-large, continue to provide information, leadership and direction to the existing inter-organizational bodies dealing with medical and allied health education;

(5) To consider and recommend the means and methods whereby physicians and allied health personnel may be assisted in maintaining their professional competence and the development of means and methods for recognition of such achievement.

(b) Membership

The Council on Medical Education shall consist of eleven Active members, one of whom shall be a resident, elected by the House of Delegates.

A medical student member of AMA, appointed annually by the Board of Trustees, shall be a non-voting member of the Council on Medical Education.

(c) Term of Service — Tenure

Voting members of the Council shall be elected by the House of Delegates for terms of three years, with a maximum of three terms, so arranged that at each of two annual conventions the terms of four members shall expire and at one annual convention the terms of three members shall expire, provided that the term of the resident member shall terminate if said resident member does not remain in an approved training program for the entire term for which he or she was elected.

B. COUNCIL ON MEDICAL SERVICE

The Council on Medical Service had no basic changes to recommend in its composition, term of service, or maximum tenure. If desired, a non-voting student representative may continue to serve with the Council.

The Board suggested an increase in size of the Council from ten to eleven members for uniformity and with the thought that a larger council size might enable this and other Association councils to accomplish much of their work internally and without the extensive use of ad hoc committees.

The Council is in the process of reviewing its current activities to determine if any ad hoc committees are needed immediately. As noted earlier in this report, most of the Council's existing committees will be discontinued within six months after the House acts on Bylaw amendments related to the new council structure. On recommendation of the Council, the Board has approved continuation of the Council's Ad Hoc Committee on Professional Standards Review Organizations.

RECOMMENDATION 2

The Board recommends that the Council on Medical Service be continued with the following characteristics:

(a) Charge

The functions of the Council on Medical Service shall be:

(1) To study and evaluate the social and economic aspects of medical care; and, on behalf of the public and the profession, to suggest means for the timely development of services in a changing socioeconomic environment;

(2) To investigate social and economic factors influencing the practice of medicine;

(3) To inform state associations and component societies of changing conditions and anticipated proposals that would affect medical care;

(4) To assist medical service committees established by state associations and component societies of the American Medical Association.

(b) Membership

The Council on Medical Service shall consist of eleven Active members, one of whom shall be a resident, elected by the House of Delegates.

A medical student member of AMA, appointed annually by the Board of Trustees, shall be a non-voting member of the Council on Medical Service.

(c) Term of Service — Tenure

Voting members of the Council shall be elected by the House of Delegates for terms of three years, with a maximum tenure of three terms, so arranged that at each of two annual conventions the terms of four members expire, and at one annual convention the terms of three members expire, provided that the term of the resident member shall terminate if said resident member does not remain in an approved training program for the entire term for which he or she was elected.

C. COUNCIL ON SCIENTIFIC AFFAIRS

The creation of this Council was recommended by the Council on Long Range Planning and Development, which described its proposed function as follows:

This Council will concern itself with the adequacy of AMA policies regarding various scientific issues, scientific-medical research, and scientific-medical information to the profession and the public. It will also serve to provide membership input on the editorial policies of the Association's scientific publications.

The Ad Hoc Committee discussed the creation of this new Council and, in its review, included an examination of the functions and activities of the councils and committees staffed by the Division of Scientific Activities as well as the proposed Council's relationship to the Association's scientific publications. The Board believes that this Council's important role in recommending overall scientific policies for the Association will be helpful to the Editorial Boards of these publications in fulfilling their responsibilities of providing editorial direction for AMA's journals.

The Board is recommending a composition, term of service, and tenure similar to some of the other councils. It recognizes that the Council on Scientific Affairs must cover a substantial area, but the recommended size of eleven members should be adequate at this time.

Because of the number of AMA Auxiliary programs which fall within the scientific area, the Board of Trustees also intends to include a non-voting liaison member, nominated by the Auxiliary, on the Council on Scientific Affairs.

RECOMMENDATION 3

The Board recommends that a Council on Scientific Affairs be established with the following characteristics:

(a) Charge

The functions of the Council on Scientific Affairs shall be:

(1) To advise on substantial and promising developments in the scientific aspects of medicine and biomedical research that warrant public attention;

(2) To advise on professional and public information activities that might be undertaken by the AMA in the field of scientific medicine, and to assist in the preparation of policy positions on scientific issues raised by the public media;

(3) To advise on policy positions on aspects of government support, involvement, or control of biomedical research;

(4) To advise on opportunities to coordinate or cooperate with the scientific activities of national medical specialty societies, voluntary health agencies, other professional organizations, and government agencies;

(5) To consider and evaluate the benefits that might be derived from joint development of domestic and international programs on scientific affairs,

(6) To propose and evaluate activities that might be undertaken by the AMA as major scientific projects, either individually or jointly with state and local medical societies.

(b) Membership

The Council on Scientific Affairs shall consist of eleven Active members, one of whom shall be a resident, elected by the House of Delegates.

(c) Term of Service — Tenure

Voting members of the Council shall be elected by the House of Delegates for terms of three years, with a maximum tenure of three terms, so arranged that at each of two annual conventions the terms of four members expire and at one annual convention the terms of three members expire, provided that the term of the resident member shall terminate if said resident member does not remain in an approved training program for the entire term for which he or she was elected.

D. COUNCIL ON CONSTITUTION AND BYLAWS

The Council on Long Range Planning and Development in its desire to clarify the function of the Council on Constitution and Bylaws had recommended that its function should be to prepare "the requisite language to accomplish the intent of the House of Delegates in matters which involve changes in the Constitution and Bylaws." The Council on Constitution and Bylaws and the Board recognized the need to draw the charge of this Council in a manner that does not overlap or restrict the planning responsibilities of the Board or the Council on Long Range Planning and Development, and the Board is recommending a charge which it believes represents such clarification.

The Council recommended that it be retained at its present size and composition, and that its members continue to serve five-year terms with a maximum tenure of ten years. The Board believes that it would be appropriate to enlarge the Council to seven members, and that its members should serve one term of seven years, and that the non-voting membership should be increased to include a resident member. This would provide a broader base, greater participation of the membership, and maintain continuity.

RECOMMENDATION 4

The Board recommends that the Council on Constitution and Bylaws be continued with the following characteristics:

(a) Charge

The functions of the Council on Constitution and Bylaws shall be:

To serve as a fact finding and advisory committee on matters pertaining to the Constitution and Bylaws. The Council will recommend such changes in the Constitution and Bylaws as may be appropriate for action by the House of Delegates.

(b) Membership

The Council on Constitution and Bylaws shall consist of seven Active members elected by the House of Delegates. The President, a member of the Board of Trustees selected by the Board, the Speaker and Vice Speaker of the House of Delegates, and a resident member appointed annually by the Board shall be members of this Council without the right to vote.

(c) Term of Service – Tenure

Voting members of the Council shall be elected by the House of Delegates for one term of seven years, so arranged that at each Annual Convention the term of one member expires.

E. JUDICIAL COUNCIL

After discussion, representatives of the Judicial Council and the Board of Trustees agreed on a minor restructuring of the Council's charge as submitted in the recommendation that follows.

The Council recommended that it be retained at its present size and composition, and that its members continue to serve five-year terms with a maximum tenure of ten years. The Board believes that a single seven-year term preserves the requisite continuity of this Council while at the same time allowing an increased number of members to participate in the judicial function.

RECOMMENDATION 5

The Board recommends that the Judicial Council be continued with the following characteristics:

(a) Charge

The functions of the Judicial Council shall be:

(1) To serve as the judicial authority of the Association. The decisions of the Judicial Council shall be final.

(2) To have original jurisdiction in: (a) all questions involving membership as provided in Division One, Chapter I, Section 1, of the Bylaws; (b) all controversies arising under this Constitution and Bylaws and under the Principles of Medical Ethics to which the American Medical Association is a party; (c) controversies between two or more state associations or their members and between a state association and a component society or societies of another state association or associations or their members; (d) the establishment of principles and interpretation of medical ethics, and (e) the interpretation of the Constitution, Bylaws and rules of the Association.

(3) To have appellate jurisdiction in questions of law and procedure but not of fact in all cases which arise between a state association and one or more of its component societies, between component societies of the same state association, between a member or members and the component society to which said member or members belong or between members of different component societies of the same state association. Notice of appeal shall be filed with the Judicial Council within thirty (30) days of the date of the decision by the state association and the appeal shall be perfected within sixty (60) days thereof; provided however that the Judicial Council, for what it considers good and sufficient cause, may grant an additional thirty (30) days for perfecting the appeal.

(4) To receive appeals filed by applicants who allege that they, because of color, creed, race, religion or ethnic origin, have been unfairly denied membership in a component and/or constituent association, to determine the facts in the case, and to report the findings to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure or, in the event of repeated violations, recommend to the House of Delegates that the state association involved be declared to be no longer a constituent member of the American Medical Association.

(5) To investigate general ethical conditions and all matters pertaining to the relations of physicians to one another or to the public, and make recommendations to the House of Delegates or the state associations.

(6) To request the President to appoint investigating juries to which it may refer complaints or evidences of unethical conduct which in its judgment are of greater than local concern. Such investigating juries, if probable cause for action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against the accused before the Judicial Council in the name and on behalf of the American Medical Association. The Council may acquit, admonish, suspend or expel the accused.

(7) To approve applications and nominate candidates for affiliate membership as otherwise provided in these Bylaws.

(b) Membership

The Judicial Council shall consist of seven Active members, elected by the House of Delegates on nomination by the President.

(c) Term of Service — Tenure

Members of the Council shall be elected by the House of Delegates for one term of seven years, so arranged that at each Annual Convention the term of one member expires.

F. COUNCIL ON CONTINUING PHYSICIAN EDUCATION

The Board's responsibilities related to this Council (formerly Council on Scientific Assembly and renamed by the Council on Long Range Planning and Development the Council on Continuing Medical Studies) included the suggestion of an appropriate name. The Council representatives and the Board agreeed on the title "Council on Continuing Physician Education," which the Board is submitting to the House.

The Council developed a proposed charge, which was approved by the Board and is being submitted with minor editorial changes.

The Board and the Council have agreed on an increase in size of the Council from eight to eleven members in recognition of its "primary responsibility as the programing arm of the AMA in continuing medical education," a major priority for the Association, and in keeping with the uniform size and composition suggested for other councils.

The Board and the Council have agreed that Council members should be appointed annually by the Board, and that the maximum tenure be extended from seven to nine years.

RECOMMENDATION 6

The Board recommends that the Council on Continuing Medical Studies (formerly the Council on Scientific Assembly) be continued with the following characteristics:

(a) Revised Name

Council on Continuing Physician Education

(b) Charge

The functions of the Council on Continuing Physician Education shall be:

(1) To assume primary responsibility as the programming arm of the American Medical Association in continuing medical education;

(2) To plan, organize, supervise, and evaluate AMA-sponsored programs to meet the needs of practicing physicians for accredited continuing medical education of the highest educational and scientific quality, in all modes of delivery commensurate with quality programs, to cooperate where appropriate with state, county, and medical specialty societies of the Scientific Sections;

(3) To organize and develop the scientific and educational program for the Annual Convention, working with the Scientific Sections as provided in the Bylaws, and to develop and expand cooperation with the national specialty organizations;

(4) To work with national specialty societies and state medical societies in organizing and conducting the scientific and educational program for the Winter Scientific Meeting, and Regional Postgraduate Meetings,

(5) To advise the Board of Trustees regarding sites for the Annual Convention, Winter Scientific Meeting, and Regional Postgraduate Meetings;

(6) To select winners of awards for exhibits of the Scientific Assembly;

(7) To submit recommendations to the Board of Trustees on the establishment of new Sections of the Scientific Assembly.

(c) Membership

The Council on Continuing Physician Education shall consist of eleven Active members, one of whom shall be a resident, appointed by the Board of Trustees.

(d) Term of Service — Tenure

Members shall be appointed for terms of one year, beginning on July 1, and shall be eligible to serve a maximum tenure of nine terms, with the provision that the term of the resident member shall terminate if said resident member does not remain in an approved training program for the entire term for which he or she was appointed.

G. COUNCIL ON LEGISLATION

The Council on Legislation developed a proposed charge which was approved by the Board.

The membership of this Council is unique in that it includes a voting representative of the American Dental Association, a mechanism that is reciprocal in that an AMA appointee serves on the ADA's corresponding body. The Council has indicated that this arrangement is productive, and the Board is recommending that it be continued with the understanding that it will not detract from the number of AMA members on the Council.

The Council does not presently have a "slotted" seat for a resident, but a current member is in a training program. In view of the number of legislative issues affecting physician training, the Board believes that "slotted" resident participation should be provided since this action does not disturb the number of seats allocated to members of the Association who have completed their training and is so recommending to the House. The Board is also recommending continuance of a non-voting student member on this Council and extension of the maximum tenure to nine terms for conformity with most of the other councils.

The Board intends to continue to invite the AMA Auxiliary to nominate a non-voting liaison member to this council as a means of coordinating the AMA and Auxiliary legislative programs.

RECOMMENDATION 7

The Board recommends that the Council on Legislation be continued with the following characteristics:

(a) Charge

The functions of the Council on Legislation shall be:

(1) To review proposed federal legislation and recommend appropriate action within AMA policy;

(2) To recommend changes in existing AMA policy when necessary to accomplish effective legislative goals;

(3) To serve as a reference council through which all legislative issues of the Association are channeled prior to final consideration by the Board of Trustees,

(4) To maintain constant surveillance over the legislative scene and to anticipate future legislative needs;

(5) To recommend to the Board of Trustees new federal legislation and legislation to modify existing laws of interest to the Association;

(6) To monitor the development and issuance of federal regulations and to make recommendations to the Board of Trustees concerning action on such regulations;

(7) To develop and recommend to the Board of Trustees model state legislation.

(b) Membership

The Council on Legislation shall consist of eleven Active members, one of whom shall be a resident, appointed by the Board of Trustees.

A voting member shall be nominated by the American Dental Association and appointed by the AMA Board of Trustees, with the understanding that the AMA shall continue to nominate a voting member to the ADA Council on Legislation for appointment by the ADA.

A medical student member, appointed annually by the Board of Trustees, shall be a non-voting member of the Council on Legislation.

(c) Term of Service — Tenure

Members shall be appointed for terms of one year, beginning on July 1, and shall be eligible to serve a maximum tenure of nine terms, with the provision that the term of the resident member shall terminate if said resident member does not remain in an approved training program for the entire term for which he or she was appointed.

H. COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

The Board and representatives of the Council on Long Range Planning and Development agreed that the Council's charge and composition should remain largely as it presently exists. The charge has been modified to reflect the Council's immediate concern with the AMA's planning process and to provide for the distribution of data to the Board to assist with the Board's day-to-day planning responsibilities.

The Council also recommended that the maximum tenure of its members be extended from six to nine years to conform with some of the other councils of the Association, and the Board concurs with this recommendation.

The Board has considered the role of the Council on Long Range Planning and Development in AMA's structure, its relationship with the House of Delegates and the Board of Trustees, and the unique expertise that its members should possess. The Board believes that the original decision of the House regarding the Council's appointment has proved

to be wise and has resulted in an extremely well balanced Council. The Board recommends that the Council continue to be constituted as it has been since its inception and that the membership be appointed by the Speaker of the House and the Board, as originally established by the House, with the exception that the voting student member would be appointed by the Board rather than by the President of the American Medical Student Association.

This arrangement would divide the appointments equally between the Board of Trustees and the Speaker of the House, thus ensuring the participation of the two major bodies to which the Council on Long Range Planning and Development relates. This arrangement is also consistent with the Council's obligation to advise the House on the Association's planning structure and long-term planning commitments and to provide the Board with information for its day-to-day planning.

The Council has spoken strongly in favor of the continuation of its current "slotted" configuration which calls for two trustees, two delegates, four members-at-large, a housestaff member, and a medical student. The Council believes that this configuration has provided for a diverse set of philosophies and viewpoints that has been one of its major strengths in the past. It is particularly appropriate for a planning council to have a broad base which represents the various elements of the AMA. The Board concurs with this view and believes that the Council's present configuration can be best preserved by an appointive process.

The Council has also emphasized that its role in the AMA structure is unique. In its statements to the House of Delegates and the Board, the Council has defined its role as one that stimulates planning, provides information and advice to those responsible for making planning decisions, performs special studies, and evaluates the impact of planning on the Association. The Council has the responsibility of evaluating the effectiveness of planning in terms of assuring that important issues are dealt with within the planning process and that decisions on each of these issues are reached. The Board has the responsibility of evaluating planning results in terms of the appropriateness of these decisions.

In view of the kind of expertise necessary for service on this Council and the unique tripartite relationship between the Council, the House and the Board, the Board believes that retention of the existing appointive system is appropriate.

RECOMMENDATION 8

The Board recommends that the Council on Long Range Planning and Development be continued with the following characteristics:

(a) Charge

The functions of the Council on Long Range Planning and Development shall be:

(1) To study and make recommendations concerning the long-range objectives of the Association.

(2) To study and make recommendations concerning the projected resources, programs, and organizational structure by which the Association attempts to reach its long-range objectives in (1) above;

(3) To serve as a focal point for the planning activities of the Association and to stimulate and evaluate planning activities throughout the organization;

(4) To study, or cause to be studied, the future environment in which medicine and the Association must function, collect relevant data and transmit interpretations of these studies and data to the Board of Trustees for distribution to decision-making centers throughout the Association, and submit reports to the House of Delegates at appropriate times.

(b) Membership

The Council on Long Range Planning and Development shall consist of ten Active members. Five members shall be appointed by the Speaker of the House of Delegates, two of whom shall be members of the House of Delegates, two of whom shall be appointed from the AMA membership at-large, and one of whom shall be appointed from the resident membership of the AMA. Five members of the Council shall be appointed by the Board of Trustees, two of whom shall be members of the Board of Trustees, two of whom shall be appointed from the AMA membership at-large, and one of whom shall be a student member of the AMA.

(c) Term of Service — Tenure

Members of the Council shall be appointed for terms of three years, beginning on July 1, with a maximum tenure of three terms, so arranged that the terms of three members shall expire in each of two years and the terms of four members shall expire during the third year. The term of the resident member shall terminate if he or she does not remain in an approved training program for the entire term. The term of the medical student member shall terminate if he or she does not remain enrolled in an accredited school of medicine for the entire term.

I. CANDIDATES

The charge to the Board as contained in Recommendation 19 asks that the Board submit suitable candidates for positions on seven of the eight proposed Councils (excluding the Judicial Council). In considering this aspect of its responsibilities, the Board believed that it was the House's desire to allow those members of councils now serving to complete their current terms and to be eligible to complete their remaining tenure, rather than to begin the Council reorganization with a substantially revised roster of members. This also appears to be the only practical manner of assuring the continuity of, and an informed approach toward, existing council activities and programs.

As already provided for some councils, maximum tenures have been set at three terms, except for the Judicial Council and Council on Constitution and Bylaws. The current terms of the members of the three councils which are presently on a calendar year

basis (Council on Long Range Planning and Development, Council on Legislation, and Council on Continuing Physician Education) would be extended to June 30, 1977, to bring them into conformity with the other councils.

RECOMMENDATION 9

That members of the seven existing Councils proposed for continuation whose terms have not expired shall be eligible for their remaining tenure, as provided in previous recommendations in this report.

Nominations for vacancies on the Council on Constitution and Bylaws, Council on Medical Education, and Council on Medical Service which will exist under the present Bylaws and for which the Board nominates will be submitted in the usual manner in separate reports to the House. Additional nominations which may be required following House action on this report will be submitted following that action.

Nominations for the Judicial Council will be submitted to the House by the AMA President.

SUMMATION

The events of 1974 and 1975, as traumatic as they have been in several instances, have produced major benefits, and the opportunity to reexamine the Association's Council and Committee Structure has been one of these. The Special Committee of the House of Delegates, the Council on Long Range Planning and Development, the Board of Trustees and the House have agreed on the need for a strong basic Council structure, on the use of short-term ad hoc committees to give the Association the flexibility it needs in addressing new programs and priorities, and on a redefinition of the reporting relationships between the councils, the Board, and the House. Several of the Mission Groups that functioned during the initial planning cycle also endorsed the ad hoc committee approach. This agreement can be of direct immediate benefit to the Association.

In its discussion of Recommendation 15 of Report B, the adoption of which identified all councils as councils of the AMA, the Council on Long Range Planning and Development commented:

"The above recommendation is based on the premise that all functioning components of AMA are ultimately responsible to the House of Delegates as the primary policy-making body of the Association. At the same time, the Council recognizes that it is impossible for a body of 250 individuals that meets only twice a year to supervise and coordinate adequately the ongoing activities of a series of councils. Hence, the Board should be delegated the responsibility and authority, as the executive committee of the House of Delegates, to actively direct, supervise, and coordinate the activities of the councils and committees. The Board should establish such mechanisms and take such actions as are necessary to become fully familiar with the activities of the various councils, and it should see to it that the councils pursue programs that are consistent with the policies of the House. The Board should provide specific program direction, including the program objectives and time deadlines when appropriate."

(Board of Trustees — A)

The Board of Trustees strongly concurs with the need for a closer working relationship between it and the eight AMA Councils in addressing problems and priorities, particularly as they are established in the AMA Plan approved annually by the House. It intends to continue to review and strengthen its current working relationships with the Councils.

As a final comment, the Board believes that each Council's charge and composition should be subject to an annual review by the Board and the individual Council. Recommendations for possible future revisions will be brought to the House for approval.

SUPPLEMENTARY A. AMA COUNCILS
(Reference Committee on Amendements to Constitution and Bylaws, page 315)

HOUSE ACTION: ACTIONS TAKEN REGARDING AMA COUNCILS ARE ON PAGE 185, REPORT F OF THE COUNCIL ON CONSTITUTION AND BYLAWS

During the 1975 Clinical Convention, the House of Delegates voted to elect the members of the Council on Long Range Planning and Development. To implement this policy, the Board of Trustees would ordinarily submit at least two nominees for each vacancy on the Council, and additional nominations could be made from the floor.

Recommendation 8(b) of Report A of the Board, "AMA Councils," provides for the continued appointment of the Council as it is presently structured. This change in policy proposed by the House has been suggested by the Board in order to preserve the Council's existing relationship to the House and the Board and in recognition of its unique role in advising on the AMA's planning structure and long-term planning commitments.

The Board recognizes that the House may wish to reaffirm its policy regarding the election of the Council and is submitting the following amendment to Recommendation 8(b) of Report A as optional language:

> (b) Membership
>
> The Council on Long Range Planning and Development shall consist of ten Active members. Two members shall be members of the House of Delegates, four members shall be from the AMA membership at-large, one member shall be a resident, and one member shall be a medical student, and these members shall be elected by the House of Delegates on nomination by the Board of Trustees. Two members shall be members of the Board of Trustees appointed by the Board.

The Board believes that the Trustee members of the Council should continue to be appointed by the Board in accordance with the procedures established within its Standing Rules. The retention of this appointment process is consistent with the Board's overall management responsibilities as outlined in the Constitution and Bylaws and established under the corporate laws of the State of Illinois.

(Board of Trustees — Q)

Q. AMA PLAN — 1976
(Reference Committee F, page 380)

HOUSE ACTION: ADOPTED

Following is the AMA Plan — 1976 which was developed by the Board of Trustees with the assistance of the Council on Long Range Planning and Development and approved for transmittal to the House of Delegates.

The third annual AMA Plan raises issues covering ten major areas of concern for the American Medical Association, some of which are continuing issues that were raised in previous plans and some of which have not previously been considered in the planning process. In addition, it reports progress on nine issues which were addressed in previous planning cycles, and are now at the operational planning or implementation stage.

The issues addressed through the planning process represent the concerns of the AMA membership as reflected in Board of Trustees and House of Delegates actions. At the 1975 Clinical Convention, Resolution 17 called for the Board of Trustees to report on efforts to pursue the broad AMA goals of "active participation in the solution of problems in public health and health delivery, functioning in these areas as the advocate of the patient as well as the physician." The Board believes that the issues addressed in this Plan reflect those goals and that the planning process constitutes an orderly and effective process for pursuing them.

The Plan reports significant progress in addressing AMA's organizational structure, the overall federation structure, the House of Delegates structure and the council/committee structure. The Plan also reports on the new staff organization and on the new management planning and budgeting processes that have been adopted to improve program and financial accountability.

The Plan describes the coordination of AMA activities with those of other organizations in responding to legislative challenges and in the development of a private sector medical data base. Progress is reported on several aspects of regulatory activity of concern to the Association and on the new negotiations program.

In the scientific and education arena, AMA's role in medical education is discussed and a new mechanism for developing AMA policy on scientific issues is reported.

ISSUES

Not all issues can be properly addressed in a single planning cycle. The 1976 AMA Plan includes several "continuing" issues from prior planning cycles that require additional attention. Significant progress in the membership arena is reported for 1975 but concerns for the future are also raised. Professional liability insurance is perhaps the most immediate problem facing medicine, but it also has long term implications that must be considered at the same time. Continuing attention must be paid to such issues such as certification and licensure, access and availability of care, and physician-hospital relations. These are all areas where the possibility of regulatory action exists. Finally, AMA's role in continuing medical education is a subject of ongoing interest since continuing education looms as the fastest growing facet of medical education.

Several issues which have not been previously addressed through strategic planning are introduced in the 1976 Plan. While previous plans discussed the general trend toward increased regulation of medicine, they did not address specific regulatory efforts. Five such specific concerns are raised in the 1976 Plan: Health Planning Legislation, Health Manpower Legislation, the Maximum Allowable Cost Regulations, the Federal Trade Commission's Advertising "Complaint" Against AMA, and the Federal Trade Commission's investigation of AMA's alleged restriction of health manpower and health services. The Plan also raises the question of how AMA's excellent data base should be used and what is the appropriate role of AMA's health services research program. Lastly, the Plan raises a perennial issue that was not addressed in the 1975 planning cycle. What can AMA do to improve its public relations?

AMA PLAN — 1976

INTRODUCTION

AMA is now entering the third cycle of the long range planning program which was adopted by the House of Delegates at the Annual Convention in 1973. During the first two cycles, the planning system has been refined, and AMA now has a smoothly operating planning process with two major phases:

1. Long range strategic planning is referred to as "Critical Issue Planning." Its purpose is to identify major issues with serious, long term implications and develop "strategies" for addressing them. Critical issues identified by the Council on Long Range Planning and Development and by the Board are presented in the annual AMA Plan and are subsequently addressed in Critical Issue Plans.

2. A program management mechanism was developed during 1975 to carry planning to the operating level. The financial problems of 1974-75 pointed out the need for more sophisticated operational planning and budgeting techniques to insure that program implementation at AMA is responsive to policy needs, consistent with modern management techniques that stress results accountability, and responsive to the need for tighter fiscal management. The program management process involves a program planning phase that establishes what programs will be pursued to implement AMA policies, subject to approval and continuing evaluation by the Board of Trustees.

In addition to significant progress in refining the planning process, there has also been substantive progress toward developing solutions to issues identified in previous AMA Plans. This year's AMA Plan is the first one to report on issues that were raised in previous plans, addressed in Critical Issue Plans, and are at the implementation stage. These issues have been "retired" from the critical issue planning phase and are now part of the program planning phase through which the operational details of implementation are established. The next section, Progress Report, describes what has happened on these issues.

PROGRESS REPORT

1. ORGANIZATIONAL STRUCTURE — The 1975 AMA Plan reviewed two facets of AMA's organizational structure. First, the federation structure was identified as an area that needed careful analysis to determine whether the current structure, which was established many years ago, is still adequate and whether it will serve the AMA adequately in the future. It was noted that in recent years, AMA's structure as a territorial federation has

come under increasing scrutiny and pressure as the number of nonterritorially based organizations has grown (e.g., specialty societies, student and housestaff organizations, etc.). The Plan noted that the changing environment within which medicine exists makes it essential that the structure of organized medicine be continually evaluated and updated.

The second facet of AMA's organizational structure that was identified in the 1975 AMA Plan related to internal organization. Included in this discussion were such considerations as the structure of the House of Delegates, the role of the Board of Trustees, and the configuration of AMA's council and committee system. The Plan emphasized that flexibility to respond to the changing needs of the future is an essential characteristic of the internal structure of AMA.

Significant progress can be reported in both areas of organizational structure mentioned above. A comprehensive study of AMA's organizational structure was prepared by the Council on Long Range Planning and Development including numerous recommendations for changes. What is probably most significant from the entire effort is that the issues were raised, the concept of the need for a flexible organizational structure was agreed upon in principle, and a mechanism and process for continuing to assess AMA's structure was established.

Significant progress was also made on restructuring AMA's management configuration. The entire staff organization was revised in September 1975 to conform more closely to modern corporate organizational form. This will enhance program accountability and will reduce the amount of day-to-day administrative activity at top management levels so that top management can devote more time to providing the kind of executive management direction that a fifty million dollar organization needs to meet the major challenges of today and the future.

2. COALITION ACTIVITIES -- The 1975 AMA Plan commented that AMA involvement in coalitions is an increasingly important activity. Two types of coalitions were identified; temporary coalitions which form around specific issues, often of a legislative or regulatory nature, and permanent coalitions that are established to perform basic ongoing activities which call for interorganizational cooperation (usually between organizations within the health industry).

The Plan went on to caution, however, that "...while cooperative efforts with other organizations seem to be inevitable ... AMA must be careful to retain its identity and organizational integrity. The nature of AMA's participation in coalition activities will also depend in large measure on the type of leadership role the Association wishes to pursue for the future."

This issue was addressed in several Critical Issue Plans during 1975. AMA's participation with business interests and organized labor was discussed as a flexible strategy for dealing with specific issues on which there is common concern, especially in the legislative/regulatory arena. Several of the Plans addressed AMA participation in the more permanent, operational type of coalition in the context of other issues. (See Regulation of Medicine, AMA's Role in Medical Education, and Computers and Medical Data Bases). The various discussions and analyses of these issues has raised the level of awareness of the importance and also the dangers of participating in such coalitions.

3. RESOURCE STRENGTH — This issue has been discussed in both previous AMA Plans, and has been indirectly addressed in several Critical Issue Plans. However, the most direct treatment of this issue has been by the Special Committee of the House of Delegates, Reference Committee F, the House of Delegates itself, the Board of Trustees, and staff in a concerted effort over the past year and a half. Those efforts have resulted in a dues increase to supplement revenue, and a series of actions to reduce and reorder expenditures. AMA's publishing activity was given a thorough analysis resulting in the discontinuation of "Prism," the sale of "Today's Health," numerous changes in JAMA and the specialty journals, and perhaps most importantly, the restructuring of AMA's publishing activity through organizational and staff changes reflecting a typical corporate publishing activity. On a broader scale, AMA management initiated an organization-wide reordering of the Association's approach to program planning and budgeting.

   Through the techniques of program planning and zero-based budgeting, and the fiscal restraint that was exercised during FY 1975, a projected FY 1975 deficit of $3.8 million was reduced to an actual deficit of only $146,000. In the process, many AMA programs were critically analyzed and inefficient or outdated ones were discontinued while new and more innovative ones were initiated.

4. REGULATION OF MEDICINE — This issue, as a broadly stated, ongoing concern facing all of medicine, was addressed in both prior AMA Plans. One of the important actions that AMA took during 1975 in the regulatory arena was the successful challenge to the Utilization Review Regulations that were issued by the Department of Health, Education, and Welfare. AMA went to court charging that the regulations as issued constituted a clear violation of the portion of the law that prohibits interference with the practice of medicine and the physician-patient relationship. After numerous sessions in court, HEW withdrew the regulations and AMA subsequently withdrew its suit with the provision that the suit could be reopened if the revised regulations are not satisfactory.

   The regulatory issue was addressed in several Critical Issue Plans both as a general issue and in relation to several specific regulatory topics. On the general plane, it was suggested that AMA expand its state legislative activity. An expanded program was included in the FY 1976 budget. The Critical Issue Plans also noted that the new laws affecting campaign and lobbying activities have resulted in additional emphases to certain aspects of such activities. Particularly important for the future will be AMA's ability to provide informational services to legislators.

   Picking up on the AMA Plan suggestion for a positive rather than defensive posture, one of the Critical Issue Plans proposed an intense effort to take the initiative by anticipating issues which are likely to produce regulatory response by government and developing a positive private sector solution in order to beat the government to the punch. This approach is being pursued cautiously through the selection of one issue for study during 1976 and recommendation to the Board of a specific program. This, however, is only one part of an overall "mixed" strategy that calls for continued opposition to undesirable laws and regulations, as well as for efforts to maximize AMA influence on the implementation of regulatory programs that have already become the law of the land.

5. NEGOTIATIONS — The 1975 AMA Plan indicated that third-party interference in the physician-patient relationship has resulted in a need for a direct form of representation for physicians at the local level, since component societies have been put in the position of

having to act as negotiating agents with local hospitals, insurance plans, and governmental bodies. As this need increases, local societies will require support from the state and national levels of organized medicine. It was noted that a Negotiations Department had already been established at AMA and a program was being developed.

The Critical Issue Plans elaborated on the negotiations program. Strategy options included one that would have AMA pursue a relatively passive informational role, one that would have AMA pursue a program of formal education for medical societies to teach negotiating principles and skills and another option that would have AMA become, in effect, a union organizer and bargaining unit. The educational role was adopted as the basic approach and a series of seminars conducted by experts in the art of negotiation was established. To date, several such seminars have been conducted and have been quite successful. An expanded program in this area is planned. Several of the state societies have initiated their own negotiations programs.

6. AMA'S ROLE IN MEDICAL EDUCATION — This issue was highlighted in both prior AMA Plans. The changing educational system was noted, and concern was expressed for the clarification of AMA's role in the inter-organizational coalitions that have evolved to accredit medical education programs and institutions, with specific reference to the Coordinating Council on Medical Education and the several liaison committees that operate under its auspices. The specific concern is that AMA should not relinquish or reduce its leadership role in medical education because of the new organizational relationships. Rather, AMA should continually strive to develop and maintain a leadership role in this area.

   This was addressed in some depth in a Critical Issue Plan. It concluded that continued participation in the CCME structure is the appropriate role for AMA at this time, and it presented several options for how such participation might be best pursued. AMA is continuing to provide complete staff support for the Coordinating Council on Medical Education and its liaison committees on graduate and continuing medical education and one-half of the staff support for the Liaison Committee on Medical Education. The Board of Trustees is paying close attention to the activities of CCME and its liaison committees to insure AMA's future leadership role in medical education.

7. PEER REVIEW — Peer review as an issue was specifically mentioned in the 1975 AMA Plan as a regulatory concern of particular significance. AMA's approach to this issue is an excellent example of the facet of the "mixed regulatory strategy" referred to under "Regulation of Medicine." This strategy calls for AMA to maximize its influence on the implementation phases of regulatory programs that are already the law of the land while at the same time working to change the most undesirable aspects of the law. There is now an ongoing effort to implement that strategy. AMA has submitted a series of eighteen amendments which are designed to improve the PSRO law. Several have already been passed, including a time extension for professional associations to develop PSROs, the "statewide option" for establishing PSROs on a statewide basis, and the allowance for use of sampling in reviewing Medicaid. Other proposed amendments are still pending.

8. COMPUTERS AND NATIONAL MEDICAL DATA BASES — The 1975 AMA Plan noted that "...Large medical data bases made possible by computer technology present potential threats to the confidentiality of patient records. The quasi-public nature of medical data bases generated from government sponsored programs such as PSRO and NHI would make

private-sector control of the use of such data bases difficult." The Critical Issue Plan proposed the exploration of a cooperative national health data program between AMA and other national organizations in the private sector such as the American Hospital Association, the Blue Cross Association, the National Association of Blue Shield Plans, and the Health Insurance Association of America. Exploratory discussions are currently ongoing with the various organizations.

9. AMA'S ROLE IN SCIENTIFIC POLICY MAKING — The 1975 AMA Plan raised the question of whether AMA needed a more reliable monitoring mechanism to identify issues that arise in the scientific area so that policy positions can be developed as guides to the profession. The Critical Issue Plan that addressed this subject analyzed the advantages and disadvantages of establishing the new "sensing device" as a council, which would allow for more membership participation or as a staff oriented mechanism, which would be more flexible and less expensive than a council. Subsequently, the Council on Long Range Planning and Development issued its organizational report which proposed that there be eight AMA councils, one of which would be a new Council on Scientific Affairs. The proposal was approved by the House of Delegates at the 1975 Clinical Convention and a charge for the new council will be considered by the House at the 1976 Annual Convention.

1976 AMA PLAN ISSUES

The issues discussed above were raised in previous AMA Plans, addressed in Critical Issue Plans, and have been introduced into the operational planning process for implementation according to the strategies that were adopted. The issues addressed below are ones that have been addressed in prior AMA Plans but for which further consideration through the planning process is needed, as well as issues that have not been addressed in previous AMA Plans. The planning process uses six "mission" categories as the basis for presenting issues. These six missions constitute the major arenas in which AMA is concerned and active. Indeed, they are one way of looking at what AMA actually is. The order in which they are presented does not imply a ranking by importance, because each of the missions is a major portion of AMA's total program.

STRENGTHENING AMA AS AN ORGANIZATION

The first mission under which issues are discussed deals with the viability of AMA as an organization and with the various internal decision making support systems that operate within the organization. The Progress Report section of this Plan noted significant advances in such areas as organizational structure and resource strength. As the Association looks ahead to the 1980's, one issue from previous AMA Plans -- membership -- still demands attention. AMA's membership constitutes the substantive as well as the fiscal base of the organization. It is the most fundamental internal concern of the organization at any time. In addition, this year's Plan raises two new issues which are distinct but related. AMA's internal data base is a major asset that should be used to the fullest benefit to the Association. One of the uses of the data base is in the AMA's health services research program which is in itself an issue worthy of discussion.

Membership

The membership is the single most important source of income for AMA and over the past decade has provided an even larger percentage of total revenue than in the past. However, an even

more critical dimension of AMA's membership base is the strength it gives AMA as an organization in pursuing programs, dealing with other health organizations, and dealing with the government at all levels. Particular issues which currently have strong implications in relation to membership are the AMA's success in addressing the professional liability problem, the future structure of AMA and its ability to represent an increasingly specialized profession, and increased legislative activity which calls for a more unified "medical voice" in the future. Also, the potential role of AMA as a "bargaining agent" for physicians would depend heavily on membership strength.

During 1975, membership increased to a record of 179,900 dues paying members. Tables 1 and 2 represent a statistical analysis of AMA membership over the past several years. The data show that the AMA membership profile has stabilized and is showing some improvement in the past two years. During the late 1960s and early 1970s, AMA's membership had fallen off, primarily because of dues increases and the dropping of unified membership by several states. In 1972 AMA formalized its membership program by starting a Department of Membership Development. This program resulted in significant improvements in the membership picture almost immediately.

It is clear from Table 2 that AMA's major membership strength continues to be with the office based, practicing physician. However, as a result of the Association's membership development efforts, membership has increased among other physician groups as well. Particularly encouraging is the growth in AMA membership among housestaff and medical students (see Table 1). The significance of the increased interest in AMA among medical students and housestaff is clear; these are the membership base of the future.

The improvements in AMA membership over the past several years do not, however, constitute a reason for complacency. AMA dues in 1976 are $250, an increase of $140 over 1975. The impact of the dues increase is uncertain at the time of this writing. In the past, dues increases have resulted in a decrease in membership during the first year of the increased dues, followed by a steady growth in subsequent years. The same pattern is expected this time, but the magnitude of the initial membership attrition and the rate of subsequent recovery is not certain.

Membership, as it relates to the 1976 dues increase, is an operating concern at this time. Long-range planning can do little to solve whatever problems arise in 1976 as a result of the dues increase. However, significant long range problems in the membership arena still do exist. The lack of a comprehensive, federation-wide membership program is still a major impediment to the desired quantum improvements in the membership base. The 1974 and 1975 AMA Plans both addressed this issue and noted that in the past constituent societies followed their own membership programs and a series of fifty state approaches to membership were developed. Until recently there has been no attempt at developing a systematic, federation-wide membership program. The Plans went on to describe some of the specific aspects of this complex problem.

1. The 2,000 state and county medical societies have almost as many different constitutions and bylaws. Membership eligibility requirements are not at all standardized, making it difficult for AMA to pursue a membership campaign.

2. There is practically no uniformity among the societies with regard to billing forms. Some of the forms, indirectly, or even overtly, discourage physicians from joining the AMA.

(Board of Trustees — Q)

TABLE 1

SUMMARY OF AMA MEMBERSHIP FOR 1972–1975

TYPE OF MEMBERSHIP	1972	%	1973	%	1974	%	1975	%
Total Physicians in U. S.[1]	356,534		366,379		379,748		393,700	
Total AMA Membership[2]	198,645	55.7	201,769[3]	55.1	208,872	55.0	218,400	55.5
Dues Paying Regular Membership	155,861	43.7	159,344	43.5	167,374	44.1	171,900	43.7
Interns and Residents	NA		NA		5,800	1.5	6,800	1.7
Medical Student Membership	NA		NA		4,700	1.2	8,000	2.0

1. Not all physicians in the U. S. are eligible for AMA membership and percentages based on these figures should be carefully interpreted.
2. Includes special affiliate and honorary M.D. members, members who died or left the country during the year, and non-M.D. members such as osteopaths, dentists, pharmacists, etc. (1973=3351).
3. Part of the 1973 increase is due to non-M.D. student members who were not eligible for AMA membership in prior years (1973=1148).

Source: Report on the Membership of the American Medical Association as of December 31, 1974; AMA Center for Health Services Research and Development and from unpublished data.

TABLE 2

OFFICE BASED PHYSICIAN MEMBERSHIP OF AMA – 1972-1975

	1972	%	1973	%	1974	%	1975	%
Total Office Based, Patient Care Physicians	201,300		204,400		205,900		206,600	
Total Office Based AMA Members	146,300	72.7	145,800	71.3	148,000	71.9	146,600	71.0
Dues Paying Office Based AMA Members	135,000	67.1	135,700	66.4	137,700	66.9	135,400	65.5

Source: Data for these calculations were derived from "Report on the Membership of the American Medical Association as of December 31, 1974" and from unpublished data on the December 31, 1975 physician population, both prepared by the AMA Center for Health Services Research and Development.

3. The potential membership pool is not precisely known. AMA currently has difficulty identifying non-AMA members who are eligible for membership through their membership in state and county societies. This makes AMA's recruitment effort largely dependent on the success of the county and state recruitment efforts and, if local efforts are not made, AMA's hands are tied.

Progress toward solving these fundamental problems has been slow. This effort requires a program of close cooperation with the state and county societies over an extended period of time to overcome the institutional obstacles that thwart more rapid progress.

The Critical Issue Plan that addressed the membership problem during 1975 explored several approaches to more rapid progress in membership growth. The Plan presented several options for new direct membership provisions and for restructuring the federation to become truly federated in the sense that the physician's decision would be whether to join organized medicine, not what components of organized medicine to join. The Council on Long Range Planning's study of AMA's organizational structure recommended a restructured federation that would result in a more unified membership base and would strengthen the federation by "tightening" it up. The House of Delegates did not adopt the Council's proposals, but asked that the Council reconsider certain portions of its recommended new approach to organizing the federation. At the same time, a number of state medical societies have addressed the issue of unification. California recently voted to retain unified membership but is conducting a referendum on the subject. Oklahoma dropped unified and adopted a system whereby physicians can opt in or out of AMA but will have to pay the same amount of dues either way. Pennsylvania will review the question of unified membership next fall, and several other states have recently showed some interest in considering unified membership. Meanwhile, the fundamental obstacles to a more cohesive, federation-wide membership effort continue to exist. A continuing plan to address them is needed.

The AMA Internal Data Base

In today's society, information can be a major source of both influence and revenue if it is used properly. AMA has a unique informational asset in the physicians' record system and the various data bases that have been established by the Center for Health Services Research and Development, the Division of Medical Education, and others. An opportunity exists for AMA to further expand its informational capability to provide program support (e.g., in legislative campaigns), strengthen AMA's influence, and increase AMA revenue. As this program is pursued, considerations of assuring confidentiality and assuring the proper use of the information will be important.

In recent years, pressures from various sources including government, private research institutions, other health organizations, and even the federation itself, have increased for the release of AMA data. As the data base expands into new areas and as society becomes more dependent on informational resources, these pressures will increase both in volume and intensity. In the past, AMA has responded to these pressures as they have arisen. Internal operating procedures have been established to deal with data requests within the rather informal and broad AMA policies on this subject. A plan for expansion of the data base to include new areas that will be important to support future policy decisions should be developed. For example, what are the data base implications of AMA's expanded role in continuing medical education? This is just one of the areas in which the existence and use of data could be extremely important to the AMA.

(Board of Trustees – Q)

Health Services Research and Development – AMA's Role

Related to but separate from the above discussion of the AMA data base, is the question of what AMA's role should be in the rapidly expanding health services research and development arena. The number of organizations involved in health services research has increased dramatically in recent years, and the use of research in the development of legislation at the federal as well as the state level has become more significant. The federal government funds much of the research. AMA's own Center for Health Services Research and Development is one of the longer standing health services research programs, and it has developed a reputation for being a reliable source of data and analysis. The relationship between AMA's research program and those of other organizations will become increasingly important. Also, the way AMA uses its in-house research capabilities will become more important.

The implications of having an overall awareness of, and a planned approach toward, AMA research activities are potentially far-reaching. The use of research as a means of impacting on the development of legislation and regulations is, of course, one of the more important areas to be considered. In addition, AMA's relationship with other health research organizations is important so that AMA is aware of what research is being done in the field. It is also important for AMA to be aware of the research being funded by various foundations and other research funding agencies because of their impact on the kinds of research being conducted.

REPRESENTING THE PROFESSION

One of AMA's major missions is to represent the medical profession and act as a spokesman for physicians to the public, the government, industry, and others.

Two general subjects related to representing the profession are covered under this section:

1. Topics or issues on which it is important that the profession's feelings and attitudes be known and considered by Congress, the public, etc.

2. Mechanisms for communicating the profession's attitudes and opinions and maximizing their impact on decision making.

Regulation of Medicine

In the coming years, the AMA will continue to face the direct threat of legislation and other regulatory activity that interferes with the physician's responsibility to his patient. Such efforts usually interject one or more third parties into the physician-patient relationship, thereby interfering with the delivery of care and infringing on the physician's independence and self-determination as a practitioner. In previous AMA Plans, the question of increased regulatory activities was raised, and general approaches to the overall regulatory problem were addressed in Critical Issue Plans (see the Progress Report section of this Plan). Additional analysis of the regulation of medicine as a generalized problem would probably not result in significant new insights at this time. However, there are several specific regulatory issues that are currently facing AMA. These are of such importance that they should be addressed in this Plan. Since each of these specific issues is current, AMA has intense ongoing activity addressing them, including a strategic approach to overcome the immediate threat posed by each. Since several of the issues involve litigation, the specifics of the strategies cannot be widely publicized.

(Board of Trustees – Q)

These issues, however, in addition to posing very immediate threats, also have long term implications for AMA. The Critical Issue Plans that are prepared in response to these issues should focus on an analysis of the long range implications of the issues and should suggest strategies for dealing with the issues after the immediate crises are past.

HEALTH PLANNING LEGISLATION — The health planning legislation passed by the 93rd Congress is possibly the most far reaching single piece of health legislation ever enacted. It provides for a nationwide comprehensive network of planning bodies that will be active in almost all aspects of health delivery. The very nature of medical practice could be affected by the implementation of this law. This complex law has received sufficient analysis and publicity and it need not be summarized in detail in this Plan. However, some of the more disturbing implications should be mentioned:

- The Secretary of HEW has extensive powers, which, if exercised, could result in decisions that directly affect the practice of medicine.
- Most health facility construction (including some group practices or even smaller physician offices) could come under federal control.
- The law could result in the establishment of an extensive data base on health delivery over which the private sector would have no control.
- The law requires mandatory "certificate of need" legislation at the state level.
- The law emphasizes the development of certain types of medical practices (i.e., group practice; HMOs, etc.) over others.

In short, this law provides the potential for making the health delivery system a type of public utility under federal control, which could include traditional utility-type regulation. The entire nature of health delivery in the U. S. could be significantly affected.

The AMA has spoken strongly against this law — prior to its passage by Congress, prior to approval by the President, and since it has been put into the phase of regulation drafting and implementation. At the 1975 Annual Convention the House of Delegates supported "any action, including legal action," deemed appropriate in preventing implementation of the National Health Planning and Resources Development Act. The Board of Trustees has announced its intention to take legal action to challenge the constitutionality of the law at the appropriate time, and has now identified a "test case" in North Carolina. AMA will join the North Carolina State Medical Society in a suit that focuses principally on the certificate of need provisions of the law.

The Critical Issue Plan that addresses this issue should examine the long term implications of the planning act as a basis for developing the health system into a public utility. What strategies should AMA pursue to reduce the threat of further actions along this line, and what can private medicine do to demonstrate that a public utility approach is not needed?

HEALTH MANPOWER LEGISLATION – There are a number of health manpower bills pending in Congress. Together, they constitute a health policy package which, if enacted, would introduce numerous artificial constraints and pressures on the production and distribution of health manpower. Some of the legislation relates to aid to medical education directly while other legislation deals with such programs as the National Health Service Corps. Among the concepts that AMA has objected to are capitation grants conditioned on mandatory service or mandatory paybacks.

punitive payback provisions attached to scholarships, control of the number and types of residency positions, and federal licensure of physicians. These concepts were proposed in the various bills based on a perception of manpower imbalances of various types. For the long term, AMA must either find alternative, more desirable solutions or show that the imbalances do not really exist. Otherwise, even if the current objectionable manpower legislation is defeated, other similar proposals will continue to persist. This is, of course, part of the overall problem of access and availability of care, an issue discussed elsewhere in this Plan. The pressure for additional controls on health manpower could increase significantly if national health insurance is passed and there is a sudden surge of demand on the existing supply of health professionals. AMA must relieve the current pressure and then go on to anticipate the kinds of pressures that will emerge under future legislation.

MAXIMUM ALLOWABLE COST REGULATIONS — The Maximum Allowable Cost regulations which have been issued by HEW establish the basis for federal reimbursement for drugs under federal medical programs, including Medicare and Medicaid. The new regulations would establish a "maximum allowable cost" based on "actual acquisition cost plus a dispensing fee." Inherent in the regulations is an assumption of bioequivalency of drugs, a concept of questionable validity. In addition, AMA has taken exception to some of the administrative processes that have been established for implementing the regulations.

The MAC regulations constitute a new dimension in the series of actions to regulate medicine in recent years. Heretofore, regulatory attempts have been aimed primarily at establishing financial constraints or constraints on the utilization of care. These obviously can have an impact on the overall kind of care a physician delivers, but they do not directly dictate what kind of clinical decisions the physician can make. Even the aspects of PSRO that deal with clinical standards of care are left to the profession to establish. However, the MAC regulations interfere directly with the physician's clinical and therapeutic decisions by imposing decisions made by government employees on the drugs he may prescribe, based on cost considerations rather than clinical efficacy. This comes a step closer to actually dictating clinical decisions than any other program has up to this time. This implication of the MAC regulations should be examined and projected to the future. A strategy for addressing it should be developed.

FEDERAL TRADE COMMISSION'S ADVERTISING "COMPLAINT" — In December of 1975, the Federal Trade Commission issued a "complaint" charging that the portion of the AMA's Principles of Medical Ethics that prohibits "solicitation of patients" is a ban on advertising and restricts competition among physicians. Hence, it is charged that AMA is restraining trade. AMA immediately challenged the FTC's finding and is pursuing legal action through the appropriate procedures to formally challenge the complaint. AMA's policy, as stated in the Principles, is that "solicitation of patients" is unethical. However, the AMA has never considered it unethical for physicians to make known to the public, through appropriate means, their availability to see patients, office hours, etc., and AMA encourages physicians and patients to discuss fees openly.

The implications of the FTC's complaint are far reaching. At stake is the very essence of professionalism in medicine. Some of the day-to-day implications involve the effect of advertising on fraudulent misleading of the public by various quacks, the tendency to restrict the free flow of information on new procedures and other medical findings, as well as the probable increase in the cost of care to the patient as a result of the physician passing along the cost of advertising. Is the FTC's action part of an effort to eliminate "professionalism" from the professions? If so, what is the next likely step? How should the professions unite to resist this trend?

(Board of Trustees — Q)

FEDERAL TRADE COMMISSION'S CHARGES ON MEDICAL EDUCATION — In addition to its "complaint" on AMA policy on physician advertising, the Federal Trade Commission has announed that it will investigate AMA "to determine whether AMA may have illegally restrained the supply of physicians and health care services." The FTC said it would be looking into AMA activities related to:

- accreditation of medical schools and graduate programs,
- definition of fields of practice for physicians and allied health personnel, and
- limitations on forms of health care delivery inconsistent with a traditional fee-for-service approach.

No other medical organizations that participiate in accreditation and policy making in medical education were cited in the FTC's announcement. AMA has responded by citing the increasing number of medical schools and physicians and AMA's activities to increase the health manpower pool. It is interesting that at the same time AMA is being investigated by the FTC for restraining the supply of physicians and training programs, AMA has been testifying against health manpower legislation that proposes to restrict the number of residencies.

Professional Liability

Of all the issues now facing medicine, the availability of professional liability insurance at an acceptable cost is probably the most important in the minds of the members. It is an issue that presents immediate and severe problems which go to the very roots of medical practice. This issue was addressed in the 1975 AMA Plan which identified a number of specific areas that needed to be addressed, including pain and suffering and punitive damages, duplication of payments, windfall recoveries, ceilings on damages, statutes of limitations, contingency fees, Ad Damnum clauses, guarantees of medical results, the principle of Res Ipsa Loquitur, informed consent, and counterclaim for abuse of process. The Plan went on to conclude that "... These specific concerns will require fundamental changes in the present tort system as it applies to professional liability. Obviously, these are long-term undertakings, and any immediate relief to the current crisis will be stop-gap in nature. Hence, at the same time that short-term solutions to the immediate crisis are being pursued and implemented, the Association will also be working on a longer term, more permanent solution to the problem."

During 1975, AMA took significant action to alleviate this problem. Some progress was achieved, but this remains one of the most serious problems facing medicine. During 1975, AMA conducted practically continuous liaison with representatives of the insurance industry, developed model legislation for use at the state level (which was used as the basis for successful legislation in a number of states), and established the corporate base for the AMA "reinsurance corporation" which is in the process of becoming operative as enough states have established their own "captive" insurance companies. At the same time, AMA has worked with the states so that as more and more of them contemplate their own captive insurance companies, the pitfalls and mistakes of earlier state efforts can be avoided. All of this was within a Three-Point Action Plan which the Board adopted in January 1975 calling for a program to:

1. Meet the immediate short-term need of insurance availability at reasonable cost.
2. Make necessary changes to improve the tort system and the underwriting climate in the states.

3. Begin developing long-range solutions designed to alter the present tort liability-indemnity system.

The emphasis of this three-point program is on reform of the tort system and other fundamental causes of the professional liability problem at the state level rather than on insurance mechanisms. AMA does not see insurance per se as the answer to this problem.

A multi-dimensional strategy exists for eventually achieving a solution to this problem and that strategy is being pursued on an intensive basis. However, since the professional liability problem is of such critical importance to the profession, both now and for the future, it has been included in this Plan. The strategy will be continuously evaluated and refined as the problem itself takes on new complexions over time.

Public Relations

A full and fair analysis of AMA public relations is not a simple proposition because individual attitudes are riddled with so many contradictions. There is, for example, resentment over unpredictable and unwanted medical bills, yet demand for only the best when services are needed. People accept a romanticized picture of the physician (Marcus Welby, et al.), but they are jealous of his income. High regard for physician training and altruism coexists with resistance to his views on how care might best be organized. There is an expectation of surgical miracles, but a predisposition to sue for malpractice when they are not delivered. The public bemoans rising costs, yet displays little willingness to make individual health decisions that would reduce them.

There are, demonstrably, many dualities. But when the question is considered as a whole, the public perception of the AMA (or organized medicine) is obvious: the AMA stands out as an entity opposed to social change in an era characterized by almost unrelieved enthusiasm for social change. Only twice since 1930 has the national Congress been a Republican Congress. The other 21 have been dedicated, in varying degrees, to the social changes embodied in the New Deal, the Fair Deal, the New Frontier and the Great Society. In this context, the AMA is viewed negatively, right along with other organizations which swim against the popular tide: business organizations, the Bar Association and the Republican Party.

The image of physicians, the AMA, organized medicine — the terms are synonymous - could be reversed overnight by a deep and fundamental policy change. The AMA could, for example, do what the National Education Association did: convert itself from a professional association dedicated to the maintenance of professional standards, incorporate as a union, and jump into the mainstream of popularly perceived social "progress." Such a course obviously must be rejected, for it represents the convictions of only a small minority of American physicians. While it might erase the AMA's negative image, such a policy change would have little emotional appeal for a profession that seems to say, "We'd rather do the right thing than be popular."

Fortunately, such a policy change is not the only course open to the AMA. The AMA can gain public respect and wider public support with this three-pronged public relations policy:

1. INTERNAL. Physicians generally do well in handling patient relations. But many of them do not, and many of them — even doctors with high awareness of patient relations — ignore the petty annoyances that are not one bit petty to the worried, sometimes terrified patient. Physicians have to come across to the public as universally compassionate men and women. The public demands more responsiveness. When it is not forthcoming - in a reception room, during a phone call at

night or a request for an appointment, in a clinic or hospital bureaucracy — the physician's image suffers lasting damage, even though the medical care provided may be of the highest caliber. Many physicians individually have much to learn about public relations.

2. EXTERNAL. Today's public places great emphasis on public responsibilities. From its institutions, the public expects much that is "pro bono publico." Recent Board of Trustees discussions have focused on this point, and more actions, such as that proposed on TV violence, are highly desirable.

   At the same time, the AMA must continue to participate vigorously in the public dialogue that surrounds health care issues. It must keep the data and the logic honest. Through speeches, interviews, publications and Congressional testimony, the AMA can contribute constructively to the consensus-making process that shapes public policy. This has been the focus of AMA public relations efforts in recent years.

3. POLICY. In the formulation of policy by the House of Delegates, greater emphasis should be placed on the concept of a social contract between the medical profession and the public. The public expects, in return for the financing it provides for the education of physicians, a response to public demands. If these are not met voluntarily, then the public will demand they be met by law. Among these: stronger, more effective self-discipline within the profession; a more equitable distribution of physician services; a more vigorous effort to restrain rising costs; the continued maintenance of quality.

Above all, the public expects a leadership role, a definition of health priorities for future development. Americans like to see things improve. Every generation expects to live better and longer than the last. More and more, the public turns to its institutions and asks, "What are you going to do, or more precisely, what are you doing, to make this a better country for my children?" An AMA document, a blueprint for future health policy, is urgently needed.

Despite all the negatives, the public does look to the profession for guidance. And it urgently asks, "What does the medical profession itself think should be done?"

ASSURING QUALITY

A fundamental mission of AMA is to assure the quality of medical care. AMA was originally founded for this very purpose. AMA activities that work toward assuring the quality of care fall under almost all of the six missions in some form. The specific activities and issues discussed under the mission heading of Assuring Quality relate directly to assuring that health professionals are well trained and continue to keep up with their profession, concern the elimination of quackery, and pertain to the development of standards for the actual delivery of care and the monitoring of medical care delivery against such standards through appropriate mechanisms. Prior AMA Plans and Critical Issue Plans have emphasized the Association's activities in medical education. The issue that was singled out for special treatment in the 1976 planning cycle is related to medical education but has implications far beyond medical education per se.

Certification and Licensure

Licensure is the major institutional mechanism for guaranteeing to the public and the profession that medical practitioners are qualified. The fact that a physician is licensed to practice medicine indicates that he has completed a formal education program, has received some practical training, and has passed an examination that gives at least some indication of his knowledge and his ability to apply it. In medicine, as in other professions, there are additional measures used by the profession and the public to indicate that individuals have mastered their profession. In medicine, board certification serves this purpose.

Of course, neither licensure nor certification guarantees that all practitioners will make the right medical decisions in all instances. Medicine is an inexact science, and it is an art as well as a science. Concern has increased in recent years over the extent to which medical licenses and certification certificates are adequate assurance of competence. Medicine is perhaps the most dramatic example of what modern science and technology can do. Many techniques, drugs and medical appliances used routinely today did not exist as little as ten years ago. What does a license or certificate dating back to 1950 or before mean in today's medical environment? This question has been raised with increasing frequency in recent years. The implications are far-reaching.

AMA has participated in the profession's response to the challenge. One of the major answers is continuing medical education, including mechanisms that accredit continuing education programs to assure that they are sound, as well as mechanisms to record and recognize individual physician's efforts to maintain and increase competence through continuing education. The most recent development is the formalization of relicensure and recertification. In 1974, the first recertification examination was given by the American Board of Internal Medicine. Of 3,300 who took the exam all but 150 passed. The American Board of Family Practice is the first to issue certificates with fixed expiration dates, requiring recertification every six years. Currently, there are twelve state medical associations and six specialty organizations that have compulsory continuing education requirements for membership. In 1947, the American Academy of Family Physicians (then AAGP) became the first specialty society to require participation in CME as a formal requirement for membership. In 1967, Oregon became the first state medical association to do so. In 1971, New Mexico became the first state to set formal CME requirements for license renewal. Since then, nine additional states have either established CME requirements for relicensure or have passed legislation that allows for such action to be taken. None has yet required re-examination for renewal of medical licenses.

This subject obviously has far-reaching implications for AMA. They should be thoroughly explored and a long range strategy should be fashioned from the analysis. This one subject is so multi-faceted and complex that it has been singled out as the only topic to be addressed under the mission of Assuring Quality during 1976.

PROMOTING THE EFFECTIVE DELIVERY OF CARE

The 1975 AMA Plan pointed out that "...many of the major issues facing medicine in the next decade, as in the past several decades, relate to the delivery of medical care and the various aspects of the delivery system. Most of the issues are complex and do not lend themselves to simple solutions. AMA's activities in relation to these issues generally involve multi-divisional and multi-committee efforts. Recent statutes and legislative proposals have set the stage for considerable activity on health delivery issues during the next decade, and there are numerous problems and opportunities facing AMA in relation to them."

(Board of Trustees — Q)

The Plan went on to discuss three specific issues, two of which deserve continuing attention through strategic planning.

Access and Availability of Care

Three major related aspects of the problem of access and availability of care may be identified:

- Health manpower
- Health care financing
- Organization of medical care delivery

Together, these constitute a framework for looking at the problem. The three components of the problem are often confused. For example, proposed approaches to the financing of care, such as national health insurance, are often confused with proposed solutions to the organizational aspects of the problem, such as a national health service. The two concepts are very different and should not be used synonymously. An analogy may be drawn between the three parts of this issue and the three part goal of U. S. economic policy since 1946: stable prices, high employment, and a stable rate of economic growth. Solutions to one part of the problem tend to exacerbate one or both of the others. Efforts to stabilize prices tend to result in higher than desirable levels of employment and vice versa. Similarly, solutions to the financial obstacles to medical care tend to aggravate the health manpower problem, as happened with Medicare.

Currently, there are federal legislative programs aimed at two of the three aspects of the overall problem. The various health manpower bills before Congress were discussed in a previous section of this Plan (see Regulation of Medicine). National health insurance is, of course, the major approach that is currently being pursued toward alleviating financial obstacles to access to medical care.

The third facet of the problem, organization of medical care delivery, has been addressed in legislation that has already passed: the health planning legislation of the last session of Congress (also discussed under Regulation of Medicine elsewhere in this Plan). Discussions of this subject usually tend to assume away certain basic realities. For example, it must be recognized that no matter how sophisticated medical technology becomes, medical care is still basically a personal service. In today's society, all personal services are costly, especially when they involve professionals who require the level of training needed to practice modern medicine. Often, analyses of complex topics such as the access and availability of care get caught up in the complexities of the medical education system and the various financing mechanisms, and lose sight of the nature of the problem being addressed.

It is not likely that a single strategy is going to provide the AMA with appropriate direction for addressing this issue. However, an understanding of the relationships between the various strategies will be essential. The pursuit of a series of strategies should take place within that realization. Since there will always be areas where additional medical resources could be used, this issue is long term in nature. However, there may be considerable focus on particular aspects of this issue in the several years immediately following implementation of NHI. As is the case with most issues, the federal government will be involved. In this instance, state governments will also play a role through their licensing functions. Specialty societies are intimately involved in the question of distribution by specialty, as are the AHA and JCAH. In questions regarding the

overall production of health manpower, the entire medical education complex will be involved. The specific solutions proposed for access/availability problems may spill over to many other issues: certification and licensure; various issues related to medical education; legal questions related to the use of allied health personnel and the liability of physician supervisors, and the whole topic of foreign medical graduates, just to name a few.

Physician-Hospital Relations

The 1975 AMA Plan presented a summary analysis of this issue. Since this was not specifically addressed in any of the Critical Issue Plans during 1975, the need for a strategy still exists. This issue centers around complex and difficult questions regarding the appropriate roles, responsibilities, liability and authority of the hospital and its medical staff. Other aspects of the issue relate to the distinction between the educational and patient care aspects of housestaff activities, hospital liability for medical staff actions, relationships between hospitals and physicians on salary or with other contractual patient care relations, the role of hospital directors of medical education; and the role of full-time program directors and chiefs of staff. There are other aspects of this issue in which the medical profession has an interest, such as the use of hospitals by chiropractors. Since physician involvement in these matters is often through the hospital medical staff, the relationship between organized medicine (at the local, state and national levels) and the medical staff will affect the solution to specific problems. Solutions to such problems are best when worked out at the local level.

This appears to be primarily a long term problem at this time. Although there are a number of currently active "cases" in this area, they do not appear likely to precipitate a crisis which cannot be handled at least on a temporary basis until more fundamental solutions can be developed. However, under NHI and other governmental health programs, this issue could "heat up" very quickly, and the government could enter such jurisdictional disputes as an interested third party. Hence, there is a substantial unknown timing element in this issue. Currently, most aspects of this issue remain in the private sector and are being addressed by representatives of the medical profession and the hospital industry. If these issues can be kept from developing into crises, the participation of unwanted third parties may be avoided.

SCIENTIFIC SERVICE TO PHYSICIANS

AMA provides many scientific services to physicians, both members and non-members. This activity is primarily directed toward providing information to help keep the physician informed and up-to-date in his profession. The major vehicles for accomplishing this are the AMA journals, public statements, and special reports issued by AMA.

Continuing Medical Education

There is a shift in emphasis taking place in the arena of providing scientific information to physicians. With the increased emphasis on continuing medical education in recent years, and in light of the trends mentioned under the discussion of certification and licensure earlier in this Plan, the provision of scientific information is becoming more and more important. The specific context within which this subject will be pursued in the future is continuing medical education. The entire discussion of this mission in the 1976 AMA Plan is therefore devoted to the subject of continuing medical education.

Two major aspects of AMA activity in continuing medical education were discussed in the 1975 AMA Plan:

1. Accreditation of continuing medical education programs and AMA policy on continuing medical education

2. The actual offering of continuing education courses

A strong case was presented in a Critical Issue Plan for aggressive involvement by the AMA in offering continuing education opportunities for physicians. An expanded program for the Council on Scientific Assembly was suggested. The intensified program was approved, and the 1976 budget contains an increased appropriation for this purpose. The new series of regional continuing education programs was initiated during the year. So far, these regional programs have been very successful. They have been well attended, and reactions to the sessions have been very favorable. It would seem appropriate during 1976 that a specific strategy be developed to further define the nature of AMA's increased involvement in continuing education. What "market" is AMA going to appeal to with its program? How will AMA coordinate its activities with those of the specialty societies? How extensive a program is envisioned for the future? These strategic questions need answers.

The role of AMA in accrediting continuing medical education programs was addressed in the 1975 AMA Plan but not in a Critical Issue Plan. The 1975 AMA Plan pointed out that AMA is currently involved in the accreditation of institutions offering continuing education programs. However, in the future, accreditation of institutions may not be sufficient. It may be necessary to accredit specific departments within institutions and even specific continuing education programs. While this would be an immense task, the central importance of continuing education in the future may very well warrant such activity.

This issue has not been addressed in a strategic context. A 1976 Critical Issue Plan should address it. In addition, the question of which specific areas within the continuing education arena will require AMA policy needs to be anticipated. Currently, the AMA Council on Medical Education and the Liaison Committee on Continuing Education (of the Coordinating Council on Medical Education) are the principal bodies working in this area.

DIRECT SERVICE TO THE PUBLIC

As has been pointed out in numerous previous planning documents, AMA's primary service to the public is indirect. Such activities as those discussed under Assuring Quality and Promoting the Effective Delivery of Care produce benefits that ultimately accrue to the public. Such benefits, however, accrue to the public primarily through the medical profession rather than directly from the AMA.

There are, however, several important AMA programs that are aimed directly at the public. They are primarily in the area of providing health education information. This activity covers a broad range of topics, from foods and nutrition to cutaneous health and cosmetics and health career information for young people. These activities generally do not produce major issues for AMA for which strategic solutions are needed.

that the Board of Otolaryngology, the Conjoint Board and the Council on Medical Education should consider ways in which this might be done. Possible actions could be an expanded statement on education in allergy in the Essentials and greater consideration of the content of experience in allergy in residency programs by the Residency Review Committee for Otolaryngology.

In the light of the foregoing discussion, the Ad Hoc Liaison Committee recommends, and the Board concurs, that:

1. The American Board of Allergy and Immunology, a Conjoint Board of the American Board of Internal Medicine and the American Board of Pediatrics, continue to use the complete name of the Board at all times;

2. Discussions between the Conjoint Board and the American Board of Otolaryngology which have been initiated be encouraged to continue in an effort to develop a mechanism for appropriate recognition in the field of allergy for diplomates of the American Board of Otolaryngology;

3. The AMA reaffirm strongly and publicize widely to state and county medical societies, to specialty societies, to specialty boards, to government agencies, to medical foundations and to third party payers the principles contained in this report relating to the rights of physicians to practice in special fields of medicine and to be compensated for their services;

4. The Council on Medical Service be asked to investigate the problems which certain physicians have encountered in requesting compensation for services provided in the care of allergic patients, and to make recommendations concerning those problems; and

5. The Council on Medical Education be requested to consider, with the Conjoint Board and the American Board of Otolaryngology, the possibility of strengthening education in allergy in otolaryngology residencies.

X. AMA LIFETIME MEMBERSHIP
(RESOLUTION 94, A-75)
(Reference Committee F, page 380)

HOUSE ACTION: ADOPTED

Resolution 94 (A-75), adopted by the House of Delegates, recommended study of the feasibility of lifetime membership in the AMA on a reasonable actuarial basis and, if lifetime membership proved to be feasible, requested submission of possible Bylaw amendments to effectuate such a program.

During consideration of this matter, state medical associations and specialty societies were contacted to determine their lifetime membership provisions, if any. It was found that only two specialty societies have a lifetime provision: the American College of Physicians has 5,000 life fellows (approximately 150 physicians annually join this membership category), and the College of American Pathologists has 18 life fellows (the CAP requires that a physician be a member for five years before his request for lifetime membership can be considered by the College Board of

Governors). Other societies previously offering lifetime membership were the American College of Radiology and the American College of Surgeons. Both dropped this provision a few years ago because of possible future dues increases and because most physicians found the lump sum payment difficult to meet.

The Board also found that there are complications inherent in such membership if a physician were to resign from state society membership since the basic requirement for AMA membership under the Federation concept is membership in the state medical association. This concept was recently reaffirmed by the House of Delegates.

In addition, assuming that an equitable lump-sum payment could be calculated, the question of refunds would arise if a physician were to resign his lifetime membership or if he did not fulfill the continuing medical education requirements of a state association or specialty society.

It is the conclusion of the Board, therefore, that implementation of an AMA lifetime membership program would not be a wise expenditure of time, effort and funds, and it recommends that such membership not be established.

Y. STERILIZATION PROCEDURE REGULATIONS (SUBSTITUTE RESOLUTION 15, C-75) (Reference Committee E, page 369)

HOUSE ACTION: FILED

At the 1975 Clinical Convention, the House of Delegates adopted Substitute Resolution 15, as follows:

> RESOLVED, That the American Medical Association reaffirm its position adopted at the 1975 Annual Convention that the Secretary of Health, Education, and Welfare be requested "to amend regulations entitled 'Special Requirements Applicable to Sterilization Procedures' governing state plans under Titles IV-A, VI and XIX of the Social Security Act to permit more expeditious, economical and flexible management of voluntary sterilization procedures"; and be it further
>
> RESOLVED, That an advisory committee comprised of practicing physicians in the appropriate specialties be appointed by the American Medical Association to meet and discuss with the United States Department of Health, Education, and Welfare the redrafting of more realistic and reasonable regulations applicable to sterilization procedures in federally assisted family planning projects and Medicaid programs.

Although the resolution speaks of appointing an advisory committee to discuss this matter with Department of HEW officials, the Board has requested the Council on Medical Service (a Committee of practicing physicians) to seek the needed changes. The Council has a long-established liaison with HEW, including those responsible for Medicaid, and can follow through on this matter expeditiously, calling on medical specialty society involvement as appropriate.

The Board has been advised that the Council on Medical Service will report to the House of Delegates at a future date on its efforts to secure amendments making the controlling regulations more realistic and reasonable.

REPORTS OF JUDICIAL COUNCIL

The following Report was presented by Henry I. Fineberg, M. D., Chairman:

A. NOMINATIONS FOR AFFILIATE MEMBERSHIP IN THE AMA

HOUSE ACTION: ADOPTED

The Judicial Council recommends the following named individuals for Affiliate Membership in the American Medical Association:

NATIONAL MEDICAL SOCIETIES

Louis Armand Aube, M. D.
Chatham, New Brunswick, Canada

Christoph Ying-Wai Yung, M. D.
Montreal, Quebec, Canada

U. S. PHYSICIANS IN FOREIGN COUNTRIES

Alan Gary Gordon, M. D.
Dovrados MT, Brazil

Albert Green, M. D.
Dakar, Senegal

Marlene Elizabeth Long, M. D.
Papua, New Guinea

Roger Grant Thorpe, M. D.
Gemena, Republic of Zaire

Carlyle D. Welch, M. D.
Taipai, Taiwan, Republic of China

William Thomas Kent, M. D.
San Jose, Costa Rica

INDIVIDUALS WHO HAVE ACHIEVED DISTINCTION IN THEIR FIELDS OF ENDEAVOR

Marcia S. Ellwood, Ph. D.
Beverly Hills, California

Ben O. White, Jr.
San Antonio, Texas

REPORTS OF COUNCIL ON CONSTITUTION AND BYLAWS

The following Reports, A—H, were presented by Carroll L. Witten, M. D., Chairman:

A. OFFICE OF VICE PRESIDENT

(Reference Committee on Amendments to Constitution and Bylaws, page 321)

HOUSE ACTION: POSTPONED until the Opening Session of the House of Delegates at the 1976 Clinical Convention

At the 1975 Clinical Meeting, the House of Delegates adopted a modified form of Recommendations No. 10 and No. 11 of Report B of the Council on Long Range Planning and Development. In substance these recommendations were to abolish the office of Vice President and to provide that the President-Elect succeed to the office of President in the event of the death,

B. INDEPENDENCE OF FUNCTION
(Reference Committee on Amendments to Constitution and Bylaws, page 321)

HOUSE ACTION: ADOPTED AS FOLLOWS AND THE BYLAWS AMENDED ACCORDINGLY:

In the course of its constant study and review of the Constitution and Bylaws of the Association, the Council has concluded that it has always been the intention of the membership to have the organization structured generally along the lines of a federation concept with a separation and independence of function for the Executive, Legislative and Judicial branches of the organization. This basic separation of functions is important enough to place under close scrutiny. The Bylaws do not contain any provision enforcing this separation, but through the years it has usually been voluntarily observed.

The Council has discussed this matter with many people, including members of the Board of Trustees, officers of the Association, members of the Judicial Council and all of the living past Chairmen of the Judicial Council. It is with their concurrence that the Council proposes the amendments to the Bylaws set forth below.

These amendments provide that a member of the Board of Trustees must resign as a delegate or alternate delegate and as a member of any standing committee of the AMA upon his election to the Board. Thus, when elected to a position in the Executive branch of the Association, he must relinquish any positions held in the Legislative branch (House of Delegates) or the Judicial branch (Judicial Council). These amendments would not prevent members of the Board of Trustees from serving on any committee created by the Board under authority granted to the Board in Chapter XVII, Section 4, of the Bylaws. Also, these amendments would not prevent members of the Board of Trustees from serving on any Council or Committee when specifically provided for in the Bylaws.

These amendments also provide that a member of the Judicial Council must resign as a delegate or alternate delegate upon election to the Judicial Council, and while serving on the Judicial Council a member shall not also serve as a General Officer of the Association or a member of any other council or committee. Thus, when elected to a position in the Judicial branch of the Association, a member must relinquish any positions held in the Executive branch (General Officer) or the Legislative branch (House of Delegates).

The Council recommends an amendment by addition to Chapter XVII — Board of Trustees, Section 1. — Composition, as follows:

> Voting members of the Board of Trustees shall resign all other positions held by them in the Association upon their election to the Board of Trustees. No person, while serving as a Voting member of the Board of Trustees, shall be a delegate or an alternate delegate to the House of Delegates. Members of the Board of Trustees may serve on Councils or Committees when specifically provided for in the Bylaws.

The Council further recommends an amendment by addition to Chapter XI — Standing Committees (Councils) of the House of Delegates, Section 2 (D) Membership (Judicial Council):

Members elected to the Judicial Council shall resign all other positions held by them in the Association upon their election to the Judicial Council. No member, while serving on the Judicial Council, shall be a delegate or an alternate delegate to the House of Delegates, nor a General Officer of the Association, nor serve on any other council or committee of the American Medical Association.

This provision shall not apply to any member serving on the Judicial Council as of 1 July 1976. (This provision shall automatically be removed from the Bylaws at the conclusion of the 1986 Annual Meeting.)

C. REVISION OF BYLAWS
(Reference Committee on Amendments to Constitution and Bylaws, page 322)

HOUSE ACTION: FILED

Due to other matters assigned to the Council which have necessarily taken precedence, the time for completion of the revisions of the Bylaws has been extended. Certain matters which are to be incorporated in the complete revision of the Bylaws are therefore delayed. This report is for the information of the House.

D. RESTRUCTURING OF INTERN AND RESIDENT BUSINESS SESSION
(Reference Committee on Amendments to Constitution and Bylaws, page 322)

HOUSE ACTION: ADOPTED AND THE BYLAWS AMENDED ACCORDINGLY

At the 1974 Clinical Convention, the House of Delegates adopted Substitute Resolution 65, which provided in part as follows:

> RESOLVED, That the Council on Constitution and Bylaws be directed to develop in consultation with the appropriate Councils and Committees of the House of Delegates and the Board of Trustees recommendations for the most appropriate mechanisms by which intern and resident members may more effectively participate in the activities of AMA.

At the 1975 Annual Meeting, Council on Constitution and Bylaws Report E covered two major subjects: (1) Membership opportunities for Interns and Residents and (2) the election of officers to the Intern and Resident Business Session.

With reference to the former, the Council urged that Interns and Residents be provided with full membership opportunities and programs at all levels of the federation. Furthermore, Report G (A-75) of the Council contained Model Membership Bylaw provisions which, in part, were designed to provide full membership opportunities for Interns and Residents. Report G (A-75) was approved, and at the direction of the House was distributed to all state medical associations for use as guidelines.

With reference to the second subject of the Council's Report E (A-75), the Council noted that officers are elected at the business meeting prior to the Clinical Convention upon nomination from the floor. Thus, only those who attend the meeting have a vote in the election of officers. The Council also reported that Housestaff was dissatisfied with this method of election because it was not representative of the membership. The Council concluded its report by stating that it agreed with Housestaff on this point and would pursue the matter further.

F. AMA COUNCILS
(Reference Committee on Amendments to Constitution and Bylaws, page 315)

HOUSE ACTION: ADOPTED AS FOLLOWS:

The Council met in Special Session on May 20-22, 1976 to receive and review Report A of the Board of Trustees (A-76) and transmits this report accordingly.

CHAPTER X — COMMITTEES OF THE HOUSE OF DELEGATES

Section 1. Classification

The following classes of committees are hereby provided:

~~(A) Standing Committees (Councils)~~
~~(B)~~ (A) Reference Committees
~~(C)~~ (B) Convention Committees and Special Committees

Section 2. Qualifications of Members

Any Active member is eligible to serve ~~on a standing or~~ on a special committee ...

* * *

~~Section 4. Interim Vacancies~~

~~In case a vacancy occurs in a Standing Committee between conventions of the House, the officer or body which made the original nomination to the House may appoint an eligible member to fill the vacancy until the next convention at which time the House shall elect an eligible person for the unexpired portion of the term.~~

~~CHAPTER XI — STANDING COMMITTEES (COUNCILS) OF THE HOUSE OF DELEGATES~~

NOTE: The provisions of this Chapter are deleted in full. The text is not reproduced here because of its length. However, the provisions which replace this text are found under new Chapter XIII below.

~~CHAPTER XII~~ — CHAPTER XI — REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES

* * *

~~CHAPTER XIII~~ — CHAPTER XII — CONVENTION COMMITTEES AND SPECIAL COMMITTEES OF THE HOUSE OF DELEGATES

* * *

CHAPTER XIII — COUNCILS OF THE AMA

NOTE: The Provisions of this Chapter are completely new. These provisions replace those deleted from old Chapter XI.

Section 1. Council on Constitution and Bylaws

(A) Charge. The functions of the Council on Constitution and Bylaws shall be:

To serve as a fact-finding and advisory committee on matters pertaining to the Constitution and Bylaws. The Council will recommend such changes in the Constitution and Bylaws as may be appropriate for action by the House of Delegates.

(B) Membership: The Council on Constitution and Bylaws shall consist of six Active members. The members of the Council shall be elected by the House of Delegates. The Board of Trustees shall nominate two or more eligible members for each vacancy on the Council, and further nominations may be made from the floor of the House of Delegates. In addition, the President, a member of the Board of Trustees selected by the Board, the Speaker and Vice Speaker of the House of Delegates, and a Resident member appointed by the Board of Trustees shall be ex-officio members of the Council on Constitution and Bylaws without the right to vote.

(C) Term of Service: Voting members of the Council on Constitution and Bylaws shall be elected by the House of Delegates for terms of three years, so arranged that at each Annual Convention the term of two members expire.

(D) Tenure. Members of the Council on Constitution and Bylaws shall serve for no more than three terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless he has served two or more years.

(E) Vacancies: Any vacancy occurring on the Council shall be filled at the next meeting of the House of Delegates. The new member shall be elected by the House of Delegates for the remainder of the unexpired term.

(F) Implementation: In order to implement the transition from five members being elected for five year terms to six members being elected for three year terms, a member shall be elected to the new position on the Council at the 1976 Annual Convention, for a two year term. In addition, for each of the five existing positions on the Council, upon expiration of the existing five year term the incumbent shall be eligible for election to one additional three year term. (This provision shall automatically be removed from the Bylaws at the 1980 Annual Meeting.)

Section 2. Council on Medical Education

(A) Charge: The functions of the Council on Medical Education shall be:

(1) To study and evaluate all phases of medical education, including the development of programs approved by the House of Delegates for the provision of a continuing supply of well-qualified physicians to meet the medical manpower needs of the public;

(2) To study and evaluate health manpower and education needs in the allied health professions and services, including the development of programs approved by the House of Delegates, to ensure the provision of a continuing supply of well-qualified allied health personnel;

(3) To review and recommend sound policies for medical and allied health education, whereby the AMA may provide the highest educational service to both the public and the profession;

(4) To consider and recommend the means by which the AMA may, on behalf of the public and the medical profession at-large, continue to provide information, leadership and direction to the existing inter-organizational bodies dealing with medical and allied health education;

(5) To consider and recommend the means and methods whereby physicians and allied health personnel may be assisted in maintaining their professional competence and the development of means and methods for recognition of such achievement.

(B) Membership: The Council on Medical Education shall consist of eleven Active members, at least one of whom shall be a private practitioner of medicine who is not a salaried faculty member of a medical school, and one of whom shall be a Resident. In addition, a medical student member of AMA shall serve on the Council as a non-voting member, upon appointment by the Governing Council of the AMA Student Business Session with the concurrence of the Board of Trustees. The voting members of the Council shall be elected by the House of Delegates. The Board of Trustees shall nominate two or more eligible members for each vacancy on the Council, and further nominations may be made from the floor of the House of Delegates.

(C) Term of Service: Voting members of the Council on Medical Education shall be elected by the House of Delegates for terms of three years, so arranged that at two annual conventions the terms of four members shall expire and at one annual convention the terms of three members shall expire, provided that if the Resident member ceases to be in an approved training program at any time prior to the expiration of the term for which he or she was elected, the service of such Resident member on the Council shall thereupon terminate and the position shall be declared vacant.

(D) Tenure: Members of the Council on Medical Education shall serve for no more than three terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless he has served two or more years.

(E) Vacancies: Any vacancy occurring on the Council shall be filled at the next meeting of the House of Delegates. The new member shall be elected by the House of Delegates for the remainder of the unexpired term.

Section 3. Council on Medical Service

(A) Charge: The functions of the Council on Medical Service shall be:

(1) To study and evaluate the social and economic aspects of medical care; and, on behalf of the public and the profession, to suggest means for the timely development of services in a changing socio-economic environment;

(2) To investigate social and economic factors influencing the practice of medicine;

(3) To inform state associations, component societies and National Medical Specialty Societies through their respective Section Councils of changing conditions and anticipated proposals that would affect medical care;

(4) To assist medical service committees established by state associations, component societies of the American Medical Association, and National Medical Specialty Societies through their respective Section Councils.

(B) Membership: The Council on Medical Service shall consist of eleven Active members, one of whom shall be a Resident. In addition, a medical student member of AMA shall serve on the Council as a non-voting member, upon appointment by the Governing Council of the AMA Student Business Session with the concurrence of the Board of Trustees. The voting members of the Council shall be elected by the House of Delegates. The Board of Trustees shall nominate two or more eligible members for each vacancy on the Council, and further nominations may be made from the floor of the House of Delegates.

(C) Term of Service: Voting members of the Council on Medical Service shall be elected by the House of Delegates for terms of three years, so arranged that at two annual conventions the terms of four members shall expire and at one annual convention the terms of three members shall expire, provided that if the Resident member ceases to be in an approved training program at any time prior to the expiration of the term for which he or she was elected, the service of such Resident member on the Council shall thereupon terminate and the position shall be declared vacant.

(D) Tenure: Members of the Council on Medical Service shall serve for no more than three terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless he has served two or more years.

(E) Vacancies: Any vacancy occurring on the Council shall be filled at the next meeting of the House of Delegates. The new member shall be elected by the House of Delegates for the remainder of the unexpired term.

(F) Implementation: In order to implement the increase in the size of the Council on Medical Service from ten members to eleven members, a member shall be elected to the new position on the Council at the 1976 annual convention, to serve for a full three year term. (This provision shall automatically be removed from the Bylaws at the 1977 annual meeting.)

Section 4. Judicial Council

(A) Charge: The functions of the Judicial Council shall be:

(1) To serve as the judicial authority of the Association. The decisions of the Judicial Council shall be final.

(2) To have original jurisdiction in: (a) all questions involving membership as provided in Division One, Chapter I, Section 1, of the Bylaws, (b) all controversies arising under this Constitution and Bylaws and under the Principles of Medical Ethics to which the American Medical Association is a party, (c) controversies between two or more state

associations or their members and between a state association and a component society or societies of another state association or associations or their members, (d) the establishment of principles and interpretation of medical ethics, and (e) the interpretation of the Constitution, Bylaws and rules of the Association.

(3) To have appellate jurisdiction in questions of law and procedure but not of fact in all cases which arise between a state association and one or more of its component societies, between component societies of the same state association, between a member or members and the component society to which said member or members belong or between members of different component societies of the same state association. Notice of appeal shall be filed with the Judicial Council within thirty (30) days of the date of the decision by the state association and the appeal shall be perfected within sixty (60) days thereof; provided however that the Judicial Council, for what it considers good and sufficient cause, may grant an additional thirty (30) days for perfecting the appeal.

(4) To receive appeals filed by applicants who allege that they, because of color, creed, race, religion or ethnic origin, have been unfairly denied membership in a component and/or constituent association, to determine the facts in the case, and to report the findings to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure, or, in the event of repeated violations, recommend to the House of Delegates that the state association involved be declared to be no longer a constituent member of the American Medical Association.

(5) To investigate general ethical conditions and all matters pertaining to the relations of physicians to one another or to the public, and make recommendations to the House of Delegates or the state associations.

(6) To request the President to appoint investigating juries to which it may refer complaints or evidences of unethical conduct which in its judgment are of greater than local concern. Such investigating juries, if probable cause for action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against the accused before the Judicial Council in the name and on behalf of the American Medical Association. The Council may acquit, admonish, suspend or expel the accused.

(7) To approve applications and nominate candidates for affiliate membership as otherwise provided for in these Bylaws.

(B) Membership: The Judicial Council shall consist of five Active members. The members of the Council shall be elected by the House of Delegates on nomination by the President.

(C) Term of Service: Members of the Judicial Council shall be elected by the House of Delegates for terms of five years, so arranged that at each annual convention the term of one member expires.

(D) Tenure: Members of the Judicial Council shall serve for no more than two terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless he has served three or more years.

(E) Vacancies: Any vacancy occurring on the Judicial Council shall be filled at the next meeting of the House of Delegates. The new member shall be elected by the House of Delegates, on nomination by the President, for the remainder of the unexpired term.

Section 5. Council on Long Range Planning and Development

(A) Charge: The functions of the Council on Long Range Planning and Development shall be:

(1) To study and make recommendations concerning the long-range objectives of the Association;

(2) To study and make recommendations concerning the projected resources, programs, and organizational structure by which the Association attempts to reach its long-range objectives in (1) above;

(3) To serve as a focal point for the planning activities of the Association and to stimulate and evaluate planning activities throughout the organization;

(4) To study, or cause to be studied, the future environment in which medicine and the Association must function, collect relevant data and transmit interpretations of these studies and data to the Board of Trustees for distribution to decision-making centers throughout the Association, and submit reports to the House of Delegates at appropriate times.

(B) Membership: The Council on Long Range Planning and Development shall consist of ten Active members. Five members of the Council shall be appointed by the Speaker of the House of Delegates as follows: two members shall be appointed from the membership of the House of Delegates, two members hall be appointed from the AMA membership at large and one member appointed shall be a Resident. Four members of the Council shall be appointed by the Board of Trustees as follows: two members shall be appointed from the membership of the Board of Trustees and two members shall be appointed from the AMA membership at large. One member appointed shall be a medical student member of AMA appointed by the Governing Council of the AMA Student Business Session with the concurrence of the Board of Trustees.

(C) Term of Service: Members of the Council on Long Range Planning and Development shall be appointed for terms of three years beginning on July 1 and so arranged that in each of two years the terms of three members shall expire and in the third year the terms of four members shall expire, provided that if the Resident member ceases to be in an approved training program at any time prior to the expiration of the term for which he or she was appointed, the service of such Resident member on the Council shall thereupon terminate and the position shall be declared vacant; and provided further that if the medical student member ceases to be enrolled in an approved medical school at any time prior to the expiration of the term for which he or she was appointed, the service of such medical student member on the Council shall thereupon terminate and the position shall be declared vacant.

(D) Tenure: Members of the Council on Long Range Planning and Development shall serve for no more than three terms, but a member appointed to serve an unexpired term shall not be regarded as having served a term unless he has served two or more years.

(E) Vacancies: Any vacancy occurring on the Council on Long Range Planning and Development shall be filled by appointment by either the Speaker of the House of Delegates or by the Board of Trustees as provided in subparagraph (B) of this section. The new member shall be appointed for the remainder of the unexpired term.

(F) Implementation: In order to implement the transition from a calendar year Term of Service to a Term of Service beginning on July 1, the terms of all existing members of the Council shall automatically be extended to June 30 following the expiration date of the terms for which they were appointed. (This provision shall automatically be removed from the Bylaws at the 1979 annual meeting.)

Section 6. Council on Legislation

(A) Charge: The functions of the Council on Legislation shall be:

(1) To review proposed federal legislation and recommend appropriate action within AMA policy;

(2) To recommend changes in existing AMA policy when necessary to accomplish effective legislative goals;

(3) To serve as a reference council through which all legislative issues of the Association are channeled prior to final consideration by the Board of Trustees;

(4) To maintain constant surveillance over the legislation scene and to anticipate future legislative needs;

(5) To recommend to the Board of Trustees new federal legislation and legislation to modify existing laws of interest to the Association;

(6) To monitor the development and issuance of federal regulations and to make recommendations to the Board of Trustees concerning action on sucl. regulations;

(7) To develop and recommend to the Board of Trustees model state legislation.

(B) Membership: The Council on Legislation shall consist of eleven Active members, one of whom shall be a Resident. The members of the Council on Legislation shall be appointed by the Board of Trustees. In addition, the Board of Trustees may appoint a member of the American Dental Association to the Council on Legislation, said member shall be nominated by the American Dental Association and shall be a voting member of the Council. The appointment of a member of the American Dental Association to the Council on Legislation is subject to a reciprocal right to have an AMA member, nominated by the AMA Board of Trustees, appointed as a voting member of the American Dental Association Counci. on Legislation. The Board of Trustees shall also appoint a medical student member of AMA as a non-voting member of the Council on Legislation.

(C) Term of Service. Members of the Council on Legislation shall be appointed by the Board of Trustees for terms of one year, beginning on July 1 of each year, provided that if the Resident member ceases to be in an approved training program at any time prior to the expiration of the term for which he or she was appointed, the service of such Resident member on the Council shall thereupon terminate and the position shall be declared vacant.

(D) Tenure. Members of the Council on Legislation shall serve no more than nine terms.

(E) Vacancies: Any vacancies occurring on the Council shall be filled at the next meeting of the Board of Trustees. The new member shall be appointed by the Board of Trustees for the remainder of the unexpired term.

(F) Implementation: In order to implement the transition from a calendar year Term of Service to a Term of Service beginning on July 1, the terms of all existing members of the Council shall automatically be extended to June 30 following the expiration date of the term for which they were appointed. (This provision shall automatically be removed from the Bylaws at the 1977 annual meeting.

Section 7. Council on Continuing Physician Education

(A) Charge: The functions of the Council on Continuing Physician Education shall be:

(1) To assume primary responsibility as the programming arm of the American Medical Association in continuing medical education;

(2) To plan, organize, supervise, and evaluate AMA-sponsored programs to meet the needs of physicians for accredited continuing medical education of the highest educational and scientific quality, in all modes of delivery commensurate with quality programs; to cooperate where appropriate with state, county and medical specialty societies or the Scientific Sections;

(3) To organize and develop the scientific and educational program for the Annual Convention, working with the Scientific Sections as provided in the Bylaws, and to develop and expand cooperation with the national specialty organizations;

(4) To work with national specialty societies, state medical societies and AMA Section Councils in organizing and conducting the scientific and educational program for the Winter Scientific Meeting and Regional Postgraduate Meetings;

(5) To advise the Board of Trustees regarding sites for the Annual Convention, Winter Scientific Meeting, and Regional Postgraduate Meetings;

(6) To select winners of awards for exhibits of the Scientific Assembly;

(7) To submit recommendations to the Board of Trustees on the establishment of new Sections of the Scientific Assembly.

(B) Membership: The Council on Continuing Physician Education shall consist of eleven Active members, one of whom shall be a Resident. The members of the Council on Continuing Physician Education shall be appointed by the Board of Trustees.

(C) Term of Service: Members of the Council on Continuing Physician Education shall be appointed by the Board of Trustees for terms of one year, beginning on July 1 of each year, provided that if the Resident member ceases to be in an approved training program at any time prior to the expiration of the term for which he or she was appointed, the service of such Resident member on the Council shall thereupon terminate and the position shall be declared vacant.

(D) Tenure: Members of the Council on Continuing Physician Education shall serve for no more than nine terms.

(E) Vacancies: Any vacancy occurring on the Council shall be filled at the next meeting of the Board of Trustees. The new member shall be appointed by the Board of Trustees for the remainder of the unexpired term.

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

The following Reports, A and B, were presented by Dale C. Reynolds, M. D., Chairman:

A. PROGRESS REPORT
(Reference Committee F, page 381)

HOUSE ACTION: FILED

Since the Council on Long Range Planning last reported to the House of Delegates at the 1975 Clinical Convention, it has met twice to discuss several important subjects. In addition, the 1976 planning cycle has been initiated and there has been additional progress in refining the planning system.

PROGRESS IN PLANNING

Before this House of Delegates is the 1976 AMA Plan. This represents the third annual planning document to be presented by the Board of Trustees to the House of Delegates. The Council on Long Range Planning and Development participates actively in the development of the AMA Plan. This year's Plan reports substantive progress in nine important areas, raises five "new" issues that have not previously been addressed through the planning process, and presents six issues of "continuing" interest to AMA which should be further addressed by the planning mechanisms.

At the 1975 Clinical Convention, the Council reported that a new "operational" planning mechanism had been developed in conjunction with the new management approaches to budgeting and cost control. Since that time, this activity has been refined and is being implemented. This will result in a better base upon which program and fiscal management can take place, consistent with the more modern management techniques that have been adopted.

ORGANIZATIONAL REVIEW

During 1975, the Council devoted much of its time and energy to the study of AMA's organizational structure, resulting in the report that was submitted to the House for the 1975 Clinical Convention. The House referred back to the Council for further study several of the topics that were covered in the report:

SPECIALTY REPRESENTATION IN AMA — One of the subjects that the House referred back to the Council was the whole topic of specialty representation in AMA and the relationship between AMA and the various specialty organizations. In its report, Reference Committee F suggested that the Council conduct a survey of the section councils and specialty societies to get further information on the subject. The Council has designed a questionnaire for this purpose, and is gratified with the response so far. The Council will evaluate the responses and will submit a report on the whole subject of specialty relations with AMA for consideration by the House at the 1976 Clinical Convention.

(Long Range Planning — A)

As it pursues the subject of specialty participation in AMA, the Council is continually reminded that specialty representation is not a subject that can be discussed in a vacuum. Specialty participation in AMA is part of a larger organizational question of how AMA can be best structured in order to perform its basic function of representing the medical profession and the public on matters related to health and medical care. In order to perform that function in an increasingly complex and sometimes hostile environment, internal strength is essential. Hence, the Council is continuing its search for ways to strengthen organized medicine by providing mechanisms through which a physician's decision to participate in organized medicine provides strength to all of medicine, not just one component.

HOUSESTAFF PARTICIPATION IN AMA — Another subject referred back to the Council was the whole topic of housestaff and student participation and representation in AMA. The Council has discussed this on several occasions and is continuing to collect information in order to develop recommendations in this area. The Council's discussions have pursued the question of how housestaff representation in AMA could be related to their membership participation in AMA.

STUDENT PARTICIPATION IN AMA — The Council is also studying medical student participation in AMA in much the same manner as it is considering the role of housestaff. However, while the two are similar in some respects, the Council is concerned that the problems facing housestaff and those facing medical students are also quite different in several important ways. Hence, the Council is looking at the housestaff question and the medical student question separately.

COUNCILS AND COMMITTEES — The Council is pleased that its recommendations on AMA's council and committee structure were adopted by the House of Delegates and that a new approach to the functioning of councils and committees is being implemented as a result. The Council is aware that the Board of Trustees has made a number of recommendations on the implementation of the new council and committee system, and the Council is looking forward to the new and productive working relationships that will result for the councils and committees, the Board of Trustees, and the House of Delegates.

B. SPECIALTY COMPOSITION OF THE HOUSE OF DELEGATES
(Reference Committee F, page 381)

HOUSE ACTION: FILED

At the 1975 Clinical Convention, the House of Delegates asked that the Council report back to the House at the 1976 Annual Convention on the specialty composition of the House, including both delegates and alternate delegates. The following table presents a statistical profile of the 1976 AMA House of Delegates by specialty. For purposes of comparison, data are also presented on the specialty distribution of the total physician population and the dues paying AMA membership.

SPECIALTY	1976 DELEGATES		1976 ALTERNATE DELEGATES		TOTAL 1976 HOUSE		TOTAL PHYSICIANS (1974)*		TOTAL AMA DUES PAYING MEMBERS (1974)*	
	No.	%	No.	%	No.	%	No.	%	No.	%
General Practice and Family Practice	49	19.1	59	23.0	108	21.1	53,997	14.2	32,157	19.2
Medical Specialties	59	23.1	58	22.7	117	22.9	89,919	23.6	38,154	22.8
Allergy	5	2.0	2	0.8	7	1.4	1,657	0.4	1,086	0.7
Cardiovascular Diseases	7	2.7	8	3.1	15	2.9	6,229	1.6	3,666	2.2
Dermatology	5	2.0	2	0.8	7	1.4	4,479	1.2	2,664	1.5
Gastroenterology	0	–	4	1.6	4	0.8	2,063	0.5	1,084	0.7
Internal Medicine	33	12.9	32	12.5	65	12.7	51,752	13.6	20,864	12.5
Pediatrics	7	2.7	10	3.9	17	3.3	21,645	5.7	7,897	4.7
Pulmonary Diseases	2	0.8	0	–	2	0.4	2,094	0.6	893	0.5
Surgical Specialties	107	41.9	86	33.6	193	37.8	93,386	24.6	53,486	32.0
General Surgery	53	20.7	38	14.8	91	17.8	31,085	8.2	16,350	9.8
Neurological Surgery	5	2.0	6	2.3	11	2.1	2,859	0.8	1,777	1.1
OB–GYN	18	7.0	17	6.6	35	6.8	20,987	5.5	11,504	6.9
Ophthamology	5	2.0	5	2.0	10	2.0	10,741	2.8	6,781	4.1
Orthopedic Surgery	7	2.7	8	3.1	15	2.9	10,985	2.9	6,684	4.0
Otolaryngology	4	1.6	3	1.2	7	1.4	5,588	1.5	3,289	2.0
Plastic Surgery	5	2.0	2	0.8	7	1.4	2,088	0.5	1,348	0.8
Colon and Rectal Surgery	1	0.4	2	0.8	3	0.6	662	0.2	454	0.2
Thoracic Surgery	3	1.2	2	0.8	5	1.0	1,925	0.5	1,211	0.7
Urology	6	2.3	3	1.2	9	1.8	6,466	1.7	4,088	2.4
Other Specialties	36	14.7	46	18.0	82	16.3	92,964	24.5	38,191	22.7
Aerospace	1	0.4	0	–	1	0.2	708	0.2	130	0.1
Anesthesiology	2	0.8	9	3.5	11	2.1	12,484	3.3	7,095	4.2
Child Psychiatry	0	–	1	0.4	1	0.2	2,411	0.6	838	0.5
Diagnostic Radiology	3	1.2	0	–	3	0.6	3,083	0.8	1,492	0.9

SPECIALTY	1976 DELEGATES		1976 ALTERNATE DELEGATES		TOTAL 1976 HOUSE		TOTAL PHYSICIANS (1974)*		TOTAL AMA DUES PAYING MEMBERS (1974)*	
	No.	%	No.	%	No.	%	No.	%	No.	%
Other Specialties (continued)										
Forensic Pathology	2	0.8	0	–	2	0.4	198	0.1	85	0.1
Neurology	1	0.4	0	–	1	0.2	3,839	1.0	1,431	0.8
Occupational Medicine	1	0.4	2	0.8	3	0.6	2,365	0.6	1,474	0.9
Psychiatry	3	1.2	7	2.7	10	2.0	23,302	6.1	8,585	5.1
Pathology	5	2.0	10	3.9	15	2.9	11,393	3.0	4,989	3.0
Physical Medicine and Rehabilitation	1	0.4	1	0.4	2	0.4	1,610	0.4	666	0.4
General Preventive Medicine	1	0.4	0	–	1	0.2	758	0.2	220	0.1
Public Health	3	1.2	1	0.4	4	0.8	2,695	0.7	678	0.4
Radiology	7	2.7	8	3.1	15	2.9	11,600	3.1	6,753	4.0
Therapeutic Radiology	1	0.4	2	0.8	3	0.6	1,070	0.3	566	0.3
Other Specialty	5	2.0	4	1.6	9	1.8	6,688	1.8	2,058	1.2
Unspecified	1	0.4	1	0.4	2	0.4	8,760	2.3	1,130	0.7
Not Classified, Inactive, and Address Unknown	0	–	0	–	0	–	49,482	13.0	5,386	3.2
TOTAL	252	98.4	249	97.3	501	97.9	379,748	100.0	167,374	100.0
Vacancies	3	1.2	6	2.3	9	1.8				
Medical Student	1	0.4	1	0.4	2	0.4				
	256	100.0	256	100.0	512	100.0				

*1974 data are used because 1975 data are not available. However, the percentage distribution of the physician population by specialty does not change very significantly from year to year and these 1974 data are valid for comparative purposes.

Sources: Report on the Membership of the AMA as of December 31, 1974; AMA Center for Health Services Research and Development and unpublished data from the AMA Department of Registration Services.

REPORT OF THE EXECUTIVE VICE PRESIDENT

(Reference Committee F, page 382)

HOUSE ACTION: FILED AND FOLLOWING RECOMMENDATION ADOPTED:

That the Executive Vice President prepare a report for each session of the House of Delegates, that the report be submitted in written form and referred to the appropriate reference committee, and that the Executive Vice President be prepared to present a brief oral summary of his report on request of the House of Delegates

During the 1968 Clinical Convention, the House of Delegates adopted Resolution 2, which requested that the Executive Vice President prepare a report for the sessions of the House of Delegates as frequently as necessary but at least for each annual meeting, that the report be submitted in written form and referred to the appropriate reference committee, and that the Executive Vice President be prepared to present a brief oral summary of his report on request of the House of Delegates.

In keeping with this direction, reports have been submitted by the Executive Vice President to the House during each Annual Convention, with the exception of 1974. In general, these reports have discussed program priorities and major staff changes.

Our avenues of communication with the members of the House of Delegates, state and county medical societies, allied organizations and individual members have expanded a great deal since 1968, and an annual report from the Executive Vice President may no longer be appropriate. The number and scope of the reports submitted to the House by the Board and the AMA Councils have increased substantially over the past eight years. The "American Medical News" has expanded its coverage of AMA activities and topics of general interest to medicine, both in its own pages and in the newly-added "Impact" section. The "AMA Newsletter" was created in 1969 to provide a timely summary of major events to the Association's official family, and the "Speakers' Letter" was begun in 1975 to maintain a direct line of communication between the Speakers and the members of the House.

There is merit in allowing the AMA's chief executive officer the opportunity of addressing the House on matters of importance and great urgency, and the option of presenting such an address should be retained.

With this in mind, the following revision to the existing policy is presented for consideration:

Recommendation:

That the Executive Vice President prepare a report for the sessions of the House of Delegates as frequently as necessary and at his discretion, that the report be submitted in written form and referred to the appropriate reference committee, and that the Executive Vice President be prepared to present a brief oral summary of his report on request of the House of Delegates.

No. 26 PSRO SUPPORT CENTERS
Introduced by Matthew C. Gleason, M. D.,
Delegate, California
(Reference Committee A, page 328)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the American Medical Association assist the thirteen medical societies holding contracts as statewide PSRO support centers in ending their contracts with the Department of Health, Education, and Welfare as quickly as possible.

No. 27 MEMBERSHIP POLICY
Introduced by Matthew C. Gleason, M. D.,
Delegate, California
(Reference Committee F, page 383)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the American Medical Association take a strictly neutral stance regarding unified or voluntary AMA membership; and be it further

RESOLVED, That the American Medical Association not utilize AMA funds in such controversies.

No. 28 TRANSFER OF EDUCATIONAL FUNCTION
Introduced by Matthew C. Gleason, M. D.,
Delegate, California
(Reference Committee F, page 383)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That an Ad Hoc Committee look into the matter of returning educational functions to state societies and specialty societies to whatever degree compatible with retaining the American Medical Association's tax deductible status.

No. 29 INVESTMENT POLICY
Introduced by Matthew C. Gleason, M. D.,
Delegate, California
(Reference Committee F, page 384)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the House of Delegates direct the American Medical Association Board of Trustees not to join in joint business ventures which are in excess of $1,000,000 without the concurrence of the House.

No. 30 MEMBERSHIP SOLICITATION
Introduced by Matthew C. Gleason, M. D.,
Delegate, California
(Reference Committee on Amendments to
Constitution and Bylaws, page 278)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the American Medical Association, with the permission of the affected state and local component medical societies, be encouraged to solicit memberships from physicians who have not been a member of their component medical society for at least two years preceding such solicitation.

No. 31 CURRENT PROCEDURAL TERMINOLOGY, 4TH EDITION
Introduced by California Delegation
(Reference Committee A, page 334)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the American Medical Association utilize the 1974 revision of the 1969 California "Relative Value Studies," without unit values, for its Fourth Edition of "Current Procedural Terminology"; and be it further

RESOLVED, That AMA recognize that these descriptors are basically accurate for the reporting of services by physicians, and be it further

RESOLVED, That AMA make every possible effort to achieve recognition of CPT-4 by the Department of Health, Education, and Welfare, the Social Security Administration and other third party payors.

No. 32 DRUG PACKAGE INSERTS
Introduced by California Delegation
(Reference Committee B, page 340)

HOUSE ACTION: ADOPTED

RESOLVED, That the American Medical Association strongly oppose passage of the Federal Drug and Devices Act, S 2697, which would fine a doctor $10,000 for each day of prescribing a drug for an indication not listed on its package insert, and be it further

RESOLVED, That the drug package insert should not be made a legal document for punishment of physicians by federal agencies or civil courts, but should remain an unofficial guide for medical practitioners in their own evaluation of risk vs. benefit in individual cases; and be it further

RESOLVED, That any proposed legislation which in any way would rigidly restrain use of good judgment by a licensed physician in carrying out duties to individual patients, or would propose search of a patient's hospital or office records by governmental agencies, should be condemned by patients, physicians, courts and the Congress; and be it further

RESOLVED, That copies of this entire resolution, including its whereas, be sent to members of appropriate Congressional Committees.

(Resolutions)

No. 37 PERIODIC PAYMENT OF DUES
Introduced by California Delegation
(Reference Committee F, page 384)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the American Medical Association and component medical societies be encouraged to structure their dues collection system in such a way as to permit periodic payments of dues, rather than a single annual payment.

No. 38 VIOLENCE ON TV: AN ENVIRONMENTAL HAZARD
Introduced by California Delegation
(Reference Committee E, page 367)

HOUSE ACTION: ADOPTED AS FOLLOWS:

RESOLVED, That the House of Delegates of the American Medical Association:

1. Declare its recognition of the fact that TV violence is a risk factor threatening the health and welfare of young Americans, indeed our future society.
2. Commit itself to remedial action in concert with industry, government and other interested parties.
3. Encourage all physicians, their families and their patients to actively oppose TV programs containing violence, as well as products and/or services sponsoring such programs.

No. 39 GUIDELINES FOR FELLOWSHIP TRAINING
Introduced by California Delegation
(Reference Committee C, page 353)

HOUSE ACTION: REFERRED TO BOARD OF TRUSTEES

RESOLVED, That the American Medical Association develop an "Essentials of Fellowship Training" as such training applies to the clinical aspects of such postgraduate education.

No. 40 DUES EXEMPTION FOR THIRTY-FIVE YEARS ACTIVE MEMBERSHIP
Introduced by California Delegation
(Reference Committee on Amendments to Constitution and Bylaws, page 324)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the American Medical Association Bylaws, Chapter III, Section D, paragraph (a), be amended to exempt physicians who have been active members of the AMA for thirty-five years or more from dues payment by adding the following (addition in bold type):

(a) a member, on request, regardless of state or local dues exemptions, on January 1 following his 70th birthday or following completion of regular membership in good standing of this Association for thirty-five years, regardless of age.

No. 82 UNIFIED MEMBERSHIP
Introduced by Illinois Delegation
(Reference Committee F, page 386)

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION 82 ADOPTED:

RESOLVED, That the AMA provide all feasible and reasonable services, in keeping with the Federation concept, to state associations that seek assistance for their efforts to maintain or accomplish unified membership.

No. 83 DESIGNATED SPECIALTY CODES
Introduced by Section Council on Plastic, Reconstructive and Maxillofacial Surgery
(Reference Committee G, page 390)

HOUSE ACTION: REFERRED TO BOARD OF TRUSTEES

RESOLVED, That for uniformity within the American Medical Association, the list of 69 designated specialty codes be no longer utilized, that this list be replaced by a list of 28 specialties reflected in the AMA Section Council titles, and that this be implemented as soon as possible.

No. 84 PL 93-641, HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974
Introduced by Georgia Delegation
(Reference Committee B, page 340)

HOUSE ACTION: REFERRED TO BOARD OF TRUSTEES for appropriate action

RESOLVED, That the American Medical Association test the constitutionality of Public Law 93-641, the Health Planning and Resources Development Act of 1974.

No. 85 UTILIZATION REVIEW REGULATIONS
Introduced by Georgia Delegation

Resolution 85 was considered together with Resolutions 52 and 70

See page 283

No. 89 ACCESS TO PUBLIC BUILDINGS FOR HANDICAPPED PERSONS

Introduced by Ian Jones, M. D., Delegate
Intern and Resident Business Session
(Reference Committee E, page 375)

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION 89 ADOPTED:

RESOLVED, That the American Medical Association encourage the implementation of requirements that provide access to public facilities for the handicapped and wheelchair bound persons.

No. 90 HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

Introduced by Section Council on Federal and Military Medicine
(Reference Committee B, page 343)

HOUSE ACTION: ADOPTED AS FOLLOWS:

RESOLVED, That the American Medical Association, through letters to the President and appropriate committees of the Congress of the United States and through such other means as appropriate, give full support to the enactment of legislation to relieve the tax burden on participants in the Health Professions Scholarship Program and maintain the effectiveness of this program in the military and Public Health Service.

No. 91 VARIABLE INCENTIVE PAY PROGRAM

Introduced by Section Council on Federal and Military Medicine
(Reference Committee B, page 343)

HOUSE ACTION: ADOPTED AS FOLLOWS:

RESOLVED, That the American Medical Association, through letters to the President and appropriate members of the Congress of the United States and through such other means as are appropriate, strongly support timely reenactment of the Variable Incentive Pay Program for physicians in the uniformed services.

No. 92 MODEL MEMBERSHIP BYLAWS

Introduced by Texas Delegation
(Reference Committee on Amendments to Constitution and Bylaws, page 324)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the Model Membership Bylaws be amended by deleting the second sentence of Part III of the section on Active Membership (regarding full membership for Medical Students).

No. 119 CONFIDENTIALITY IN PEER REVIEW
Introduced by Ian Jones, M. D., Delegate
Intern and Resident Business Session
(Reference Committee A, page 331)

HOUSE ACTION: REFERRED TO COUNCIL ON MEDICAL SERVICE
for study and report

RESOLVED, That the American Medical Association Board of Trustees develop guidelines to protect the confidentiality of peer review findings and to protect against inappropriate use of this information by non-medical personnel, and be it further

RESOLVED, That these guidelines be submitted to the House of Delegates at the 1976 Clinical Convention.

No. 120 DUE PROCESS
Introduced by Ian Jones, M. D., Delegate
Intern and Resident Business Session
(Reference Committee D, page 361)

HOUSE ACTION: REFERRED TO BOARD OF TRUSTEES for study and report
to the House of Delegates at the 1976 Clinical Convention

RESOLVED, That guidelines for due process for medical training program faculty and attending physicians in medical institutions be developed by the American Medical Association Board of Trustees and presented to the House of Delegates at the 1976 Clinical Convention.

No. 121 PROVISION OF HEALTH CARE IN CORRECTIONAL FACILITIES
Introduced by Ian Jones, M. D., Delegate
Intern and Resident Business Session
(Reference Committee D, page 366)

HOUSE ACTION: ADOPTED AS FOLLOWS:

RESOLVED, That the American Medical Association endorse the principle that correctional facilities provide adequate medical care to their inmates which is subject to physician peer review in each community.

No. 122 REINSTATEMENT OF AMA FIELD SERVICE DEPARTMENT
Introduced by Missouri Delegation
(Reference Committee F, page 387)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the American Medical Association Board of Trustees be instructed to reinstitute vitally needed two-way communcation within organized medicine by reinstatement of the AMA Field Service Department as soon as fiscal and budgetary integrity allows.

(Resolutions)

No. 123 VOTING RECORDS OF AMPAC ASSISTED LEGISLATORS

Introduced by Frank A. Rogers, M. D.
Delegate, California
(Reference Committee G, page 390)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the American Medical Association request the American Medical Political Action Committee to publish, at least annually, voting records on bills of significance to the medical and health care professions for each member of Congress who receives financial assistance from AMPAC.

No. 124 DEDUCTIBLE AUTOMOBILE EXPENSE LEGISLATION

Introduced by Oregon Delegation
(Reference Committee B, page 342)

HOUSE ACTION: ADOPTED AS FOLLOWS:

RESOLVED, That the American Medical Association continue its support for passage of HR 10768 which would statutorily clarify deductible automobile travel expenses for physicians and other professionals.

No. 125 AMATEUR ATHLETIC UNION RULE REQUIRING PHYSICIAN'S ATTENDANCE AT ANY AAU-SANCTIONED BOXING MATCHES

Introduced by Oregon Delegation
(Reference Committee E, page 376)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the American Medical Association suggest to the Amateur Athletic Union that the presence of a physician at sanctioned boxing matches is not medically necessary; and that certified emergency medical technicians or similarly qualified personnel will adequately achieve the laudable goal of the AAU that emergency medical attention be available at all boxing matches under its purview.

No. 126 WEIGHT LOSS IN AMATEUR WRESTLING

Introduced by Oregon Delegation
(Reference Committee E, page 377)

HOUSE ACTION: REFERRED TO BOARD OF TRUSTEES

RESOLVED, That the American Medical Association strongly and emphatically declare its formal opposition to the common practice of rapid and significant weight loss or unrealistic weight maintenance over protracted periods among amateur wrestlers, particularly rapidly developing young people at the grade and high school level, on the grounds that such practices are inimical to good health and can pose potential life threatening situations.

REPORTS OF REFERENCE COMMITTEES AS PRESENTED TO THE HOUSE OF DELEGATES

The following Reports of the Reference Committees DO NOT REPRESENT FINAL HOUSE ACTION. The page number at the end of each item refers to the final action of the House of Delegates.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

George E. Burket, Kansas, Chairman
Oscar B. Hunter, Section on Pathology
William J. MacDonald, Rhode Island
David I. Olch, California
Frank R. Reynolds, North Carolina

(1) REPORT A OF BOARD OF TRUSTEES
AMA COUNCILS
SUPPLEMENTARY REPORT A OF BOARD OF TRUSTEES
REPORT F OF COUNCIL ON CONSTITUTION AND BYLAWS
AMA COUNCILS

These three reports were considered together as they all pertain to the reorganization of the AMA Council and Committee structure. The Board of Trustees Report A is in response to the action taken by the House of Delegates at the 1975 Clinical Convention on Report B of the Council on Long Range Planning and Development. Report A contains nine separate recommendations which your Reference Committee believes should be considered separately. Supplementary Report A is an alternative proposal to part of Recommendation No. 8. Report F of the Council on Constitution and Bylaws contains the proposed Bylaw amendments to implement the recommendations made in the Board of Trustees Report A.

RECOMMENDATION NO. 1 — COUNCIL ON MEDICAL EDUCATION: Your Reference Committee heard a request for a slight change in the language of the charge to this Council to avoid an apparent overlap in the charge to the Council on Continuing Physician Education. However, on closer examination it appears that there is no conflict because the Council on Medical Education is concerned with concepts related to the accrediting process, while the Council on Continuing Physician Education will be concerned with actually conducting educational programs.

Your Reference Committee considered the proposal to delete the provision requiring one member of the Council on Medical Education to be "a private practitioner of medicine who is not a faculty member of a medical school nor a member of the staff of a hospital associated with a medical school or university." Your Reference Committee is in agreement with the statements set forth in Report A that this provision, presently in the Bylaws, should now be removed.

Finally, there was some testimony in support of electing, rather than appointing, the non-voting medical student member of the Council on Medical Education. Your Reference Committee agrees that election by the House of Delegates is preferable here and recommends accordingly that part (b) Membership be amended to read as follows:

"A medical student member of the AMA, nominated by the Board of Trustees on recommendation of the Governing Council of the Medical Students Business Session shall be elected annually by the House of Delegates as a non-voting member of the Council on Medical Education."

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Recommendation No. 1 of Board of Trustees Report A, as amended, be adopted. (see page 185)

RECOMMENDATION NO. 2 — COUNCIL ON MEDICAL SERVICE: Your Reference Committee heard testimony recommending the following amendments by addition to the charge of the Council on Medical Service. Your Reference Committee concurs in these additions.

Under (a) Charge, item 3, after the words "component societies," add "and National Medical Specialty Societies through their respective Section Councils."

Under (a) Charge, item 4, at the conclusion of the paragraph add "and National Medical Specialty Societies through their respective Section Councils."

Your Reference Committee also recommends that the non-voting medical student member of the Council on Medical Service be elected by the House of Delegates rather than be appointed by the Board of Trustees. Accordingly, your Reference Committee recommends that part (b) Membership be amended to read as follows:

"A medical student member of the AMA, nominated by the Board of Trustees on recommendation of the Governing Council of the Medical Students Business Session shall be elected annually by the House of Delegates as a non-voting member of the Council on Medical Service."

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Recommendation No. 2 of Board of Trustees Report A, as amended, be adopted. (see page 185)

RECOMMENDATION NO. 3 — COUNCIL ON SCIENTIFIC AFFAIRS: Your Reference Committee heard no objections to the provisions for the establishment of this new Council. Your Reference Committee reviewed the provisions and recommends their adoption.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Recommendation No. 3 of Board of Trustees Report A be adopted. (see page 185)

RECOMMENDATION NO. 4 — COUNCIL ON CONSTITUTION AND BYLAWS: Your Reference Committee heard a very substantial amount of testimony in opposition to the proposed single seven year term for members of the Council on Constitution and Bylaws. The strong contention was made that shorter terms would provide for greater accountability. After careful and thorough consideration, your Reference Committee recommends a maximum of three terms of three years each, to accomplish the highest level of accountability to this House. However, your Reference Committee also recommends that the size of the Council be increased to six members so that no more than two members of this Council will change in any one year.

Your Reference Committee therefore proposes the following amendments to Recommendation No. 4:

Under (b) Membership, change "seven" to "six."

Under (c) Term of Service—Tenure, change to read: "Voting members of the Council on Constitution and Bylaws shall be elected by the House of Delegates for a maximum of three terms of three years each, so arranged that at each Annual Convention the term of two members expire."

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Recommendation No. 4 of Board of Trustees Report A, as amended, be adopted. (see page 185)

RECOMMENDATION NO. 5 — JUDICIAL COUNCIL: Your Reference Committee heard testimony calling for a term shorter than seven years for members of the Judicial Council to provide greater accountability. Your Reference Committee also heard testimony to the effect that seven members would be too large to be efficient. However, your Reference Committee believes that the unique responsibilities of this Council will be best served by increasing its size to seven members and changing the tenure to one seven year term.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Recommendation No. 5 of Board of Trustees Report A be adopted. (see page 185)

RECOMMENDATION NO. 6 — COUNCIL ON CONTINUING PHYSICIAN EDUCATION: The testimony before your Reference Committee suggested two small amendments to the charge for this Council which your Reference Committee believes should be accepted. Your Reference Committee therefore recommends the following amendments:

Under (b) Charge, item 2, delete the word "practicing."

Under (b) Charge, item 4, after word "societies," add "and AMA Section Councils."

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Recommendation No. 6 of Board of Trustees Report A, as amended, be adopted. (see page 185)

RECOMMENDATION NO. 7 — COUNCIL ON LEGISLATION: Your Reference Committee heard no objections to the provisions relating to the Council on Legislation.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Recommendation No. 7 of Board of Trustees Report A be adopted. (see page 185)

RECOMMENDATION NO. 8 — COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT: Your Reference Committee heard considerable debate on the merits of electing the members of this Council as opposed to appointing them. Report A of the Board of Trustees has recommended that they be appointed. The Board of Trustees has emphasized that they believe appointment is a better mechanism because of the unusual makeup of this Council as mandated in the Bylaws.

However, Supplementary Report A contains the alternative of electing the Council members. After long deliberation, your Reference Committee believes that a compromise might be the best solution and offers the following amendment to part (b) Membership of Report A:

"The Council on Long Range Planning and Development shall consist of ten Active members. Two members shall be members of the House of Delegates, elected by the House of Delegates on nomination by the Board of Trustees. Three members shall be appointed by the Speaker of the House of Delegates, two of whom shall be appointed from the AMA membership at large and one of whom shall be appointed from the resident membership of the AMA. Five members of the Council shall be appointed by the Board of Trustees, two of whom shall be members of the Board of Trustees, two of whom shall be appointed from the AMA membership at large, and one of whom shall be a medical student member of AMA."

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Recommendation No. 8 of Board of Trustees Report A, as amended, be adopted in lieu of Supplementary Report A. (see page 185)

RECOMMENDATION NO. 9: This recommendation provided that members of existing councils be eligible for their remaining tenure. There was no objection to this recommendation.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Recommendation No. 9 of Report A be adopted. (see page 185)

If the foregoing recommendations are adopted by the House of Delegates, the following corresponding amendments will be necessary in Report F of the Council on Constitution and Bylaws to provide for the implementation of Board of Trustees Report A, as amended. The following full paragraphs should be substituted for the corresponding paragraphs in Report F of the Council on Constitution and Bylaws:

Section 1: Council on Constitution and Bylaws

(B) Membership: The Council on Constitution and Bylaws shall consist of six Active members. The members of the Council shall be elected by the House of Delegates. The Board of Trustees shall nominate two or more eligible members for each vacancy on the Council, and further nominations may be made from the floor of the House of Delegates. In addition, the President, a member of the Board of Trustees selected by the Board, the Speaker and Vice Speaker of the House of Delegates, and a Resident member appointed by the Board of Trustees shall be ex-officio members of the Council on Constitution and Bylaws without the right to vote.

(C) Term of Service: Voting members of the Council on Constitution and Bylaws shall be elected by the House of Delegates for terms of three years, so arranged that at each Annual Convention the term of two members expires.

(D) Tenure: Members of the Council on Constitution and Bylaws shall serve for no more than three terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless he has served two or more years.

(F) Implementation: In order to implement the transition from five members being elected for five year terms to six members being elected for three year terms, a member shall be elected to the new position on the Council at the 1976 Annual Convention, for a two year term. In addition, for each of the five existing positions on the Council, upon expiration of the existing five year term the incumbent shall be eligible for election to one additional three year term. (This provision shall automatically be removed from the Bylaws at the 1980 Annual Meeting.)

Section 2: Council on Medical Education

(B) Membership: The Council on Medical Education shall consist of eleven Active members, one of whom shall be a Resident and at least one of whom shall not be a salaried faculty member of a medical school, or a hospital associated with a medical school or university. In addition, a medical student member of AMA shall be elected annually as a non-voting member of the Council on Medical Education. The voting members of the Council shall be elected by the House of Delegates. The Board of Trustees shall nominate two or more eligible members for each vacancy on the Council and further nominations may be made from the floor of the House of Delegates.

Section 3: Cou ·il on Medical Service

(A) Charge: The functions of the Council on Medical Service shall be:

(1) To study and evaluate the social and economic aspects of medical care; and, on behalf of the public and the profession, to suggest means for the timely development of services in a changing socio-economic environment;

(2) To investigate social and economic factors influencing the practice of medicine;

(3) To inform state associations, component societies and National Medical Specialty Societies through their respective Section Councils of changing conditions and anticipated proposals that would affect medical care,

(4) To assist medical service committees established by state associations, component societies of the American Medical Association, and National Medical Specialty Societies through their respective Section Councils.

(B) Membership: The Council on Medical Service shall consist of eleven Active members, one of whom shall be a Resident. In addition, a medical student member of AMA shall be elected annually as a non-voting member of the Council on Medical Service. The voting members of the Council shall be elected by the House of Delegates. The Board of Trustees shall nominate two or more eligible members for each vacancy on the Council, and further nominations may be made from the floor of the House of Delegates.

Section 4: Judicial Council

(b) Membership: The Judicial Council shall consist of five Active members. The members of the Council shall be elected by the House of Delegates on nomination by the President.

(C) Term of Service: Members of the Judicial Council shall be elected by the House of Delegates for terms of five years, so arranged that at each Annual Convention the term of one member expires.

(D) Tenure: Members of the Judicial Council shall serve for no more than two terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless he has served three or more years.

Section 7: Council on Continuing Physician Education

(A) Charge: The functions of the Council on Continuing Physician Education shall be:

(1) To assume primary responsibility as the programming arm of the American Medical Association in continuing medical education;

(2) To plan, organize, supervise, and evaluate AMA-sponsored programs to meet the needs of physicians for accredited continuing medical education of the highest educational and scientific quality, in all modes of delivery commensurate with quality programs; to cooperate where appropriate with state, county, and medical specialty societies or the Scientific Sections;

(3) To organize and develop the scientific and educational program for the Annual Convention, working with the Scientific Sections as provided in the Bylaws, and to develop and expand cooperation with the national specialty organizations;

(4) To work with national specialty societies, state medical societies and AMA Section Councils in organizing and conducting the scientific and educational program for the Winter Scientific Meeting and Regional Postgraduate Meetings;

(5) To advise the Board of Trustees regarding sites for the Annual Convention, Winter Scientific Meeting, and Regional Postgraduate Meetings;

(6) To select winners of awards for exhibits of the Scientific Assembly;

(7) To submit recommendations to the Board of Trustees on the establishment of new Sections of the Scientific Assembly.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report F of the Council on Constitution and Bylaws, as amended, be adopted and the Bylaws be amended accordingly. (see page 185)

(2) REPORT A OF COUNCIL ON CONSTITUTION AND BYLAWS
OFFICE OF VICE PRESIDENT

Report A of the Council on Constitution and Bylaws provides the necessary amendments to both the Constitution and the Bylaws of the Association to abolish the Office of Vice President. Since the amendments to the Constitution cannot be acted upon until the 1976 Clinical Meeting, this report should be discussed but action should be deferred.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that after appropriate discussion, consideration of Report A of the Council on Constitution and Bylaws be postponed to the opening session of the 1976 Clinical Meeting of this House of Delegates. (see page 175)

(3) REPORT B OF COUNCIL ON CONSTITUTION AND BYLAWS
INDEPENDENCE OF FUNCTION

Report B of the Council on Constitution and Bylaws provides Bylaw amendments to assure the complete independence of the Executive, Legislative and Judicial branches of the Association. More specifically, these amendments provide that voting members of the Board of Trustees may not be a delegate or an alternate delegate and may not serve on Councils or Committees except when specifically provided for in the Bylaws. The amendments also provide that a member of the Judicial Council may not serve as a delegate or alternate delegate, may not be a General

Officer of the Association and may not serve on any other council or committee of the AMA. The provisions are applicable only to members elected to the Judicial Council after adoption of this report.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report B of the Council on Constitution and Bylaws be adopted and the Bylaws amended accordingly. (see page 178)

(4) REPORT C OF COUNCIL ON CONSTITUTION AND BYLAWS
REVISION OF BYLAWS

Report C of the Council on Constitution and Bylaws is an informational report to the House advising it of a delay in the completion of the revision of the Bylaws.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report C of the Council on Constitution and Bylaws be filed. (see page 179)

(5) REPORT D OF COUNCIL ON CONSTITUTION AND BYLAWS
RESTRUCTURING OF INTERN AND
RESIDENT BUSINESS SESSION

Report D of the Council on Constitution and Bylaws contains the necessary Bylaw amendments to completely restructure the organization of the Resident Physicians within the AMA. Although there was support for this report in the open hearings, your Reference Committee was advised in Executive Session that both the Council on Long Range Planning and Development and the AMA Board of Trustees have not had an adequate opportunity to study this matter and present their recommendations to the House of Delegates as directed by the House at the 1975 Clinical Convention.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report D of the Council on Constitution and Bylaws be referred to the Board of Trustees for report at the 1976 Clinical Meeting of this House. (see page 179)

(6) REPORT E OF COUNCIL ON CONSTITUTION AND BYLAWS
CIVILIAN PHYSICIANS EMPLOYED
BY U. S. MILITARY SERVICES

Report E of the Council on Constitution and Bylaws proposes amendments to the Bylaws which would provide that Civilian Physicians employed by U. S. Military Services may be Direct Members in the same category as Commissioned Medical Officers of the U. S. Military Services.

At the present time, civilian physicians employed by the Military Services may be Direct members only in the category designated for civilian physicians employed by Federal agencies. Since the adoption of a dues structure for commissioned medical officers, there is no reason to have civilian physicians employed by the military in a separate membership category.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report E of the Council on Constitution and Bylaws be adopted and the Bylaws amended accordingly. (see page 84)

(7) REPORT G OF COUNCIL ON CONSTITUTION AND BYLAWS
REVIEW AND DECIMALIZATION OF BYLAWS

Report G of the Council on Constitution and Bylaws is an informational report to the House containing a sample of the decimalization of the Bylaws which has been undertaken. Your Reference Committee commends the Council for undertaking this laudable task and urges the Council to continue its efforts in this regard.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report G of the Council on Constitution and Bylaws be filed. (see page 195)

(8) REPORT H OF COUNCIL ON CONSTITUTION AND BYLAWS
PERMITTING THE PRESIDENT TO SUCCEED HIMSELF

Report H of the Council on Constitution and Bylaws is an informational report to the House, advising it of the steps necessary and the nature of the amendments necessary to permit the President to succeed himself.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report H of the Council on Constitution and Bylaws be filed. (see page 205)

(9) RESOLUTION 30 — MEMBERSHIP SOLICITATION

Resolution 30 proposes that the AMA be permitted to solicit memberships from among physicians who are not members of their component or state medical society, although eligible for such membership. Your Reference Committee heard considerable testimony to the effect that this proposal was contrary to the Federation concept.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 30 not be adopted. (see page 278)

(10) RESOLUTION 40 — DUES EXEMPTION FOR 35 YEARS ACTIVE MEMBERSHIP

Resolution 40 proposes an amendment to the Bylaws which would exempt a member from the payment of dues after 35 years of membership in the Association. The fiscal note and testimony before your Reference Committee indicate to your Reference Committee that this proposal is financially unsound.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 40 not be adopted. (see page 280)

(11) RESOLUTION 43 — AMA PRESIDENT

Resolution 43 proposes that the President of the AMA be elected by a balloting of all members of the AMA, that he be elected for a two year term, and be compensated by a salary. Your Reference Committee heard sufficient objections to this resolution to conclude that this is not a practical proposal.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 43 not be adopted. (see page 281)

(12) RESOLUTION 92 — MODEL MEMBERSHIP BYLAWS

Resolution 92 asks that the provision in the Model Membership Bylaws providing full membership for Medical Students be deleted. Your Reference Committee heard substantial opposition to this resolution. Your Reference Committee would also point out that these Model Membership Bylaws are only presented for the consideration of the state associations and are not mandatory provisions.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 92 not be adopted. (see page 295)

(Committee F)

(3) REPORT D OF BOARD OF TRUSTEES
EXISTING AMA CONTRACTS

Report D of the Board of Trustees presents a listing and a brief description of each of the existing contracts between the AMA and the Department of Health, Education, and Welfare, as required by Resolution 5 (C-75).

The Reference Committee noted the information provided by this report and heard no criticism of it.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report D of the Board of Trustees be filed. (see page 58)

(4) REPORT Q OF BOARD OF TRUSTEES
AMA PLAN — 1976

Report Q of the Board of Trustees presents the 1976 AMA Plan, the third effort in the context of the Association's long range planning process. The 1976 Plan describes progress on nine issues which continue from the 1975 Plan, and focuses on several issues not previously addressed within the framework of planning.

The Reference Committee noted the fine work documented in the Progress Report section of the Plan and commends the Board of Trustees and Council on Long Range Planning and Development for their effort and progress.

After careful review and thorough discussic.. in its executive session, the Reference Committee is pleased to commend this Plan for the Association's activities in 1976. Further, no opposition was voiced in the Reference Committee's hearing. The proposals are excellent and on target.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report Q of the Board of Trustees be adopted. (see page 110)

(5) REPORT X OF BOARD OF TRUSTEES
AMA LIFETIME MEMBERSHIP

Report X of the Board of Trustees responds to Resolution 94 (A-75), which recommended study of the feasibility of lifetime membership in the AMA, and concludes that a lifetime membership program should not be established.

The potential for conflict if AMA lifetime members neglected to remain members of their state societies argues effectively against establishing an AMA lifetime membership in the opinion of your Reference Committee.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report X of the Board of Trustees be adopted. (see page 139)

(6) REPORT EE OF BOARD OF TRUSTEES
MEDICAL CARE COSTS

Report EE of the Board of Trustees presents informational data on medical care costs and comments on the establishment of the Commission on the Cost of Medical Care. The Reference Committee commends the information to the attention of the House of Delegates.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report EE of the Board of Trustees be filed. (see page 169)

(7) REPORT A OF COUNCIL ON LONG RANGE PLANNING
AND DEVELOPMENT — PROGRESS REPORT

Report A of the Council on Long Range Planning and Development informs the House of Delegates regarding the Council's progress with certain issues and problems referred to their attention. The Reference Committee notes this information with great interest.

RECOMMEND..TION:

Mr. Speaker, your Reference Committee recommends that Report A of the Council on Long Range Planning and Development be filed. (see page 207)

(8) REPORT B OF COUNCIL ON LONG RANGE PLANNING
AND DEVELOPMENT — SPECIALTY COMPOSITION
OF HOUSE OF DELEGATES

Report B of the Council on Long Range Planning and Development presents a profile of the 1976 House of Delegates, categorized by the specialties of the delegates and the alternate delegates, compared with data on the distribution of all physicians and AMA members among the specialties, in response to a request by the House of Delegates (C-75).

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report B of the Council on Long Range Planning and Develcpment be filed. (see page 208)

(11) RESOLUTION 2 — INTERIM MEETING OF AMA HOUSE OF DELEGATES

Resolution 2 proposes that the Board of Trustees be requested to review the sites already selected for future Interim Meetings of the House of Delegates and possible alternate sites, and to submit new recommendations, including cost estimates, at the 1976 Interim Meeting.

The House of Delegates has expressed itself, in response to recommendations of the Board of Trustees, regarding the location of Interim Meetings through 1981. The selection of Chicago for the Interim Business Sessions of the House was well thought out with respect to costs and deserves the opportunity to be proven. Testimony favoring Resolution 2 was not persuasive to your Reference Committee.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 2 not be adopted. (see page 269)

(12) RESOLUTION 27 — MEMBERSHIP POLICY

Resolution 27 proposes that the AMA refrain from using its influence and funds to support the concept of unified AMA membership among members of state medical societies.

At the Clinical Convention (C-75), the following recommendation of Reference Committee F was adopted:

"It was recommended that AMA remain a federation of its state associations as currently provided for in its Constitution. Further, it is recommended that state medical associations pursue the worthy goal of unified membership."

Further, the testimony presented before the Reference Committee strongly supported AMA's continuing efforts in membership recruitment.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 27 be not adopted. (see page 277)

(13) RESOLUTION 28 — TRANSFER OF EDUCATIONAL FUNCTION

Resolution 28 proposes that the AMA limit its educational programs to the degree required to maintain the Association's tax exempt status in order to provide more available funds to support the AMA's role as the advocate of members with government and other third parties.

(Committee F)

(19) RESOLUTION 82 — UNIFIED MEMBERSHIP

Resolution 82 proposes that the Board of Trustees assist efforts to maintain existing unified memberships by providing certain specific information on AMA benefits.

The testimony presented indicated that the AMA is very responsive to requests for assistance with membership problems from state associations. Also, there was agreement among the members of the Reference Committee that the continuation of this policy should be encouraged. Toward that end, the following Substitute Resolution is offered:

RESOLVED, That the AMA provide all feasible and reasonable services, in keeping with the Federation concept, to state associations that seek assistance for their efforts to maintain or accomplish unified membership.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 82 be adopted. (see page 293)

(20) RESOLUTION 105 — CONTINUING MEDICAL EDUCATION NEWSLETTER

Resolution 105 proposes that the discontinued AMA newsletter titled "Continuing Medical Education" be reinstated as soon as financially feasible, preferably on a self-sustaining financial basis; and that the Board of Trustees report on its status at the 1976 Interim Meeting.

While the Reference Committee is willing to accept that the information provided by the Continuing Medical Education Newsletter was very valuable, we feel obliged to note that a newsletter is only one of many mechanisms useful in the transmission of information. We believe that useful information on continuing medical education could well be included in "American Medical News" or JAMA, and that the choice of a vehicle should be left open.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 105 be not adopted. (see page 300)

(21) RESOLUTION 107 — AMERICAN MEDICAL NEWS

Resolution 107 proposes that consideration be given to sending those issues of "American Medical News" that deal with actions of the House of Delegates to all physicians, AMA members and non-members, with priority to AMA non-members who are members of state medical associations.

The Reference Committee heard testimony favoring this resolution and some proposing that it be expanded to include medical students. All the testimony considered that the adoption of this resolution would be helpful in recruiting new members.

Your Committee believes that this proposal should be considered in conjunction with AMA's overall membership recruitment program to assure coordination of the recruitment effort; therefore:

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 107 be referred to the Board of Trustees. (see page 300)

(22) RESOLUTION 122 – REINSTATEMENT OF AMA FIELD SERVICE DEPARTMENT

Resolution 122 proposes that the AMA Field Service be reinstated to facilitate two-way communication within organized medicine as soon as fiscal and budgetary integrity allow.

While there was some support for this proposal in the testimony, it was indicated that the Board of Trustees is planning a modified version of the Field Service Department that would be even more useful and less expensive than the previous service. The Reference Committee is disinclined to discourage the Board's innovative efforts.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 122 be not adopted. (see page 305)

(23) RESOLUTION 143 – AMA GOALS AND PRIORITIES

Resolution 143 proposes through a series of suggestions that the AMA direct its goals in the planning process toward meeting public needs.

The Reference Committee applauds the students for their sensitivity to the public's needs, and believes that their recommendations deserve serious consideration.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 143 be referred to the Council on Long Range Planning and Development for consideration. (see page 312)

(Committee G)

(5) RESOLUTION 83 — DESIGNATED SPECIALTY CODES

Resolution 83 seeks uniformity by replacing the AMA list of 69 designated specialty codes with a list of codes representing only the 28 specialties included in AMA Section Council titles.

Testimony was presented indicating the need for conformity in specialty code designations.

Your Reference Committee notes that there are financial implications to this issue which should be considered further.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 83 be referred to the Board of Trustees. (see page 293)

(6) RESOLUTION 88 — DISCRIMINATION IN ADVERTISEMENTS APPEARING IN AMA PUBLICATIONS

Resolution 88 asks the House of Delegates to direct the editors of all AMA publications to refuse any advertisements which include any element of discrimination.

Testimony was presented indicating that the AMA already has a policy against discrimination on the basis of race, color, creed or national origins in advertising included in AMA publications.

Your Reference Committee notes that the intent of Resolution 88 appears to be satisfied by the uniform application of the Association's current advertising policy.

RECOMMENDATION:

Mr. Speaker, your Reference Committee respectfully recommends that Resolution 88 not be adopted. (see page 294)

(7) RESOLUTION 123 -- VOTING RECORDS OF AMPAC ASSISTED LEGISLATORS

Resolution 123 proposes that AMA ask the American Medical Political Action Committee to publish, at least annually, the voting records of AMPAC assisted Congressmen on significant medical and health care legislation.

Your Reference Committee heard testimony indicating that this information is freely available from many sources to anyone who requests it.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 123 not be adopted. (see page 306)

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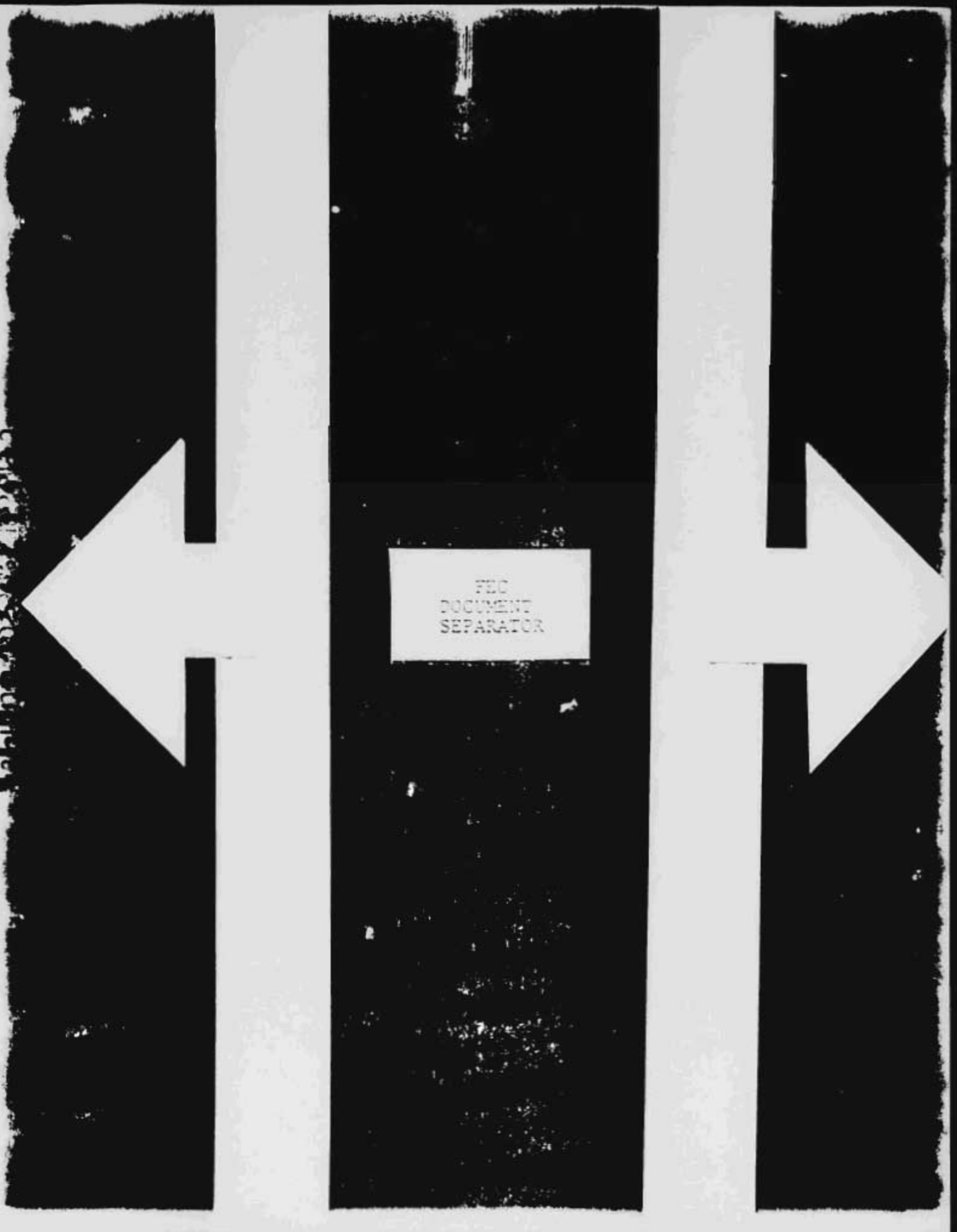
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American Medical Association

Proceedings of the House of Delegates

25th Clinical Convention
New Orleans, Louisiana
November 28-December 1, 1971

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(*Alternate Delegate)

ANNUAL REPORTS

JULY 1, 1970 TO JUNE 30, 1971

The House of Delegates recieved the Annual Reports as information

The following Annual Reports were submitted to the House of Delegates by the Board of Trustees. Each Division and Department of the AMA was asked to prepare a comprehensive report of its activities from July 1, 1970 to June 30, 1971. These reports contain detailed information regarding the programs and contributions of the Standing Committees of the House as well as Councils, Committees and Commissions of the Board of Trustees and the AMA Education and Research Foundation.

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BOARD OF TRUSTEES

Many important subjects were considered by the Board of Trustees during the past year. In addition to those summarized below were computer systems in medicine, current procedural terminology, occupational health programs, AMA direct membership, foreign medical graduates, legalization of marihuana and status of drug abuse, policy statement on relationships between voluntary health agencies and governmental health programs, blood for medical use, emergency medical services, guidelines for community health programs, centralized community and regionalized perinatal intensive care, teenage pregnancy, and increased liaison with house officers. These and others (totaling 49) were submitted to the House of Delegates and will be found in the Proceedings of the Nov. 29-Dec. 2, 1970, and the June 20-24, 1971, Conventions.

Liaison and Affiliations: The American Medical Association continues its membership in the Joint Commission on Accreditation of Hospitals, Board of Commissioners of the National Association of Blue Shield Plans, U. S. Chamber of Commerce, World Medical Association, National Health Council, National Better Business Bureau, Conference of National Organizations, World Federation of Mental Health, Commission on Foreign Medical Graduates, and the Interagency Council on Smoking and Health.

Previously established liaison committees continued their activities with similar committees of the American Hospital Association, American Bar Association, National Medical Association, American Medical Women's Association, Student American Medical Association, Association of American Medical Colleges, and others. Representatives of the AMA have also met with or cooperated with the American Association of Medical Assistants, American Association for the Advancement of Science, the National Research Council, Division of Medical Sciences, National Society for Medical Research, National Fire Protection Association, and the National Council for Homemaker Services. Meetings also have been held between the Board and representatives of the AMA Woman's Auxiliary, the American Academy of Family Physicians, the American Society of Internal Medicine, and others.

Allied Health Manpower: The subject of allied health manpower continued to receive special attention by the Board and its Council on Health Manpower. Attempts have been made to establish a more uniform interpretation of terms such as "allied health sciences," "allied health professions," "ancillary services," "paramedical personnel" and others, and recommended that the terms "ancillary" and "paramedical" no longer be used in AMA statements but that the term "allied" be used in their stead. Concern was also expressed relative to the present systems of licensure for health occupations and it was decided that a nationwide moratorium on licensure of any additional health occupations be declared. Implementation of a study of the entire subject of licensing or credentialling of allied health personnel was authorized by the Board. Studies are continuing with regard to the terminology, evaluation and use of the physician's assistant.

AMA Medicredit Bill: Following consultation with concerned organizations, the Board reviewed several legislative proposals for the financing and delivery of medical and hospital care and began drafting the 1971 version of the Medicredit bill early in the year. Because of the expected passage of legislation with regard to Peer Review Organization, the decision was made to delete PRO from the Medicredit bill, with the idea of introducing it as a separate proposal. An analysis of the Medicredit proposal was sent to the state medical societies and was introduced into the Congress on February 25 sponsored by Senator Hansen, Representative Brayhill, and Representative Fulton. The plan provided government-financed catastrophic illness benefits for all and a system of tax credits, varying according to one's tax liability, for purchase of basic health insurance coverage. The proposal was backed by 150 members of the Congress.

In May 1971 the AMA's Peer Review Organization bill was introduced into the Congress. The proposal called for state medical societies and the HEW secretary to enter into separate agreements to establish statewide systems for review of reasonableness of charges and quality of medical and other health care services provided under Medicare and Medicaid.

Professional Liability: As a result of numerous conferences, negotiations, and explorations by its Committee on Professional Liability, the Board of Trustees approved an AMA-sponsored professional liability insurance program with the provision that any contract with USA not be exclusive and that proposals from other carriers continue to be considered. The program, conducted in cooperation with state and local medical societies, was expected to include a maximum of three to five programs in four to seven states during 1972, and would include eligibility to all qualified physicians of the state and/or local association, guaranteed renewability, guaranteed rates for three years, profit sharing incentives, and protection to $5 million.

Drug Abuse: Following adoption of a policy statement that marihuana is a dangerous drug and should not be legalized, a report on the status of the drug abuse problem was presented by the Board and its Council on Mental Health. The Board also recommended support of President Nixon's establishment of a Special Action Office of Drug Abuse Prevention within the Executive Office and his proposal to strengthen resources and programs for the treatment and rehabilitation of drug-dependent persons. The AMA House of Delegates, on recommendation of the Board, adopted a statement that the AMA strengthen and expand its program to combat drug dependence with particular attention to prevention, identification, treatment, rehabilitation and research and that the state and local medical societies be urged to give priority to the implementation of this program at the community level throughout the nation. Individual physicians were also urged to give special attention to problems of drug abuse and to volunteer their efforts to community programs.

Guam Medical Society: On recommendation of the Board, another constituent society was added - the Guam Medical Society - by the House of Delegates with all of the rights and privileges afforded to existing state, commonwealth and territorial medical associations of the AMA.

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Career Training: The Board endorsed a program proposed by the Northwestern University in collaboration with the Chicago Central YMCA College to train underprivileged students for careers as physicians. Students participating in the experimental project would serve part-time with neighborhood health centers in under privileged areas during their training and would be encouraged to practice medicine in the inner city.

Special Communications Program: The Board approved initiation of a special communications program which would feature full-page messages in magazines and newspapers with the expectation that it would reach 75% of the nation's population. The informational program was an effort to remind Americans of the fact that physicians care and are deeply and genuinely concerned with the health of the people.

Advisory Committee on Medical Science: The Board's charge to this Committee was revised to request it to consider primarily the medical scientific activities of the AMA to assure (1) comprehensiveness of programming; (2) responsiveness to national demands and needs; (3) optimal use of AMA resources; and (4) effective AMA medical scientific leadership.

Annual and Clinical Conventions: The following places and dates were approved for Annual and Clinical Conventions of the Association:

Annual:	1972	San Francisco, June 18-22
	1973	New York, June 24-28
	1974	Chicago, June 23-27
	1975	Atlantic City, June 15-19
	1976	Dallas, June 27-July 1
Clinical:	1971	New Orleans, November 28-December 1
	1972	Cincinnati, November 26-29
	1973	Anaheim, California, November 25-28
	1974	Portland, Oregon, December 1-4
	1975	Honolulu, November 30-December 3
	1976	Philadelphia, November 28-December 1

DEPARTMENT OF MEDICINE AND RELIGION

The purpose of the Department is to provide opportunities for communication between physicians and clergymen in their mutual efforts to give total care to patients and their families, and to find and develop viable models of programs in which the professions can work together. To accomplish this task, the Board of Trustees Committee on Medicine and Religion has recommended three major areas of emphasis:

State and County Societies: Through state committees already established, various programs are carried on to inform physicians and clergy of existing opportunities for discussion about their concerns for the whole man. These committees encourage county societies to engage in this activity on a county or community basis. In this past year, an increasing number of other organizations have sought the cooperation of medicine in co-sponsoring such programs. Many programs have been planned in cooperation with American Cancer Societies, American Heart Associations, Veterans Administration hospitals, local community hospitals and other institutions. A Department newsletter was started during the year to provide information on program developments for state committee members and other interested persons.

Theological Education: The Department provides consultation and resources to assist county societies in developing seminary courses on medicine and religion. Such courses have been arranged during the year to help seminarians understand their cooperative role in working with physicians in caring for patients. Physicians are involved as faculty or seminar leaders.

Medical Education: Medical schools are encouraged to include medicine and religion as part of their continuing education courses. Medical schools that have such courses report good attendance and deep concern on the part of both professions. Across the country, thirty-six clergymen are directly involved to varying degrees as faculty members and seminar leaders in medical schools. Postgraduate education departments of medical schools continue to offer programs on medicine and religion.

The Department held its Ninth Annual Program during the Annual Convention. Chaplain Robert Reeves of Presbyterian Hospital, New York City, spoke on the subject "How Put Man Together Again?". Four regional workshops were held for state committee chairmen and state society staff members who work with medicine and religion committees.

OFFICERS SERVICES DEPARTMENT

Advising and assisting Officers and Trustees of the AMA in regard to speaking engagements and press contacts is the major responsibility of this Department. Staff members serve the President, President-Elect, Immediate Past President and Vice President. The staff also replies to correspondence addressed to these Officers, plans travel itineraries and provides other administrative assistance for the Officers. Because of current emphasis on public health issues, special attention was given this year to developing speaking platforms before national, non-physician audiences, especially for the President.

OFFICE OF THE GENERAL COUNSEL

This report covers the activities of the Office of the General Counsel, the departments under its jurisdiction and the following Councils and Committees staffed by the Office: Council on Constitution and Bylaws, Judicial Council, Committee on Quackery, Committee on Medicolegal Problems and the AMA Liaison Committee to the American Bar Association.

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The Office of the General Counsel continued to function as a central source of information on state legislative proposals and enactments in the medicolegal field. A "State Legislative Roundup" of laws enacted during 1970 was distributed to state medical society offices. Since January 1, 1971, all state legislatures except Kentucky have been in session and periodic reports on "Current State Legislation" have been distributed. Information on such subjects as abortion, blood transfusions, body donations, chiropractic, consent by minors, Good Samaritan laws, immunity for peer review committees, malpractice, physician assistants, reportable acts and diseases, and many other topics was sent to physicians and organizations on request.

Litigation instituted by the AMA to prohibit infringement of copyrighted material in the American Medical Directory was concluded successfully against List Management, Inc. Also concluded successfully was litigation against General Medical Company to prevent the use of the Association's name in collateral advertising. Cease and desist letters were written to more than 15 companies and organizations to prevent unauthorized use of the Association's name in promotional materials. A number of memoranda were prepared for the Board of Trustees, the Executive Vice President, the divisions and various councils and committees.

Council on Constitution and Bylaws: The Council held six meetings during the period and reports were submitted to the House of Delegates at the Annual and Clinical Conventions.

CORPORATE LAW DEPARTMENT

This Department handles the business law matters of the AMA and AMA-ERF, such as contracts, leases, taxes and insurance. Among other activities, the Department reviewed leases for new field offices; negotiated the termination of the Institute for Bioredical Research including personnel separations and transfer of equipment to other institutions; filed the annual registration statement with the Securities and Exchange Commission for the AMA-Members Retirement Plan; negotiated the AMA-Continental Casualty Company (CNA)-Marsh & McLennan agreement, the printing agreement with W.A. Krueger for JAMA and several specialty journals, the Group Practice Study Contract with the University of Southern California, and two agreements with participating banks in the AMA-ERF Student Loan Program. It amended the employees' Blue Cross-Blue Shield contract and terminated the employees' pension contract with Travelers when AMA took over the funding of this program.

DEPARTMENT OF INVESTIGATION

The Department continued its activities to combat health quackery in general and chiropractic in particular.

Chiropractic: The 91st Congress continued to exclude chiropractic from the Medicare program despite intensive efforts by chiropractic and its adherents. In the Social Security Amendments of 1970, the House included a provision calling for the Secretary of HEW to conduct a study of chiropractic services covered under state plans approved under Title XIX. The Senate again wrote chiropractic services into Medicare, but the bill died at the end of the 91st Congress. AMA spokesmen and others submitted testimony to both houses of Congress opposing chiropractic inclusion. Other testimony in opposition included that of the AFL-CIO, the National Council of Senior Citizens, the Consumer Federation of America, the American Public Health Association, the Association of American Medical Colleges and the American Hospital Association. In the 92nd Congress, the House-adopted version of the Social Security Amendments of 1971 contained the same provision for the chiropractic study. Fewer than 75 members of the 92nd Congress lent their names to pro-chiropractic bills as compared to more than 125 in the 91st.

Other developments relating to chiropractic included adoption of a strong anti-chiropractic policy by the Consumer Federation of America; publication of the AFL-CIO Fact Sheet on Chiropractic; adoption of an anti-chiropractic policy statement by the Arthritis Foundation; publication of a new AMA leaflet, What They Say About Chiropractic; production of a new AMA sound-slide presentation, Protection of the Public Health. An article against chiropractic was published by Reader's Digest. Ann Landers' column twice criticized chiropractic, as did a syndicated Washington columnist, among others. All of these materials were given wide distribution.

Health Quackery in General: Liaison and cooperation continued with federal and state authorities in all areas of health quackery. The Department continued to represent the AMA in the Coordinating Conference on Health Information, a group of governmental and voluntary professional organizations working to combat quackery, and it provided representation on the American Cancer Society's Committee on New and Unproved Methods of Treatment.

Committee on Quackery: The Committee sponsored four Regional Conferences on Health Quackery-Chiropractic. In addition, a National Conference on Health Quackery-Chiropractic was sponsored in Boston at the time of the Clinical Convention. The Committee continued to stress the need for state medical societies to take legislative initiative against chiropractic.

DEPARTMENT OF MEDICAL ETHICS

This Department provides staff assistance to the Judicial Council. It also provides advice and assistance to state and local medical societies on questions of ethics and answers inquiries from the public concerning medical ethics.

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The Department provided governmental offices with information and materials, assisted American Medical News with articles, presented a panel discussion on abortion for closed circuit television at the Clinical Convention, and wrote an editorial for JAMA on "Solicitation for Abortion." A new edition, in pamphlet form, of the article "Sale or Disposition of a Medical Practice" was prepared. The Department participated in programs on ethics presented by five medical societies and by one university.

Judicial Council: The Council held five regular business meetings. It also sponsored its Third National Congress on Medical Ethics in September 1970, and co-sponsored a conference on medical ethics with the Oregon Medical Society. At its meeting in September 1970, the Council issued a press release condemning the commercialization of abortion and solicitation of abortions. It had wide circulation in both the general and medical press.

A Council report entitled "Professional Ideals" was adopted by the House of Delegates at the Clinical Convention. The House referred to the Judicial Council a resolution concerning due process for physicians. The Council's report, "Due Process in the Medical Profession," was approved by the House in June. The Council published Ethical Guidelines for Automated Multiphasic Health Testing Programs. The investigation of this subject included observations from physicians throughout the country.

The Council conducted appellate reviews of two cases in which state medical societies had imposed disciplinary sanctions on members. No convincing arguments were presented to justify reversal of the disciplinary actions.

LEGAL RESEARCH DEPARTMENT

The Department developed and made available to members and to state and county medical societies a variety of informational and instructional materials. Twenty-four issues of The Citation, the newsletter of the Office of General Counsel, were published and forty-four articles were written or reviewed for the "Law and Medicine" section of JAMA.

The Department distributed the report on the 1970 Professional Liability Survey, the text of a court decision applying the doctrine of strict liability to human blood used for transfusions, and the Interim Report of the Pennsylvania Ad Hoc Committee on Medical Malpractice Insurance. A collection of bills introduced in state legislatures relating to medical professional liability was distributed. The Department published collections of court decision digests on "Cases on Blood Transfusion" and "Cases on Hospital Staff Privileges." It also published "The Best of Law and Medicine, 1968-1970."

Under the direction of the Committee on Professional Liability, the department participated in the development of the AMA professional liability insurance program and the AMA National Data Collection Center for

Professional Liability Claims Information. It presented the National Conference on Patient Safety in the Hospital, under the direction of the Committee on Professional Liability, in cooperation with the American Hospital Association. It participated in meetings on professional liability insurance with a number of other organizations. It participated in the Second World Conference on Medicine and Law and presented the 1970 Legal Conference for Medical Society Representatives. The Department testified on the proposed abolition of the physician-patient privilege before the Advisory Committee on Proposed Rules of Evidence for U. S. District Courts.

Liaison Committee to the American Bar Association: The Committee met twice. It presented the 1971 National Medicolegal Symposium in joint sponsorship with the ABA, and it made preliminary plans for the 1973 National Medicolegal Symposium.

Committee on Medicolegal Problems: The Committee met twice. It presented a Conference for Representatives of Medical Society Medicolegal Committees in conjunction with the 1971 National Medicolegal Symposium. The Committee began assembling a booklet on all available devices for collection and analysis of breath samples for alcohol content.

CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT

The Center for Health Services Research and Development was established in September 1970. Since that time, the Center has been conducting and encouraging socioeconomic research on the environment within which medicine is practiced. The research efforts are organized to: (1) evaluate experimental delivery systems; (2) identify cost-effective models for the financing, organization and delivery of health services; (3) provide AMA with research reports and data to assist in its decision-making; (4) facilitate participation by medical societies in health services research and development; (5) provide an interface between AMA and the health services research community. The three research departments of the Center have developed and implemented studies which should influence the organization, financing and delivery of care.

Two Center Task Forces have been established to study (1) health legislation and current or proposed health programs and (2) health systems in other countries. The Center Task Force on Public Affairs Research focuses on economic analyses of national health insurance proposals; research on health maintenance organizations and foundations for medical care; history of major legislative proposals dealing with health; history of government health programs; and a health plan for the United States. This Task Force has developed cost estimates for proposals for national health insurance, including Medicredit; estimates of the financial impact on individual families of the NHI proposals; and research publications addressed to the needs

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of the AMA Public Affairs Division, constituent medical societies and the press. The Center Task Force on International Health Systems has provided assistance and impetus to a study of the British National Health Service. The purpose of this study with a British consulting firm is to evaluate the effectiveness of the NHS with respect to the allocation and use of health resources.

The departments have collaborated in a program to assist state and county medical societies with research and development projects. To facilitate these efforts, the Center has developed an extensive file on the research and development activities of constituent societies. A Data Information Center was established to maintain an up-to-date selection of health statistics and information on the health care system. The Data Information Center complements the AMA Library by providing a comprehensive source of specialized data and research texts which are not provided elsewhere. Two other collaborative efforts resulted in the Center's two widely used volumes: Reference Data on Socioeconomic Issues of Health and Reference Data on the Profile of Medical Practice.

DEPARTMENT OF SOCIAL AND ECONOMIC RESEARCH

The Department has worked toward (1) expanding and analyzing the data base on the socioeconomic characteristics of the physician population (Periodic Surveys of Physicians); (2) analyzing and evaluating the economies under different forms of medical practice; (3) analyzing the economic effects of alternative proposals for national health insurance; and (4) providing research support to various groups within the Association.

This Department has the major responsibility for the Center's collaborative research project with the University of Southern California. The first phase of this three-year project has been geared to the development of methodologies and the collection of data necessary for the comparative evaluation of the economies of alternative forms of medical practice. The Department has: developed a questionnaire which will be used in a nationwide survey to evaluate the economies of scale in medical practice; developed and tested proposed models for measuring physician productivity and evaluating the effect of ancillary personnel; designed and selected a nationwide sample of physicians; and conducted two pilot surveys for the AMA-USC project.

The Department developed articles on the demographic characteristics of the physician population, physician income and expenses and physician use of allied health personnel. Position papers have been developed and presented to HEW on manpower, financing, health care delivery and quality of care. Informational materials were developed for AMA testimony before Congress.

DEPARTMENT OF SURVEY RESEARCH

The Department was responsible for initiating the surveys which provide the information for the Center's primary data base on the physician population. It is responsible for the release of membership data. The Department has conducted the surveys performed by the Center and has published the results. Based on the physician data base, the following reports have been published since September 1970: Distribution of Physicians, Hospitals, and Hospital Beds in the U. S., 1968; Distribution of Physicians, Hospitals, and Hospital Beds in the U. S., 1969 (2 volumes); Reclassification of Physicians, 1968; Medical Groups in the U. S., 1969; and Distribution of Physicians in the U. S., 1970. The following publications will be released in late 1971 or early 1972: Foreign and Canadian Medical Graduates in the U. S., 1970; Historical Statistics of Physicians in the U. S., 1930-1970; Medical School Alumni, 1971; Selected Characteristics of the Physician Population, 1968 and 1971; and Distribution of Physicians in the U. S., 1971.

The Sixth Periodic Survey of Physicians was completed and the pilot study for the Seventh PSP is underway. The latter survey and a Survey of Medical Groups were developed for the collaborative study with the University of Southern California. Other surveys include: 1970 AMA Clinical Convention Survey; 1971 AMA Annual Convention Survey; a Marijuana Survey with Stanford University; a Consumer Health Survey with the University of Chicago and the NORC; an Ambulatory Care Study with the National Center for Health Statistics; and a Professional Liability Data Form Study.

The Department gave a presentation to the Office of Emergency Preparedness on the AMA's physician data base. Numerous requests for data tabulations were filled. Medical Societies were assisted in designing questionnaires, conducting surveys, and providing data. The Department, in addition to developing proposals for studies of medical service areas in the United States and for refining the AMA group practice and physician record keeping systems, is working with various university researchers in the preparation of joint publications on physician manpower.

DEPARTMENT OF HEALTH SYSTEMS RESEARCH AND EVALUATION

The purpose of the Department is to develop a research program to describe, analyze, and evaluate health care delivery systems. A program relating to computer applications in medicine is part of this Department's activities.

The Department prepared a Socio-Economic Curriculum for medical students, interns and residents. A proposal was written for a survey of medical school graduates in 1980. This survey will collect data for updating the Weiskotten series and will enable the Center to conduct analyses of physician mobility and location decisions. A report on the state-of-the-art of computer applications in medicine was submitted to the House of Delegates at the AMA's 1971 Annual Convention. This research document will be printed and will include a comprehensive bibliography. Proposals were developed for an experimental project on automating medical records, a project to trace the history of large government health programs and health legislation and a project to establish a data base on professional liability. The papers are being written as joint projects with the USC staff. Research papers were drafted relating to legal aspects of peer review, guides to constraining costs under Medicare,

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forms of payment for physicians' services, regional organization of health services, the concept of need for health care and infant mortality.

Work has begun on determining the applicability of new mathematical techniques to analysis of health delivery systems. This project has the potential of producing innovative breakthroughs in health systems analysis. The Department did an extensive review of "Towards a Comprehensive Health Policy for the 1970's," an HEW white paper.

DIVISION OF SCIENTIFIC PUBLICATIONS

The Division of Scientific Publications continued its efforts to improve The Journal and the ten AMA specialty journals in both content and format.

THE JOURNAL

New sections include Medicine in Metamorphosis, designed to give evidence of new movements whereby the profession is serving "to advance the art and science of medicine and protect the health of the people"; Clinical Pathological Conference, designed to enable the reader to pit his own clinical acumen against that of the chief discussant in the unveiling of the final diagnosis; Clinical Survey, designed to give the practicing physician up-to-date information and advice on the wide variety of problems he is likely to meet in office practice.

Editorials of wide social interest have increased in number. The emphasis in Medical News has been changed from reports based on papers at medical meetings to stories based on interviews and combinations of information from several sources. Occasional whimsical items have been published on such subjects as "The Loch Ness Monster" and "Nicholas Copernicus and the Inception of Bread-Buttering."

Format changes include wider use of four-color illustrations; new type faces on the editorial pages and for the abstracts; a new logo for the Law and Medicine section, the Miscellanea Medica page and the JAMA 75 Years Ago page. A new program to improve the general format includes a careful review of graphs, charts, photographs, roentgenograms and illustrations before publication and a critical review after publication. A medical art consultant was employed to provide professional advice and evaluation.

Because of a strike at the McCall Corporation in Dayton, Ohio, the issues of JAMA from April 26, 1971 through July 5, 1971 were printed at W. A. Krueger Company, Brookfield, Wisconsin.

SPECIALTY JOURNALS

On January 1, 1971, John S. Chapman, M. D., Dallas, succeed Katharine R. Boucot, M. D., as Chief Editor of Archives of Environmental Health.

Changes in format included a new pictorial cover design and redesigned name place for Archives of Environmental Health; a redesigned cover and new body typeface and display headings for Archives of General Psychiatry; a modified cover design and new name plates for Archives of Pathology and Archives of Surgery.

As of August 1970, the Archives of Internal Medicine, the Archives of Pathology and the American Journal of Diseases of Children were printed at new locations. The Archives of Pathology was transferred from Baird-Ward Printing Company, Nashville, to the Poole Printing Company, Chicago, where seven other specialty journals are printed. The Archives of Internal Medicine and the American Journal of Diseases of Children are now printed at W. A. Krueger Company, Brookfield, Wisconsin.

DIVISION OF SCIENTIFIC ACTIVITIES

The Divison has seven departments which are responsible for staffing six councils and sixteen committees. Secretariats are provided for the Advisory Committee on Medical Science, the Committee on Maternal and Child Care, the Committee on Transfusion and Transplantation, the CORE Committee on Human Sexuality, and several internal committees of the Board if Trustees and the AMA-ERF.

Advisory Committee on Medical Science: This Committee advises the Board of Trustees on a wide diversity of scientific problems. It has considered problems in medical education and health manpower, the role of research training in medical education and the implications of certain aspects of medical technology.

Committee on Maternal and Child Care: After more than a year of study, statements on intensive care for newborn infants and teenage pregnancy were submitted to the Board of Trustees for transmission to the House of Delegates. The House adopted these reports which may help reduce infant mortality in the United States.

Committee on Transfusion and Transplantation: The Committee sponsored a symposium on the current status of transplantation at the Annual Convention. A new edition of the Guide for Hospital Committees on Transfusions was produced. The House of Delegates adopted a report of the Board of Trustees on Voluntary Donations of Blood and Blood Banking which was proposed by the Committee.

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AMA Handbook on Human Sexuality: Written by a professional writer under the supervision of an editorial committee of physicians, this handbook is nearing completion. The book is intended to be a guide for practicing physicians, interns, residents and medical students to enable them to function more effectively as counselors. A late 1971 or early 1972 publication date is anticipated.

OFFICE OF CURRENT MEDICAL TERMINOLOGY

Current Procedural Terminology (CPT), Second Edition, was published in April 1970. Additions include approximately 1,000 new procedures or revised terms for old procedures, and a special index of terms arranged according to body systems. CPT is computer oriented for statistical studies or peer review.

The manuscript of Current Medical Information and Terminology (CMIT), Fourth Edition, was presented in March 1971. Approximately 500 new terms and definitions have been added. Preciseness and specificity of terminology are emphasized. A special section of preferred names of diseases and conditions in French, German and Spanish with cross references has been added. The format has been enlarged.

A Thesaurus of Medical Descriptors (TMD) is under development. Vocabularies are derived from the scanning of standard textbooks.

DEPARTMENT OF DRUGS

Council on Drugs: The Council met three times with representatives of government, industry and other medical specialty groups to discuss current policies and the future activities on the education of physicians in pharmacotherapeutics. The ad hoc Committee on Drug Evaluation met five times to review its publication, AMA-Drug Evaluations, which was mailed to all dues-paying members in April. A special ad hoc committee met with representatives of the University Group Diabetic Program to discuss the group's study of the treatment of diabetes mellitus. The ad hoc Committee of a Study Group for a National Drug Commission, chaired by a member of the Council, met with the Food and Drug Administration Commissioner to discuss the need for establishing a panel of experts for consultation on matters of interest as they come to the attention of the FDA. Council statements and articles in JAMA included five evaluations of new drugs, twelve listings of new nonproprietary names adopted by the USAN Council, one authored report on drug utilization, two editorials and three special publications. In addition, two new editions of the nomenclature print-out were published.

Committee on Cutaneous Health and Cosmetics: The Committee met twice to discuss the medical aspects of cosmetic legislation and future activities. The Committee sponsored a symposium at the American Association for the Advancement of Science Annual Meeting and co-sponsored symposia at the American Academy of Pediatrics meeting and at the American Pharmaceutical Association meeting. Articles were published in JAMA, Cutis, Professional Medical Assistant, and Southern Medicine. Three revised pamphlets were issued.

In addition to providing support for the activities of the Council and the Committee, the Department maintained liaison with many governmental agencies and medical and scientific associations, answered 3, 152 inquiries from physicians and the public, mailed 12, 758 reprints and 23,921 pamphlets, generated 2,600 abstracts on new drugs, and developed and staffed six exhibits that were shown at 16 meetings.

DEPARTMENT OF ENVIRONMENTAL, PUBLIC AND OCCUPATIONAL HEALTH

On December 1, 1970, the Department of Environmental Health and the Department of Occupational Health were combined. The Council on Occupational Health, its committees on Occupational Toxicology, Aerospace Medicine, and Mental Health in Industry, and the Council on Environmental and Public Health retain their former identities and secretaries, but there is closer liaison between these groups on allied projects.

Environmental Health: Liaison was maintained with the Environmental Protection Agency, the Council on Environmental Quality, the Center for Disease Control, and other governmental and non-governmental agencies. A meeting was held with the Administrator of the Environmental Protection Agency to offer AMA's assistance and to acquaint EPA with the AMA's environmental health activities.

The Tenth Biennial Air Pollution Medical Research Conference, sponsored by the Council, was held October 5-7, 1970. The 1972 Air Pollution Medical Research Conference will be held in Chicago in October. The Eighth Annual Congress on Environmental Health was held in New York City on April 26-27, 1971 and featured "Solid Waste Management." The 1972 Congress on Environmental Health will be held in April in Los Angeles with the theme "Housing and Health."

The Council on Environmental and Public Health met three times. The Council began sponsoring regional meetings for medical societies, state health departments, state and regional governmental agencies, and others. These meetings are structured for an exchange of information in environmental and public health affairs at the local and state levels. During 1971-72, one-day regional meetings will be conducted to include the rest of the states.

Publication of a bi-monthly newsletter, Environmental and Public Health News, was begun in October 1970. It is sent to medical societies, health departments, and a select group of organizations and individuals with interest in environmental and public health affairs. The Department printed a listing of films dealing with "Problems of Our Environment." Informational material is being developed for physicians on air, noise and water pollution, as well as a statement on air pollution episodes. In April 1971, the Council issued a Statement on Venereal Disease which was distributed to state and county medical societies.

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Occupational Health: The Department handled thousands of inquiries about recent legislation and other problems relating to occupational health and distributed about 90,000 copies of guides for industrial physicians.

The Council on Occupational Health sponsored its 30th Congress on Occupational Health in Los Angeles in September 1970. The Physician's Award of the President's Committee on Employment of the Handicapped was presented to Gerald R. Clark, M. D., of Pennsylvania. The Council and the Department contributed to implementation of the Occupational Safety and Health Act of 1970 and other similar federal laws. Numerous papers were prepared for the Environment Page of JAMA. The Council's basic guide, Scope, Objectives and Functions of Occupational Health Programs, is undergoing changes for resubmission to the House.

The Committee on Occupational Toxicology sponsored statements on "Potential Health Hazards of Materials Used in Boating," "Prevention and Management of Organophosphate Poisoning," an editorial on "Microwave Ovens," and articles for the Environment Page of JAMA. Work continues on the Committee's Registry on Adverse Reactions Due to Occupational Exposures.

The Committee on Aerospace Medicine prepared three articles for the Environment Page of JAMA. Studies continued on time zone effects on aircraft passengers, Federal Aviation Administration regulations on alcohol and drugs used by pilots, aerial applications of pesticides, and aircraft crash locator beacons. The Committee is preparing an aerospace symposium for the 1972 AMA meeting.

Members of the Joint Committee on Mental Health in Industry presented two papers at the 30th Congress on Occupational Health. Studies continue on drug abuse, sensitivity training and mental health problems in industry. A mental health symposium for the 1972 Occupational Health Congress is in preparation.

DEPARTMENT OF FOODS AND NUTRITION

J. E. Canham, M. D., and R. E. Hodges, M. D., received the Goldberger Award in Clinical Nutrition. The medical student research fellowship program and the AMA Lectures in Medical Science continue as ongoing programs. Utilizing resource conferences, symposia and policy reports, many activities were undertaken to encourage improvement in the safety and quality of our food supply, to explore the microbial safety of catered and franchised food and to develop more meaningful food labels and consumer information programs.

Through its continuing activities in clinical nutrition, the Council on Foods and Nutrition has developed several teaching video tapes and films. Nutrition education programs directed towards improving the quality of life of disadvantaged teenagers are underway. The program was prepared for the Western Hemisphere Nutrition Congress.

DEPARTMENT OF MEDICAL INSTRUMENTATION

The Department of Medical Instrumentation was created July 1, 1970, from the Medical Physics, Impairment Rating, and Rehabilitation Sections of the former Department of Postgraduate Programs. This change enables the AMA to expand activities in biomedical engineering and instrumentation and medical devices and to continue programs in rehabilitation and the guides for rating impairment. The Department has been concerned with the collection of data and the provision of information to the profession and the public on medical devices, computers in diagnosis and treatment, ionizing radiation, medical device standards, device standards, device safety and efficacy and the consideration of regulatory and legislative proposals in these areas. It provided services for the former ad hoc Committee on the Rating of Mental and Physical Impairment.

Publications: Approximately 16,000 reprints of the individual guides on impairment rating were distributed. The "Guide for the Evaluation of Permanent Impairment - The Hematopoietic System" was published in JAMA and reprints were made available. The book, Guides to the Evaluation of Permanent Impairment, was revised. The publication Medicine's Back to Work Plan, which describes a state or county association program in rehabilitation, and the Survey of State Medical Association Committees Concerned with Rehabilitation were distributed.

Service Activities: The Department participated in the National Conference on Patient Safety in the Hospital. A study was made of computer uses in diagnosis and treatment for the Committee on Computer Systems in Medicine. The Department was a source of consultation services for many AMA departments. Information was provided to physicians and others on medical device availability, standards sources and uses.

Exhibits: The new exhibit "Engineering-Medicine-Physics," explaining the basic sciences and their relation to patient safety, was shown at the AMA Convention other conventions during the year. A descriptive exhibit brochure was prepared.

Liaison: Staff worked with the Committee on Hospitals of the National Fire Protection Association and with the Committee on Device Definition and Classification of the Interassociation Committee on Devices, which is seeking to develop suitable federal legislative and regulatory activities for health care devices. A report on the use of the metric system in medicine was presented at the National Bureau of Standards-National Metric Study Conference. Other activities included participation in the University of Southern California Hospital Information Systems Conference and the Food and Drug Administration Conference on cardiac pacemaker interference, as well as service on the Executive Committee for the 1971 National Rehabilitation Association National Conference and the Medical Committee of the President's Committee on Employment of the Handicapped.

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The ad hoc Committee on the Rating of Mental and Physical Impairment completed its 15-year effort with the publication of the 13 guides and the review and revision of the previously published impairment rating guides. The guides were then combined and published in a single volume, AMA Guides to the Evaluation of Permanent Impairment.

DEPARTMENT OF MENTAL HEALTH

Council on Mental Health: The Annual Conference of State Mental Health Representatives was held in September. The Council surveyed several community mental health centers as a part of its continuing review of that federally supported program. Representatives of the Council appeared before the Advisory Committee on Federal Rules of Evidence to present the AMA's position on physician-patient privilege.

The Council developed a position paper on sensitivity training; continued its revision of the Handbook on Mental Retardation; and authorized the revision of its statement on "Medical Use of Hypnosis." The papers presented at the AMA-APA Conference on Violence and Aggression in 1969 were published.

Committee on Alcoholism and Drug Dependence: Members of the Committee testified on behalf of the AMA before several Congressional committees on the subject of drug abuse and dependence, giving full support to the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970. A detailed critique was submitted to the FDA on its proposed regulations for investigational use of methadone maintenance for narcotic addiction. The Committee and Council issued jointly with the National Research Council a statement on what they consider good medical practice in the use of methadone in maintenance programs. The Committee urged the transfer of amphetamines and methamphetamines from Schedule III to Schedule II of the Controlled Dangerous Substances Act.

The AMA jointly with the American Psychiatric Association sent a statement to appropriate government officials urging amendments to the draft of the International Protocol on Psychotropic Substances. Members of the Committee have met with a drafting committee of the Commission on Uniform State Laws in developing a model law on alcoholism.

The Committee and Council published statements on "Alcohol and Society," "Recovery from Drug Dependence," "Guidelines for Admission of Alcohol-Dependent Patients to General Hospitals." All were published in JAMA.

The Department continued liaison with state medical societies and other agencies and organizations on many problems related to mental health, drug abuse, alcoholism and mental retardation. Two department exhibits, one on alcoholism and one on drug dependence, have been displayed at state medical association and other medical meetings. Statements on legislation and regulations were presented to Congressional committees and agencies.

DEPARTMENT OF SCIENTIFIC ASSEMBLY

Annual and Clinical Conventions, Scientific Programs: The scientific programs for the Clinical Convention in Boston and the Annual Convention in Atlantic City were presented. The Clinical Convention attracted 3,665 physicians. A post-convention survey indicated that a high percentage of those attending rated as excellent the scientific program and the scientific exhibits. There were 420 participants in the scientific assembly at the Annual Convention. This year a greater percentage of the registered physicians attended the scientific sessions. The in-depth seminars dealing with "Coronary Care" and "Trauma" were extremely well attended. The general sessions on "Abortion--A Legal Fact" and "Drug Abuse" also attracted large audiences. The Section meetings -- particularly the joint sessions -- were well attended considering the relatively low registration. At the Scientific Awards Dinner at the Annual Convention, George R. Herrmann, M. D., received the Distinguished Service Award. Professor J. Z. Gougoutas accepted the Scientific Achievement Award for Robert B. Woodward, Ph. D., who was unable to attend. Mr. Malcolm A. Aldrich and Mrs. J. Raymond Knighton each received the Citation of a Layman for Distinguished Service.

Scientific Exhibits: A total of 202 exhibits was presented at the Annual Convention. The "Arthritis" exhibit at the Annual Convention was expanded to utilize closed-circuit television for the presentation of live patient-teaching sessions. The special exhibits on "Resuscitation" and on "Pulmonary Function" attracted standing-room-only attendance each day. Awards for outstanding exhibits were presented at the Scientific Awards Dinner. More than 3,600 copies of scientific exhibit pamphlets were distributed during the Conventions.

Medical Motion Pictures: More than 4,000 requests for film catalogs and information on the availability of films dealing with such subjects as venereal disease, drug abuse and sex education were distributed. The catalog listing more than 5,000 motion pictures produced in 1969 is practically out of print. The film library now contains approximately 4,000 prints of 450 subjects. More than 21,000 films were distributed to hospitals, medical schools and medical societies. In cooperation with the American College of Obstetricians and Gynecologists, the AMA is producing a film entitled Toxemia of Pregnancy. Staff organized screening juries for films sent to international film festivals approved by the State Department.

DIVISION OF MEDICAL EDUCATION

Important policy decisions were made by the Council on Medical Education and subsequent actions carried out in a number of areas. Most notable were actions to integrate internship and residency training, to approve two new conjoint specialty boards, to provide a new pathway for entrance to American medical education for students studying medicine abroad and to authorize development of a new National Council for International Health.

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Two new medical schools opened for the 1970-71 academic year, bringing the number with students enrolled to 103. An additional 12 medical schools were recognized as being in development. Steady growth was also evident in AMA survey and accreditation activities in other educational fields, particularly in continuing medical education and allied health education.

Publications and Reports: The Division is responsible for the publication of five major reports annually. Three of these are regular issues of JAMA: the Education Number, the Medical Licensure Number and the Continuing Education Number. Also published was the second edition of the Directory of Approved Allied Medical Educational Programs. The annual Directory of Approved Internships and Residencies was not published because of difficulties in electronic data processing. However, a special "Preprint of Information on Internship Programs and on Residencies Available without Prior Internship" was published to permit the National Intern and Resident Matching Program to go forward. The next edition of the Directory is anticipated for early fall, 1971.

Two special reports were presented to the House of Delegates in June 1970. One of these, "Physician Manpower and Medical Education," was prepared jointly by the Council on Medical Education and the Council on Health Manpower, with assistance from the Council on Medical Service. The other report was "How Medical Students are Being Taught." Both were recommended for wide distribution.

Annual Congress on Medical Education: The 67th Annual Congress on Medical Education was held in Chicago in February 1971. It was attended by 1,518 physicians, educators, hospitals and medical administrators and representatives of state licensing bodies. Many of the papers were published in JAMA and are being assembled as "Selected Papers from the 67th Annual Congress on Medical Education."

Committees of the Council on Medical Education: Each of the four standing advisory committees met at least four times. The Liaison Committee on Medical Education of the AMA and the AAMC, and the Liaison Committee for Specialty Boards of the AMA and the American Board of Medical Specialties met several times. The Council's Committee on Family Practice continued its activities, aimed at implementation of the recommendations of the ad hoc Committee on Education for Family Practice.

DEPARTMENT OF ALLIED MEDICAL PROFESSIONS AND SERVICES

The House of Delegates adopted the revised "Essentials" of approved educational programs for medical assistants. The AMA now approves educational programs for 15 allied medical occupations in collaboration with 14 national professional associations.

The Advisory Committee on Allied Health established the Subcommittee to Draft Essentials of an Approved Educational Program for Physician's Assistants.

Participants include representatives from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Society of Internal Medicine, Association of American Medical Colleges and the AMA.

The Advisory Committee also established task forces consisting of members of the Advisory Committee and the Panel of Consultants to consider topics of importance in allied health. The task forces established are considering career mobility and core curriculum, equivalency and proficiency examinations, continuing education, fees for accreditation services, institutional approach to program evaluation, instructor preparation, legislation, military allied medical education and terminology.

Circulation of the Allied Medical Education Newsletter has increased from 4,400 to 5,500. Approximately 5,000 copies of the 1971 edition of the Directory of Allied Medical Educational Programs had been distributed by July 1.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Eighteen institutions or organizations were granted accreditation by the Council on Medical Education after review by the Advisory Committee on Continuing Medical Education. On June 30, 1971, there were 99 accredited institutions -- 46 medical schools, 21 hospitals, 13 specialty societies and 19 others, including medical societies, voluntary health and governmental agencies. There was a one percent growth in the number of courses in the listing of "Continuing Education Courses for Physicians." The apparent reason for this smaller increase, as compared with a 15 percent increase in the previous year, is that this year all circuit courses were combined for any single institution and listed as a single course. The listing now includes 2,354 courses offered by 798 institutions and organizations.

The AMA Physician's Recognition Award attracted more than 28,000 physician applicants during 1969 and 1970. Of the 23,500 doctors who qualified and received Award Certificates, 11,788 were in residency training programs and 11,712 were practicing physicians. In February, the Board of Trustees Committee on Continuing Medical Education established a subcommittee to deal with the Award. Reciprocity arrangements for the Award were made with a medical specialty organization and several state medical societies.

The Department conducted a review of state and specialty medical associations to determine their programs and policies on continuing medical education. The review indicates that:

1. Five state medical associations (Arizona, New Mexico, Ohio, Oregon and Pennsylvania) have a requirement of participation in continuing education for continued membership.

2. One state society (New Mexico) passed a resolution that would support legislation requiring continuing medical education as a condition for relicensure. (Such legislation was passed by the New Mexico Legislature March 24, 1971.)

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3. One specialty society (the American Academy of Family Physicians) requires continuing medical education for society membership.

4. Five specialty societies have established programs of self-assessment. Seven other specialty societies are considering or developing self-assessment programs.

The Continuing Medical Education Newsletter has a readership of more than 2,600.

The Second National Conference of State Medical Association Representatives on Continuing Medical Education was held October 13-15, 1970. A one-day invitational workshop on self-assessment was attended by representatives from 24 medical specialty societies and several experts in the field of physician self-assessment and medical examination.

Guidelines are being developed to enable state medical associations to carry out an accreditation program for institutions offering continuing medical education within their jurisdiction. Institutions offering continuing medical education courses for physicians on a nationwide scale would continue to be accredited by the AMA.

DEPARTMENT OF GRADUATE MEDICAL EDUCATION

Major efforts were continued to speed the integration of the internship and residency training in accord with recommendations of the Citizens Commission on Graduate Medical Education as approved by the AMA House of Delegates. The Council on Medical Education, with the assistance of its Advisory Committee on Graduate Medical Education, developed and distributed explanatory memoranda concerning the details of integration of the internship and residency training. Several specialty boards removed the internship as a requirement for certification. To preserve the educational aspects of rotating internships during the transition period until June 30, 1975, when free-standing internships will no longer be approved, the Council recommended to all Residency Review Committees that they consider approving rotating internships with significant amounts of emphasis in their specialties if such programs are offered in institutions with corresponding approved residencies.

The Council on Medical Education and the American Board of Medical Specialties recognized two conjoint specialty boards. They are the American Board of Nuclear Medicine, a conjoint board of the American Boards of Internal Medicine, Pathology, and Radiology, and the American Board of Allergy and Immunology, a conjoint board of the American Board of Internal Medicine and the American Board of Pediatrics.

The Council approved revised guides for residencies in family practice, anesthesiology, general preventive medicine, ophthalmology and physical medicine and rehabilitation. The "Essentials" pertaining to residencies in preventive medicine, obstetrics-gynecology and internal medicine were revised and were approved by the House of Delegates. The Residency Review Committee

for Obstetrics-Gynecology was authorized by the Council to approve as straight internships programs which include services other than obstetrics-gynecology. The Residency Review Committee for Plastic Surgery was authorized to evaluate short-term specialized training programs which complement or supplement the already approved residency programs. Experimental programs in surgery were approved for four years duration with the first year designated as both an internship and first-year residency.

The following specialty boards now accept osteopaths for examination: Anesthesiology, Dermatology, Internal Medicine, Orthopedic Surgery, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Preventive Medicine, Psychiatry and Neurology and Radiology.

DEPARTMENT OF UNDERGRADUATE MEDICAL EDUCATION

With increasing activity in the development of new medical schools, the surveys and consultations conducted jointly with the Association of American Medical Colleges through the Liaison Committee on Medical Education continue to expand in number. Thirty-nine accreditation surveys were carried out. Of these, 16 were of developing schools. Three of the total were of Canadian schools. The number of surveys in which the clinical graduate educational programs were also reviewed (institutional survey) was increased to eight.

A function of the Liaison Committee is to issue "Letters of Reasonable Assurance" indicating that a new school is expected to attain accreditation status or that in an existing school a contemplated major increase in enrollment does not threaten the school's accredited status. The Liaison Committee issued 14 letters to existing schools planning expansion and one to a developing school.

An ad hoc Committee on Extramural Medical Student Educational Programs is studying a number of extramural programs, such as the Student American Medical Association-Medical Education Community Organization, as instructed by the House of Delegates.

An increasing number of United States students have sought medical school training abroad, following their unsuccessful efforts to gain admission to a U. S. school. Their dissatisfaction with existing pathways into U. S. postgraduate training and practice has become manifest. In response the Council, in conjunction with the Commission on Foreign Medical Graduates, has devised an additional pathway into the mainstream of medicine for students who have completed their premedical education in the United States and their formal academic training abroad and who have passed appropriate screening examination.

The Advisory Committee on Undergraduate Medical Education continued to examine and evaluate problems in medical education, particularly curricular changes, community projects initiated by medical students, legislation relating to medical schools, and problems relating to the growing numbers of American students in foreign medical schools. A report, "How Medical Students are Being Taught," was transmitted to the House of Delegates in June 1971. Project Talent, a research study of several thousand high school students who indicated an interest in medicine in 1960, continued during 1970-71.

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DEPARTMENT OF INTERNATIONAL MEDICINE

The major activity during the year was the creation of the Task Force for International Health. The Task Force recommended the formation of a National Council for International Health and a General Assembly of International Health Agencies. The National Council is to be sponsored jointly by a number of professional organizations and is to be composed of delegates named by the sponsoring groups, members ex-officio from government, and members appointed at-large to represent other professions and disciplines within or closely related to the health fields. The National Council was introduced and the General Assembly was proposed at the Fifth AMA Conference on International Health in September. Subjects considered at the Conference included economics, demography, environment, management and education as they relate to the delivery of health care.

Vietnam Medical School: The AMA has completed four years of support to the Faculty of Medicine, University of Saigon, under contract with the United States Agency for International Development. The contract has been extended to December 1972. The basic structure of the project activity remains unchanged, with support by "counterpart departments" of various American medical schools. Budgetary uncertainties forced the attenuation of a number of activities and the discontinuance of contractural relationship with departments of physiology, biochemistry, parasitology, neurology, otolaryngology and dermatology. This was consistent with the plan to shift emphasis toward the major clinical areas. Efforts are now concentrated upon medicine, pediatrics, obstetrics and gynecology, preventive medicine and public health, pathology, radiology and anesthesiology. Negotiations are underway with the department of surgery. A site survey of the project was conducted by the Department of State and a favorable report was made. This project was undertaken by AMA as a pilot activity to test the effectiveness of a particular form of departmental counterpart support by a group of American medical schools in a developing country. The project has brought many worthwhile issues into focus.

Volunteer Physicians for Vietnam: This program continues under contract with AID to provide voluntary service by American physicians to provincial hospitals in Vietnam. The program has been reviewed in the light of diminishing military activity; and, as a result, efforts will be concentrated in a few of the larger provincial centers, with emphasis upon continuing education for Vietnamese physicians through working relationships and formal programs. Volunteer physicians with academic qualifications are being assigned to teaching hospitals in Saigon or to provincial centers where medical students are serving as interns.

Liaison Activities: The Department publishes The International Health Bulletin, with a circulation of 2,300, and responds to inquiry about international health matters. The Department provides staff support to the AMA delegates to the World Medical Association. It maintains liaison with the World Health Organization, agencies of the U. S. government, other professional organizations with international health activities, foundations and voluntary agencies.

Doctor-to-Doctor Program: This program establishes contact between physicians of this and other countries for exchange of medical literature. More than 1,000 relationships have been established.

DIVISION OF MEDICAL PRACTICE

The Division of Medical Practice was established in September 1970 as a focal point for the socioeconomic aspects of the organization, delivery, and financing of medical care. It staffs 20 councils and committees. Prominent among the areas of concern are peer review, practice management, new health occupations, pilot projects in medical care delivery systems, emergency medical services, revised hospital standards, foundations for medical care, long-term care, group practice and the expanded role of nurses.

The Division assisted in developing the Association's approach to national health insurance by arranging and participating in meetings with other national organizations, by participating in task forces on Medicredit and by critiquing the proposals of other organizations. An informational paper summarized the background, current status and report goals of the federal government in the establishment of health maintenance organizations. Through the AMA Washington Office, government agencies were contacted periodically about changes in regulations or administration of such programs as Medicare and Medicaid.

In cooperation with the Center for Health Services Research and Development and the Department of Environmental, Public and Occupational Health, position papers were prepared on "Health Care Delivery Systems, Health Care Financing, Manpower and Facilities, Quality of Care and Evaluation, and Environmental Quality and Human Health."

Council on Medical Service: The Council sponsored the Fifth National Congress on the Socioeconomics of Health Care, the Medical Services Conference on "New Approaches to Health Care Delivery" and the "National Workshop Conference on Peer Review." The latter was the culmination of a series of eight regional meetings on peer review; the program was developed with the cooperation of the American Society of Internal Medicine. The meeting coincided with release of a newly-developed Peer Review Manual.

The Council reported to the House of Delegates on foundations for medical care, urged action by state societies and state governments to assure physician representation at the White House Conference on Aging; presented a resume of peer review activities; recommended mechanisms for resolving disputes between hospital governing bodies and their medical staffs; presented guidelines for medical staff members on hospital governing bodies; presented a glossary of terms frequently used by medical review committees; transmitted a statement on the background, current status and arguments for and against health maintenance organizations; proposed guidelines for the role of individual physicians, hospital medical staffs and medical societies

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...community health planning and reported on a study of community health de... programs. The Council made recommendations to the Board of Trustees on ... functions of health care and on the reintroduction of Peer Review ... legislation.

The organizational structure of the Council was changed slightly by the addition of a newly constituted Committee on Health Care of the Poor and by the discharge of the ad hoc Committee on Foundations for Medical Care which had completed its assignment.

Committee on Community Health Care: The Committee modified its statement of purpose to include reference to multiphasic health testing and the particular problems of the poor. It devoted a great deal of time to site visits to and evaluation of community health programs. In June 1971, a report on this subject was submitted for the information of the House of Delegates. Guidelines for Community Health Programs were developed and published as a joint undertaking with the Council on Medical Service and the Council on Rural Health.

The Committee continued its efforts to obtain and evaluate information on off-hour elective and semi-elective medical care programs. A report on regional medical programs was transmitted to the Board of Trustees and incorporated in a report to the House of Delegates. Through the Washington Office, efforts were made to improve liaison with officials of comprehensive health planning and regional medical programs, particularly at the federal level. State medical societies were urged to create committees on college health and collegiate institutions were urged to have full- or part-time medical directors. With the Department of Health Education, the Committee participated in the development of the annual Community Health Week Kit.

Committee on Aging: The Committee encouraged and assisted physicians in preparation for the White House Conference on Aging on November 28 to December 3, 1971. A report to the House of Delegates urged Conference emphasis on improving the health of the aging. A report recommending emphasis on ten select concepts was prepared for Conference delegates.

The Committee sponsored two conferences to discuss medical problems of the long-term patient. It commented on a number of legislative proposals affecting the health of the aging. Liaison continued with many private and governmental groups.

Committee on Health Care of the Poor: In October 1970, the AMA Board of Trustees discharged the ad hoc Committee on Health Care of the Poor, which served as a temporary committee of the Board, and referred its functions to the Council on Medical Service. In view of the related areas of interest, the Council reconstituted the Committee on Health Care of the Poor as an integral part of the Committee on Community Health Care.

The Committee held two meetings at which it reviewed the activities of the AMA concerning health care of the poor. The mission of the Committee is "to mobilize and utilize the resources of the medical profession and the AMA to achieve available, accessible and acceptable health care for the poor, recognizing that performance must be commensurate with promise."

The Committee maintains liaison with the American Hospital Association's Special Committee on Health Care of the Disadvantaged. A representative of the Student American Medical Association participated in Committee functions and the Committee invited representatives from SAMA and the Student National Medical Association to attend meetings when appropriate. Liaison was developed with private and government groups.

Committee on Government Medical Services: The Committee met with representatives of the U. S. Civil Service Commission to review the Federal Employees Health Benefits program and legislative proposals which would involve the Commission in administering a national health insurance program. With Veterans Administration officials, it considered a proposal for closer involvement of the VA hospitals in the community and reviewed problems related to quality of care in VA hospitals.

The Committee met with the Surgeon General, USPHS, to discuss Public Health Service problems and the future of the commissioned corps; with the administrator of the HEW Health Services and Mental Health Administration, to determine the status of the Emergency Health Personnel Act; with officials of the HEW Medical Services Administration, to present the profession's recommendations on proposed regulations on Medicaid certifications. It met in joint sessions with the national Medical Assistance Advisory Council. A Committee representative took part in the Joint Council on Medical Service-Bureau of Health Insurance meeting on Medicare problems.

Committee on Health Care Financing: The Committee met twice, including a joint session with representatives of the Board of Directors of the National Association of Blue Shield Plans. The Committee prepared recommendations on a variety of items including foundations for medical care, Medicredit, Current Procedural Terminology and the standard wording of the "Explanation of Medicare Benefits" form. It urged that the Peer Review Organization proposal of the AMA be introduced into the 92nd Congress and that it be actively supported.

Committee on Private Practice: The Committee held three meetings. It established definitions of private practice and semi-private practice and reported these definitions to the House of Delegates. The Committee continued work in the revision of the 1964 Report on Physician-Hospital Relations. It reported to the Council on the "Mediation of Physician-Hospital Disputes" and on the "Selection and Role of the Medical Staff Member on the Hospital Governing Body."

Liaison was continued with the Association for Hospital Medical Education, the Student American Medical Association, state medical associations' committees on private practice, and with other organizations interested in furthering the goals of private practice.

Ad Hoc Committee on Foundations for Medical Care: Appointed by the Council on Medical Service at the request of the House of Delegates, this five-member ad hoc Committee represented a cross section of the standing committees of the Council. Following a one-year study, the ad hoc Committee presented its report which the Council submitted at the 1971 Annual Convention. The report was approved by the House of Delegates and the ad hoc Committee was discharged by the Council.

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Joint Liaison Committee of the American Association of Medical Clinics, American Medical Association and Medical Group Management Association: The Committee published a new edition of Group Practice: Guidelines to Joining or Forming a Medical Group. The first printing of 15,000 copies was distributed in five months and a new printing was ordered. Closer liaison with the Student American Medical Association was achieved and clinic participation in the SAMA-Medical Education Community Orientation Program was initiated. The Committee studied various national health insurance proposals as they would affect group practice.

DEPARTMENT OF COMMUNITY HEALTH

The Department staffed the 1970 Medical Services Conference on "New Approaches to Health Care Delivery." The newsletters Medical-Staff-in-Action and Perspectives ... in Long-Term Care were published bimonthly. Revised editions of Role of the Physician in Disaster Medicine and Group Practice: Guidelines to Joining or Forming a Group were published and a new publication, Guidelines for Community Health Programs, was developed and approved for publication.

Activities included staff support for on-site visits to more than 30 communities by the Task Force on Community Health Programs. Three projects supported by grants from the AMA -- in Washington State, the East Harlem Triangle section in New York City and Chicago -- were visited, technical advice provided and progress reports prepared. Several state and county medical societies requested advice and assistance in developing health service programs. These were visited by staff and usually involved presentations at society meetings. The Department continued liaison with other organizations, both public and private.

Commission on Emergency Services: The Commission conducted a national conference on Categorization of Hospital Emergency Facilities. The papers from this conference are being combined into the publication Guidelines for Categorization of Hospital Emergency Facilities. A Joint Task Force was established with the American Association of Junior Colleges to develop guidelines on associate degree programs in community-junior colleges and on short-term training programs for emergency medical technicians.

Committee on Community Emergency Services: The Committee completed its first year of operation. Its meetings have been regional and included representatives of state and county medical societies, the state health departments and AMA field representatives. A revision of the pamphlet, Role of the Physician in Disaster Medicine was completed. Projects include promotion of local community councils on emergency medical services, a nationwide campaign to increase the use of the "Star of Life" as a symbol of good emergency medical services and liaison with governmental, medical and community groups to promote the improvement of emergency medical care.

DEPARTMENT OF HEALTH MANPOWER

The Department staffed the Council on Health Manpower and its four committees on Manpower Utilization, Emerging Health Manpower, Certification, Registration and Licensure, and Liaison with the Related Health Professions.

The Department worked closely with the Division of Medical Education in developing a joint report on "Physician Manpower and Medical Education." Work was begun on a document entitled "The Education and Utilization of Allied Health Manpower." An informational bulletin on the physician's assistant was revised. The Department worked with the American Hospital Association in developing the proper basis for the establishment of a National Commission for the Study of Licensure of Allied Health Occupations.

The Department served on the advisory committee to the Department of Labor and the National Council in preparing a new edition of the Health Careers Guidebook. Staff functioned in a resource capacity to experimental projects in proficiency and equivalency examination development in medical technology. The Department was responsible for coordinating arrangements and briefing AMA participants in the 1971 National Health Forum in San Francisco. A critique of the HEW Health Option Papers was prepared.

The Section on Nursing staffed the Committee on Nursing and the Inter-Agency Liaison Committee of the ANA-AMA-NLN. The Section participated in a number of meetings with national nursing organizations and served on advisory committees to such groups as the American Nurses Association, the National Commission for the Study of Nursing and Nursing Education, the National Federation of Licensed Practical Nurses, Division of Nursing of the USPHS, and the Interagency Conference on Nursing Statistics.

Approximately 5,500 copies of Medicine and Nursing in the 1970's - A Position Statement were distributed, more than 2,000 requests for information on nursing as a career were handled and some 21,500 reprints were mailed to people requesting information on nursing.

Council on Health Manpower: The Council sponsored a National Congress on Health Manpower in October 1970 in Chicago. Structured as a problem-solving effort, the Congress attempted to identify major barriers to increasing the the supply of health services and develop recommendations for overcoming these barriers. A Congress summary was sent to all participants and a comprehensive report will be issued.

Major policy statements submitted to the House of Delegates were "Working Definition of Physician's Assistant," "Terminology for Health Occupations," "Continuing Competence of Physicians," "Licensure of Health Occupations," "Use of Term 'Physician's Associate'," "Physician Manpower and Medical Education" and "Evaluation of the Primary Physician's Assistant (Generalist)."

The Council and the American Hospital Association co-hosted a meeting for representatives of 20 health professions and organizations to discuss occupational licensure activities of the AMA and AHA. The Council is working with the AMA and Association of Schools of Allied Health Professions to expedite creation of a national commission to study alternative credentialing mechanisms.

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The Council cooperated with the American Academy of Orthopaedic Surgeons in its study of more effective manpower utilization in the orthopaedic health team and in planning a fall workshop to analyze study results. The Council worked with medical specialty societies in evaluating the need for two new primary support occupations: The Urologic Physician's Assistant and Primary Physician's Assistant.

Committee on Nursing: The Committee held four meetings. In October, representatives from the American Association of Industrial Nurses, the American Nurses' Association, the Association of Operating Room Nurses, the National Association for Practical Nurses, the National League for Nursing and the National Student Nurses Association met with the Committee. The Director of the National Commission for the Study of Nursing and Nursing Education met with the Committee in November. The April meeting was held in conjunction with the Committee's Panel of Nurse Consultants. Liaison has been maintained with other national nursing organizations. Staff or a member of the Committee on Nursing participated in 12 national level meetings and four state level meetings.

Plans were made for the Committee on Nursing and AMA's Congress for Nursing Practice to meet with representatives of the National Commission for the Study of Nursing and Nursing Education as a preliminary step in establishing the National Joint Practice Commission. A resolution on the creation of a Division of Nursing for a membership category of nurses in the AMA is under consideration by the Committee on Nursing. The Committee began to implement the objectives in "Medicine and Nursing in the 1970s - A Position Statement."

AMA-ANA-NLN Inter-Agency Liaison Committee: In September 1970, the Board of Trustees authorized the establishment of an Inter-Agency Liaison Committee between the American Nurses Association, the National League for Nursing and the American Medical Association. The group held three meetings. Discussed were the recommendations of the National Commission for the Study of Nursing and Nursing Education, the emerging health occupation of physician's assistants, proposed national health insurance and pending federal legislation for nursing.

DEPARTMENT OF HOSPITALS AND HEALTH FACILITIES

The Department was created in June 1971 upon dissolution of the Department of Health Care Organization. The Department staffs three committees, one group under the Board of Trustees -- the Committee of AMA Commissioners to the Joint Commission on Accreditation of Hospitals -- and two groups under the Council on Medical Service -- the Committee on Private Practice and the Committee on Aging. Staff services are provided for the two AMA representatives to the Accreditation Council for Long Term Care Facilities of the Joint Commission on Accreditation of Hospitals.

Committee of AMA Commissioners to the Joint Commission on Accreditation of Hospitals: The Board of Commissioners of the JCAH adopted revised Standards for Hospital Accreditation together with interpretive comment, which became effective July 1, 1971. A new two-part survey questionnaire was developed for use in connection with the new Standards.

The Committee sponsored a Conference on the Revised Hospital Accreditation Standards at the 1971 AMA Annual Convention. A new Accreditation Council for Long Term Care Facilities was created under the overall control of the Board of Commissioners. The AMA is a member of the new Council with two representatives appointed by the AMA Board of Trustees.

During 1970, the JCAH conducted accreditation surveys in 1,876 hospitals and 301 long-term care facilities. Of the hospitals surveyed, 1,457 (78%) were granted full two-year accreditation; 360 (19%) were provisionally accredited for one year; and 59 (3%) were not accredited. Of the 301 long-term care facilities surveyed, 261 (87%) received full accreditation, 22 (7%) provisional accreditation and 18 (6%) non-accreditation. As of January 1971, there were 5,171 accredited hospitals and 1,514 accredited long-term facilities. This is an increase of 60 accredited hospitals and 98 long-term care facilities since January 1970.

DEPARTMENT OF INSURANCE AND PRACTICE MANAGEMENT

The Department coordinated the planning for a series of eight regional conferences on peer review which were designed to expose leaders of the medical profession to emerging peer review mechanisms and to strengthen existing peer review programs. The conferences included special presentations on foundations and Peer Review Organizations by members of the Ad Hoc Committee on Foundations for Medical Care and the AMA Council on Legislation. The year-long effort in support of peer review programs was climaxed by a National Workshop Conference on Peer Review. The Peer Review Manual, a comprehensive presentation on the activation and operation of peer review programs, was published. Within six weeks, 2,000 copies had been distributed.

During the 1970 calendar year, the Physician's Placement Service processed 6,030 registrations, an increase of 600 listings over the previous year. Of the total registrations, 31,194 were from physicians seeking locations and 2,836 concerned available practice opportunities. The International Section had 147 physicians actively seeking positions in foreign countries and was assisting 48 organizations in their recruitment for foreign positions.

The Practice Management Section of the Department continued liaison with professional consultant associations and gathered information on practice methods, overhead costs, fees and medical facilities. Computer services for the practicing physician and the planning and construction of medical facilities received special emphasis.

The Department maintained liaison with the National Association of Blue Shield Plans and the Health Insurance Council. It participated in the effort to implement Current Procedural Terminology as the preferred system for recording and reporting the services of physicians, with emphasis on the importance of CPT in computerized systems for the managing of business aspects of medical practice and for standardizing techniques for maintaining medical records.

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AMA Representatives to the NASSP Board of Directors: Three meetings were held. Discussion included the Blue Shield position on national health policy, the relationship between AMA's Current Procedural Terminology and the 1970 Blue Shield Coding and Nomenclature system, the expanded efforts of Blue Shield in the area of cost containment, the adequacy of public representation on local Plan Boards of Directors and the Blue Shield position on foundations for medical care.

DEPARTMENT OF RURAL HEALTH

A pamphlet, Health Care Delivery in Rural Areas - Selected Models, was revised and reprinted. Within eight months, approximately 10,000 copies were distributed in response to requests. A manuscript on "Delivery of Health Care in Rural Areas," prepared for the 1971 National Agricultural Outlook Conference, was distributed widely by the U. S. Department of Agriculture. Manuscripts prepared for other national meetings were "Improving Systems for Delivery of Health Care in Rural Areas," for the Western Social Research Advisory Committee, and "A Rural Emergency Medical Services Plan," for the Association of Southern Agricultural Workers. A statement on "Comprehensive Health Planning in Rural America" was prepared.

The Department cooperated with the U. S. Department of Agriculture, the Farm Foundation and the National Center for Health Services Research and Development in a review of research in rural health care, and helped with a consumer health education project in selected land-grant universities. A continuing program encourages first aid training and rural emergency medical services by the state medical associations, Boy Scout troops, 4-H Clubs and Future Farmers of America organizations.

Council on Rural Health: In cooperation with the Washington State Medical Education and Research Foundation, the Council helped initiate a rural health project in Adams and Lincoln Counties in the State of Washington. In this project, health providers and community leaders worked together to review their resources and deficiencies in the hope of establishing an innovative health delivery system. The AMA Education and Research Foundation provided a $27,500 grant to share the first-year cost of this program with the Washington State Medical Education and Research Foundation.

Reports were made to the Board of Trustees on support for SAMA's National Student Health Projects, preliminary plans for a proposed New England Council on Rural Health, and "Guidelines for Community Health Programs" prepared in cooperation with the Council on Medical Service. The Council Chairman testified on rural health problems and programs before the Senate Subcommittee on Health of the Committee on Labor and Public Welfare.

The Council sponsored its 24th National Conference on Rural Health in Atlanta in March 1971, with a registered attendance of 749 from 43 states. The Eighth Seminar for Extension Specialists in Health Education and Related Fields was held in conjunction with the Conference. A joint meeting was held with representatives from the Farm Foundation, exploring research efforts and

pilot projects in rural health care delivery. The Council held a joint meeting with the rural health committees of the state medical associations of Louisiana, Mississippi and Texas.

The 25th meeting of the Advisory Committee to the Council was held in September 1970. Fifteen members of the Committee, representing 12 national organizations, participated with Council members in the one-day meeting on "Delivery of Health Services to All People."

DEPARTMENT OF MILITARY MEDICINE

The Department provides staff services for the Council on National Security. The Department continued its information service to all medical students and military physicians, active and reserve. This program offers military physicians assistance and guidance and general military information prior to, during and subsequent to their assignment in active service.

The Council maintained liaison with the Department of Defense and the Surgeons General of the Armed Forces in formulating and coordinating programs designed to improve medical care for members of the Armed Forces.

With the induction provisions of the Selective Service Law due to expire on June 30, 1971, the Council undertook a study of the law as it relates to the conscription of physicians and its impact on the overall physician population. In submitting its study to the Board of Trustees, the Council recommended the following provisions as part of any new legislation considered by Congress.

1. That the Selective Service Law apply the same to all people, including doctors.

2. That the law limit the amount of non-volunteer service to not more than two years, thus insuring rotation of service and responsibility among the populace.

3. That the law allow for deferments for completion of medical education and for similar extensions of draft eligibility following graduation.

4. That the present special pay provisions for medical and dental officers remain in effect.

The Council opposed extended liability of physicians under the Universal Military Training and Service Act. Should Congress extend the Act, however, the Council recommended that the extension be reduced to two years and that the age liability for doctors be reduced from 35 to the lowest age possible. The Council met with Department of Defense officials and the Surgeons General to discuss improved professional programs through academic affiliations, medical facilities planning, medical manpower, supply and operations, medical legislation and trends in resources for medical research.

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The publication Selective Service, Military Service and the Physician continues in demand. A study of the Military Medical Reserve Program is being made by the Council.

PUBLIC AFFAIRS DIVISION

This Division is responsible for matters dealing with federal legislation, political education and liaison with constituent, component and special medical societies and other medical, para-medical and non-medical organizations. The Division coordinates its efforts with all levels of the Association to develop and carry on appropriate programs in the area of public affairs.

DEPARTMENT OF FIELD SERVICE

The AMA's twelve Field Offices strengthened their role as intra-organizational communications centers serving state and county medical societies and medical leadership. Requests for services increased approximately 50 percent. Emphasis remained on legislation and political education. Membership orientation was added as a third high priority activity to provide an open channel between constituent societies and the new Membership Committee of the Board of Trustees.

Legislative Activities: Analyses and summaries of key federal health proposals prepared by the Department of Legislation were distributed to state associations. In many instances the assistant directors served as legislative resource persons for state executives and state legislative committees. Priority items included: (1) Social Security Amendments encompassing Medicare, Medicaid, the HMO concept and peer review; (2) national health insurance with maximum attention to AMA's Medicredit bill; (3) coverage for chiropractic services under Medicare. The Department also worked closely with the National Pharmaceutical Council to forestall numerous attempts to repeal state anti-substitution statutes or regulations. None of these state statutes were repealed and the adoption of anti-substitution laws in Alaska and Missouri for the first time extended the principle to all 50 states.

Here are other examples of these activities:

--Medicredit: The assistant directors served as members of the AMA's National Speakers Bureau coordinated by the Program Services Department. They encouraged the development of state and local Medicredit Task Forces, gave more than 150 talks to physicians and their wives, participated in several community debates on NHI concepts, stimulated wide distribution of the Medicredit sound-slide presentation and promoted orders for thousands of copies of the AMA's Medicredit pamphlet.

--Kennedy Hearings: Senator Edward Kennedy (D-Mass.) conducted hearings on the "Health Care Crisis" in Washington, D. C., and later in eight states. It became evident that the hearings were designed to promote the Labor-sponsored Health Security Act for a universal compulsory health system. The Field Service coordinated with the Communications Division and the Program Services Department in arranging pre-hearing briefings to assist state and county medical associations with the preparation of testimony. Tapes, written summaries and verbal descriptions of previous hearings were used to acquaint local physicians with the atmosphere at the hearings.

--PRSO Amendment: Late in 1970, Senator Wallace Bennett (R-Utah) introduced a "peer Review" amendment to the Social Security Act which died in Conference Committee at the close of the 91st Congress. Regional conference telephone calls with state presidents and executive directors kept states informed of developments during the critical days prior to the close of the Congressional session.

Political Education: The assistant directors continued to serve as consultants for state PACs in promoting voluntary memberships and organizing state and regional political education workshops. Membership in AMPAC set a new record.

General Service: All field activities are designed to strengthen liaison between AMA and the membership and to help state and county associations help themselves in developing organizational programs. The Department sponsored regional meetings for state and county executives; conducted three field surveys of the organizational structure, administrative policies and community posture of constituent societies; arranged speaking engagements for AMA officers and members of the National Speakers Bureau and promoted use of AMA literature, including the Peer Review Manual and the booklet Where Do We Stand?

The assistant directors continued to attend regular meetings of state governing bodies and annual state meetings. Reports of the principal actions at state meetings were distributed to each state association.

DEPARTMENT OF SPECIALTY SOCIETIES SERVICE

The Department maintained liaison with the major national specialty societies. It assisted with the staffing of the AMA Interspecialty Committee and with the organizing and staffing of the AMA Section Councils. Twenty-six national specialty societies are now part of the liaison program. The following societies were added early in 1971: American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, American Association of Public Health Physicians, American College of Chest Physicians and American Urological Association.

The Interspecialty Committee continued to meet quarterly as an advisory committee to the AMA Board of Trustees. The Committee scheduled a special briefing on peer review and co-sponsored a workshop on self-assessment programs. The American College of Preventive Medicine was added as a member society.

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The Department worked with the Specialty Section Ad Hoc Committee and more than 40 leading specialty groups in the organization of 23 section councils, most of which held two meetings during the year. The division of the Section Council on Psychiatry and Neurology was approved by the House of Delegates at the 1971 Annual Convention, increasing the number of councils to 24.

The Department participated with the AMA Washington Office in a series of legislative liaison sessions. The meetings, held at six-week intervals, served to coordinate medicine's activities with Congress and federal agencies.

LEGISLATIVE DEPARTMENT

The Department reported national legislative activities, developments and trends of medical interest. Legislative bills were analyzed, as introduced in Congress, as modified in congressional committees, conferences and floor actions, and as finally adopted. Analyses were distributed to committees, councils and departments of AMA, state medical societies and specialty societies. In order to provide the Council on Legislation with information upon which to base decisions, staff summaries and comparative analyses on legislation were similarly distributed.

Council on Legislation: The Council met seven times. It reviewed legislation and made recommendations on AMA positions to the Board of Trustees. Some of the Council's sessions were timed to coincide with state medical society and other AMA council meetings so that the Council could participate with them in programs dealing with medical legislation. Legislation considered by the Council included HR 17550, the Social Security Amendment of 1970 (including the Bennett Amendment to establish Professional Standards Review Organizations); revision of the Medicredit and PRO bills, health manpower bills, Administration programs for HMO's, family practice bills and HR 1, the Social Security Amendments of 1971.

General Services: Publication of Legislative Roundup was continued with distribution to state, county and specialty medical societies, among others. Excerpts from the Congressional Record, the Federal Register and other publications were forwarded to appropriate staff members. New federal regulations and changes, as proposed and as promulgated, were announced and disseminated with comments to the medical profession.

Developments of Proposed Legislation: Legislative bills prepared by AMA were revised for reintroduction in the 92nd Congress. Nine bills were recommended by the Council for reintroduction and these recommendations were approved by the Board of Trustees. Draft bills were then prepared and forwarded to the Washington Office for implementation. These are:

--A bill to exempt non-profit blood banks, hospitals and physicians from antitrust laws where they refuse to obtain blood from other blood banks.

--A bill to remove limitations for psychiatric care under Medicare and Medicaid.

--A bill to authorize direct payments for physicians' and dentists' services under Medicaid.

--A bill to provide veterans an option to receive hospital care in facilities other than VA facilities.

--A bill to amend the Military Selective Service Act of 1967 as it pertains to selective service calls for physicians; and to provide for allocation of health personnel among Armed Forces, Government and civilian needs.

--A bill to establish a U. S. Department of Health.

--A bill to authorize the deductibility of all medical and drug expenses for persons 65 and over.

--A bill to require, unless otherwise directed by the physician, that the label of drug containers as dispensed to the patient bear the established or trade name (as prescribed by the physician) and the quantity and strength of the drug dispensed.

--A bill to eliminate chiropractic services under Medicaid.

In addition, AMA's Medicredit bill was revised and introduced as two separate proposals in both the House and the Senate: the Health Care Insurance Act of 1971 (HR 4960 and S 987), and the Peer Review Organization Act (HR 8684 and S 1893). Catastrophic coverage was one of the features added to the new Medicredit bill.

Medical Bills Enacted Into Law: In the second half of the 1970 session of the 91st Congress, a number of medical interest bills became law. AMA views on almost all of these measures were submitted in oral and written testimony before Congressional Committees. Among the new laws were: Public Law 91-464, Communicable Disease Control Act; PL 91-515, RMP, CHP and PHS extensions; PL 91-513, Drug Abuse Education Act; PL 91-596, Occupational Safety and Health Act; PL 91-601, Poison Prevention Packaging Act; PL 91-604, Clean Air Act Amendments; PL 91-616, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act; PL 91-623, Emergency Health Personnel Act; and PL 91-677, Appropriations for Departments of Labor and HEW.

AMA Testimony: During the 91st Congress, AMA presented statements on more than 35 occasions to committees of Congress on a broad range of topics. In statements during the last half of 1970, AMA testified on: Narcotic Addict Rehabilitation (HR 17269); Training in the Field of Family Practice (HR 15797, HR 16360 and S 3418); Family Planning and Population Research (S 2108); Alcohol Abuse, and Alcoholism Prevention, Treatment and Rehabilitation (S 3835); and the Social Security Amendments of 1970 (HR 17550). In statements during early 1971, AMA presented views on: The American Health Care System; Rural Health Services; Health Care Insurance Act of 1971 (Medicredit); Conquest of Cancer (S 34); HEW Appropriations for Maternal and Child Care, Alcoholism, Communicable Disease Control, Lead Based Paint Poison Prevention, and RMP;

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Health Maintenance of the Elderly; extension of the Health Manpower Training Act (S 334 and S 1193), and extension of the Nurse Training Act (S 1331 and S 1614); and a bill to create a Special Action Office for Drug Abuse Prevention (HR 9264). Copies of AMA testimony were sent to state, county and specialty medical societies.

Response to Regulatory Action: AMA positions on proposals which would have regulatory impact were expressed in correspondence with the responsible agencies. Subjects of such activity in early 1971 were Medicare regulations bearing on medical charges and hospital participation in programs for the aging. Comments were also addressed to FDA regulations for the implementation of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Others invoking comment were FDA regulations for efficacy evaluations of combination drugs; labeling and advertising of drug efficacy evaluations in schedules of drugs.

AMA OFFICE IN WASHINGTON

This office continued to collect, evaluate and report information and observations concerning proposed legislation and regulations; to maintain a two-way communication channel for the flow of information between the AMA and all Washington-based health related organizations and activities; and to furnish day-to-day services to national communications media. An appreciable amount of the office's effort was devoted in various ways to the mustering of support for Medicredit. All new members of the 92nd Congress were called upon and given a standing offer of AMA assistance. During the year, a number of proposals favored by medicine became law or regulation, and no health legislation opposed by medicine was enacted.

Department of Congressional Relations: Since the 92nd Congress convened in January, 13,544 bills have been introduced, some 1,030 of which have bearing on medical and health care. Among those bills of interest to the AMA are:

--Medicredit: Introduced on February 25, 1971, by Representatives Richard Fulton (D-Tenn.) and Joel Broyhill (R-Va.) and Senator Clifford Hansen (R-Wyo.), this AMA drafted legislation now has 150 sponsors -- considerably more than any other national health insurance proposal.

--Health Manpower and Nurse Training: Passed by both Houses and in conference at the date of this report, the House version of these two bills will provide some $3.1 billion over a three-year period to increase the supply of physicians, nurses, dentists and other health professionals.

--Medicare and Medicaid Amendments: Passed by the House at the end of this report period, this legislation modifies the two programs, concerns itself with the implementation of IMO's, and authorizes the HEW Secretary to conduct certain experiments, including those related to area-wide peer review.

--Peer Review: The first six months of this report period (91st Congress) saw much activity in connection with legislation introduced by Senator Wallace F. Bennett to establish Professional Standard Review Organizations. Four of the five measures opposed by AMA were deleted in the final version. This amendment died with the bill in conference but is expected to be reintroduced into the 92nd Congress.

The Department covered Congressional hearings, assisted AMA witnesses, briefed state delegations, addressed medical groups, arranged appointments and obtained Congressional speakers for various groups.

Department of Governmental Relations: During the period of this report, there has been a marked improvement of AMA relations with the federal government, particularly with the Department of Health, Education, and Welfare. A number of meetings at the secretarial and assistant secretarial level were arranged for AMA officials. AMA-White House relations have also improved, the most visible sign of this being the President's June visit to the Atlantic City meeting of the House of Delegates. The Department was successful in placing AMA input into the formulation of regulations and guidelines for programs dealing with health options, IMO's, peer review and drug abuse control. During the year, physicians were appointed by the government on the Commission on Malpractice, the Commission on Marijuana, and on advisory councils and committees for the Occupational Health and Safety Act, the National Cancer Authority, the Emergency Health Personnel Act, and alcoholism programs.

Department of Communications: The Department provided increased communications support to all Washington office departments. Speeches were written; interviews arranged; news releases were prepared and placed; background materials were compiled; information kits were revised and updated; and services to national communications media were expanded. The Department provides Washington reporting services to American Medical News and the Medical News Section of JAMA.

Washington Library: More than 7,100 inquiries were answered, some 1,000 of which originated directly or indirectly from members of Congress. Another 1,800 inquiries were made to the Library from the staffs of governmental and non-governmental agencies and organizations. The balance of the inquiries were mostly from students, many concerned with drug abuse, health careers and medical student loans. Working relationships were maintained with more than 50 libraries, with the publication offices of various agencies and organizations, and with health care researchers. The special catalog, A Partial List of the Books, Pamphlets and Reprints of the American Medical Association for the Use of Members of Congress, was revised and distributed to all members of Congress during the organization of the 92nd Congress.

DEPARTMENT OF PROGRAM SERVICES

The Department was established in the Public Affairs Division late in 1970. Its objective is to create and bring together those programs of the AMA which fulfill the service needs of county, state and specialty medical societies.

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The Department's Field Request Control Center processed 1,544 requests for information and materials during its first six months. Although a wide range of public affairs projects were developed to respond to this need, primary emphasis was given to legislative and political education programming.

There was a record attendance of 724 at the 1971 AMA-AMPAC Public Affairs Workshop in Washington, D. C., March 13-14. The theme was "Putting It All Together for a Legislative Result." A number of innovative communication tools were premiered at the Workshop and made available for use in the field. More than 200 executives attended the Conference for Senior Medical Executives on January 28-29. Sponsored jointly by the American Association of Medical Society Executives and the AMA, the program centered on national health insurance, peer review and membership. The Department conducted the New Medical Executives School for 33 executives who have been employed by their societies for one year or less. The four-day meeting was planned to describe the services of the AMA to the new executives and to provide management training assistance.

Speakers and Leadership Training Program: The Department conducted ten speakers training seminars for county and state medical associations. A new program of leadership training seminars was begun by the Department. Designed to train physicians in effective leadership principles within organizations, the new program won immediate success and six seminars were held in various parts of the country for state and county medical associations. More than 1,000 physicians were trained by the ten speakers training seminars and the six leadership training seminars.

Speakers Bureau on National Health Insurance: The Department continues to operate a Speakers Bureau on various subjects related to health and a new Speakers Bureau on National Health Insurance was organized during the year. The new Bureau is comprised of 60 physician speakers throughout the country. An organizational and training session was held in Chicago in May 1971 and since that time requests for speakers have been running close to 20 per month. The Department designed a newsletter, Hotline, to transmit information and materials to Bureau members.

Medicredit Resource Services: A basic Medicredit Resource Materials Kit was prepared. One of the items in the kit, a brochure entitled Medical and Health Care for All, provides a detailed description of Medicredit. More than 60,000 of these brochures have been distributed. More than 5,000 complete kits were sent to physician leaders. A 35-mm slide-sound presentation, Medicredit--A National Health Plan, was prepared for use in the field. The Department also coordinated a Program Development Medicredit Task Force. A new liaison program was begun with outside organizations that may be of assistance in supporting Medicredit.

Membership Services: The Department responds to individual physicians regarding AMA membership and AMA services and activities. It continued to work with the Division of Management Services in the revision of the 1970 AMA Delegate's Membership Kit and the distribution of other membership materials. A 35-mm slide-sound presentation entitled AMA--Symbol of the Medical Profession was made available through the Field Offices.

The Department provided communication services related to political education. This activity included the preparation of a quarterly newsletter, the writing of political education materials, and the development of audio-visual items.

COMMUNICATIONS DIVISION

Significant among the activities of the Division during the year were the Special Communications Program; preparation of the booklet Where Do We Stand?; participation in preparation of Congressional testimony for AMA spokesmen; and preparation of a white paper in response to critical remarks by Senator Edward M. Kennedy.

The Special Communications Program was begun during the week of May 31 in national magazines (Life, Reader's Digest, Ebony), selected newspapers and on television stations. The campaign seeks to create a more favorable attitude toward medicine by reminding the public that the American physician is concerned more than anything else with people's health. The campaign will also talk about national health care issues as time and circumstances warrant. The approach will be factual and informational.

The booklet Where Do We Stand? was prepared to set the record straight on a number of national health care issues and on the role and functions of the AMA. Written for the general public, the booklet discussed such issues as physician supply, the AMA's role as a lobby, national health insurance and programs to improve health care. It was distributed through state and county medical societies.

In cooperation with other divisions, the Communications Division assisted in the preparation of the AMA's testimony before the Senate Subcommittee on Health in March. The testimony was later adapted by the Division for an article in the Wall Street Journal.

In testimony before a Senate Subcommittee, Senator Kennedy made a number of charges about the AMA's past record on health care issues, charges that were out of date, out of context and out of balance. In response, the Communications Division prepared a White Paper setting forth the AMA's recent legislative stance and rebutting the allegations by citing the AMA's record.

NEWS BUREAU

A concentrated effort to develop an improved press and public climate has been initiated. Emphasis has been placed on personal contact with editors and writers, both by staff and elected officials.

Press Relations: This staff processes requests from the media, initiates news releases, sets up news conferences and handles press arrangements for the

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Annual and Clinical Conventions. A major function at the 1971 Convention in Atlantic City was liaison with the White House staff in preparation for the visit by President Nixon.

Science News: This staff maintains contact with science writers and media representatives. During the year, the Science News staff processed some 2,000 media queries; researched, wrote and distributed some 300 news releases in support of AMA scientific programs; organized and staffed the press rooms at more than 20 AMA scientific meetings; and conducted the annual AMA Medical Journalism Awards program. More than 600 press representatives covered the 1971 Annual Convention.

Magazine Relations: This staff alerts editors and writers to story ideas. Staff reviewed 37 manuscripts for medical accuracy; processed 51 requests for research assistance; contacted on a regular basis the editors of consumer magazines to make them aware of the AMA viewpoint; and worked closely with several writers in the development of stories.

Speakers Services: Staff prepared 85 speeches -- 77 for specific assignment from 23 different officials -- and eight speeches for general use. It also edited recordings of extemporaneous talks for publication; prepared the roundup of the House of Delegates for two conventions; wrote a background piece on health care costs and statements on illegitimacy and on maternal and child health.

AUDIO-VISUAL DEPARTMENT

This Department services both the media and the constituent societies of the AMA and provides an internal communications network at the conventions. Activities included introduction of an AMA Radio News Service which provides prerecorded news and health information, available to radio stations (used by some 2,000 radio stations during the 1971 Annual Convention); production of filmed news spots for release during the conventions to TV stations; and production and distribution of eight TV public service announcements.

Services to constituent medical societies included production of five programmed sound-slide presentations; production of a packaged modular TV kit to enable local societies to produce their own TV shows; production and distribution of audio cassette highlights of AMA meetings; and transfer from tape to film of AMA television productions for use by local societies.

The Department produced a film, Tomorrow Isn't Soon Enough, depicting medicine's involvement in the Explorer Scout Program; produced two nutritional films for use by medical schools; and expanded the closed circuit TV network at the conventions to include the state medical association meetings.

SPECIAL PROJECTS DEPARTMENT

Within the year, the Special Projects Department took on its present name (formerly Program Services) and has been reorganizing its activities and responsibilities. The Department is responsible for all creative promotional activities for the AMA, handles all special events and offers editorial services to all other departments and divisions.

The Department has expanded its activities in the health careers area with the establishment of the Health Careers Information Service. A Research and Development effort has been undertaken to look at new publications and new activities for the Division and the AMA. The Art and Layout Section is responsible for graphics in all AMA publications. It also creates special materials for AMA meetings and conventions.

PUBLICATIONS DEPARTMENT

This Department is responsible for production of non-technical, consumer-oriented publications of the Communications Division. These include Today's Health and AMA Update.

In addition to serving its primary purpose as a health educator, Today's Health made a concerted effort this year to establish itself as the leading consumer advocate in the health field. In this role, the magazine provides a vital public service, creates goodwill for the AMA and eases physician difficulties that arise from medical ignorance on the part of patients.

Reader appeal has been broadened by including articles on timely but non-medical subjects. The principle thrust of the magazine is still health, but this new type of story sustains reader interest and involvement. An interview with Mrs. Spiro Agnew brought national acclaim.

For the first time, the magazine actively promoted radio and television appearances for its writers. Several writers and personalities featured in the magazine have appeared on Chicago and New York television programs. A Today's Health article, "Copper Bracelets are a Put On," won the Russell L. Cecil Award presented by the Arthritis Foundation. Informal awards included 197 reprints.

AMA Update began publication in April 1971. The four-page newsletter is mailed monthly to national and local opinion-makers and to all members of Congress, a total readership of 13,500. It speaks about such subjects as the leading causes of death, minority group members in medical schools, AMA lobbying activities, health care in rural communities, drug abuse programs, health careers and national health insurance.

DEPARTMENT OF PROFESSIONAL COMMUNICATIONS

This Department is responsible for the AMA Newsletter, American Medical News, JAMA Medical News, The Search (Annual Report), the Annual Report published in the Clinical Convention Handbook, the Daily Bulletin and the 535 Reporter. The Department also staffs the Sheen Award Committee and performs various editorial services for the Office of the Executive Vice President.

AMA Newsletter: Sixty-six state, county and specialty medical societies now receive bulk shipments of this publication for distribution to their officers.

American Medical News: The Editors concentrated on improving the timeliness of the newspaper's reporting and on planning the in-depth coverage of issues affecting medicine. The newspaper informed physicians on the AMA budget and the reason for the dues increase. Other stories reported on the AMA's

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legislative activities, its meetings and conventions, and, in more detail than before, the candidates for AMA offices. Some of the issues that were treated in depth were abortion, professional liability, national health insurance proposals, medical society foundations, peer review, the attitudes of medical students and young physicians, drug abuse and venereal disease.

JAMA Medical News: This section of The Journal carried 402 news articles and features. Feature articles dealt with such topics as medical genetics, the effects of the liberalized abortion law in New York, methadone maintenance programs, the status of the struggle against tuberculosis and venereal disease, the marihuana problem and the possible connection between viruses and breast cancer. Special issues were devoted to the Annual and Clinical Conventions. A total of 124 articles in the "Internal Medicine at Large" section of the Archives of Internal Medicine were also prepared by the Medical News section.

DEPARTMENT OF HEALTH EDUCATION

This Department disseminated information and promoted programs in the areas of health education of the public, school and college health, safety education and administration, voluntary health agencies, exercise and fitness, medical aspects of sports and automotive safety. It answered nearly 49,000 requests from the public.

Publications included a paperback edition of Today's Health Guide; Spanish editions of five drug leaflets; the book Sports and Physical Fitness: Fifty Questions and Answers; posters on alcohol and drug dependence and pamphlets on the skin, drinking and driving, organ donations for transplantation, pollution and birth control pills. A new pamphlet on gall bladder disease is the first in a series on diagnostic and surgical procedures. Ten issues of Health Education Service for Schools and Colleges (circulation 16,000) and 12 issues of More Life for Your Years (circulation 32,000) were published.

Special health education activities include development of Community Health Week 1971 and preparation of regular columns for Today's Health, Maternal Child Health Nursing Magazine and School Health Review. Staff participated in the White House Conference on Children and Youth and numerous health and drug education workshops. The All-American School Health Association 11th Annual Session on School Health centered on "Risk-Taking Behavior Among Children and Youth." Plans were made for the 11th National Conference on Physicians and Schools. Staff served as chairman, National Safety Council's Problems and Needs Study Committee, and as consultant, U. S. Department of Transportation Alcohol Curriculum Project. Editorials on safety were published in JAMA and articles were published in other journals.

Council on Voluntary Health Agencies: The statement on "Recommended Guidelines for Relationships Between Voluntary Health Agencies and Governmental Health Programs" was approved by the House of Delegates. The seventh revision of the AMA Directory of National Voluntary Health Organizations was published. The Council's Committee on Continuing Professional Education Programs of Voluntary Health Agencies met twice and considered electronic communications procedures and the continuing education of allied health personnel.

Joint Committee on Health Problems in Education of the National Education Association and the AMA: Publications included Answers to Health Questions in Physical Education and updating of the sex education series. Over 1,500,000 publications of the Joint Committee publications were distributed and revision of the book Health Education was initiated.

Liaison Committee of the American College Health Association and the AMA: Major considerations are: college health program models; Conference on Health in the College Community; use of uniform medical record forms; free clinics in college communities; and health maintenance organizations and college health service. State medical associations were urged to establish committees on college health for liaison with college health service personnel.

Committee on Exercise and Physical Fitness: Plans were made for a Symposium on Exercise and the Heart for Pennsylvania in November in cooperation with the Pennsylvania Medical and Heart Associations and the President's Council on Physical Fitness. A joint statement with the President's Council on "Evaluation of the Apparently Healthy Candidate for Participation in Exercise" has been accepted for publication in JAMA. Statements on "Testing the Patient with a Problem Participating in Exercise" and "Guide to Prescribing Exercise" are in process. Invitations to prepare papers for the 1972 Olympic Issue of JAMA have been accepted by 14 authors. The Committee met with representatives of the Armed Services, the International Military Sports Council and the President's Council on Physical Fitness and Sports.

Committee on Medical Aspects of Automotive Safety: Publications include "Drinking and Driving," "Rating the Severity of Tissue Damage--Part I," and "Safety Spectacles and Sunglasses for All." A scientific display of the passive restraint system was shown at the 1971 Annual Convention, in sponsorship with the U. S. Department of Transportation. Work has continued on the injury scaling project and on the medical aspects of licensure (in cooperation with the American Association of Motor Vehicle Administrators). Surveillance of safety-related advertising continues and advertising which can lead to unsafe driving practices has been condemned.

Committee on the Medical Aspects of Sports: The book Fundamentals of Athletic Training was prepared in cooperation with the Athletic Institute and the National Athletic Trainers Association. Its award-winning film, The Team Physician, has been shown to an estimated audience of more than 7,500,000 persons in the last two years. The Committee is completing plans for the 13th National Conference on the Medical Aspects of Sports and is cooperating with the Committee on Exercise and Physical Fitness in publishing the Olympic issue of JAMA.

MANAGEMENT SERVICES DIVISION

The activities of the Management Services Division include advertising sales, convention services, publication sales and circulation, research and library services, physician records, building services, purchasing, transportation, job printing and personnel services.

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CIRCULATION AND RECORDS DEPARTMENT

This Department directs distribution of all regularly published AMA books and journals, operates the electronic data processing center and maintains membership records.

Of the 17 journals issued by the American Medical Association, 12 had increases in subscription and 5 showed decreases. All scientific journals except one showed increases, with JAMA leading by 27,011 additional subscriptions. The total number of subscriptions for all AMA journals was 1,595,877.

Requests for information received by the Department totaled 371,250. These included inquiries regarding biographical information (126,250); order and circulation for publications (98,250); fees, insurance and Medicare (33,750); directory information (22,500); other medical organizations (20,000).

CONVENTION SERVICES DEPARTMENT

The Department made arrangements for the Clinical Convention in Boston and the Annual Convention in Atlantic City, with total attendances of 7,098 and 22,904 respectively. In addition, 386 separate meetings and functions were handled at the headquarters hotels during these two meetings.

During the reporting period, 221 ancillary meetings were set up. Of these, 203 were arranged by the Department, involving a total of 12,271 people. Some 200 exhibits were displayed in 166 cities for a total of 2,356 show days. The AMA Exhibit Program was transferred to the Department and a more aggressive program is being planned in the fields of professional and public exhibits.

GENERAL SALES OFFICE

During the reporting period, the General Sales Office was established as part of the Management Services Division. Functions include the sale of advertising space in AMA publications, sale of subscriptions to AMA publications and the sale of books and health education materials. Other responsibilities are fund-raising for the American Medical Association Education and Research Foundation and the coordination of convention promotion activities. Extensive reorganization was instituted in order to achieve a concentrated sales effort and the production of increased income.

ARCHIVE LIBRARY DEPARTMENT

The Library handled a total of 25,793 requests for information. These reflect a variety of information needs which range from highly specialized areas of clinical medicine to socio-economic problems, medical history and international health. A total of 291,167 pages were photocopied, 6,396 books were circulated and 548 monographs or journals were borrowed from other libraries inside or outside the United States. The Library regularly indexes all major books and publications of the Association.

A total of 1,589 books were processed and listed for review in JAMA; 2,835 books were cataloged and added to collections of the Library and other departments. The Museum of AMA History was seen by more than 1,500 visitors.

In response to increasing interest in health care delivery, the Library developed Medical Socioeconomic Research Sources (MEDSOC), a monthly publication which abstracts ideas and events as they are documented in the public and scientific record. MEDSOC has world-wide coverage of English language publications and has been well received by both the academic and medical communities.

One of the few research grants of the National Library of Medicine was awarded to the Archive Library. The first comprehensive survey of health sciences libraries in the United States was completed, resulting in publication of a 197-page Directory. This will be followed by a seven-chapter Statistical Analysis which will be published by the Medical Library Association and the U. S. Public Health Service. Staff presented five papers at professional meetings and published six articles in professional journals.

OPERATING SERVICES DEPARTMENT

The Department's functions of purchasing-transportation, job printing and processing-distribution were increased by the addition of contract printing and a new section on publication production. As a result, all major publications and paper contracts were reviewed and contracts were renegotiated.

The Reproduction Section and the Processing and Distribution Section processed approximately 6,500 individual jobs. Approximately 50 tons of paper were consumed for in-house work.

The Purchasing-Transportation Section processed 4,600 orders for materials and supplies with expenditures of approximately $1,500,000. In addition, 5,700 transportation requests were processed.

The Job Printing Section processed 1,443 individual jobs which were purchased from outside sources. Major projects handled were the AMA Drug Evaluation book, the Distribution of Physicians series and the pamphet What You Should Know About the Pill.

Early in 1970, the Publication Production Section was formed, consolidating production for all AMA publications, both advertising and editorial. This centralization increased efficiency and eliminated duplication and extra costs.

PERSONNEL AND OFFICE SERVICES

This Department services AMA personnel requirements, administers pamphlet and film distribution and provides for telephone, reception, mail, cafeteria and medical services.

The Employment Section conducted 310 interviews for administrative and 654 interviews for non-administrative positions. Of these, 41 administrative and 152 non-administrative staff were hired. The Affirmative Action Program for recruiting minority group members to the staff resulted in two hires for administrative positions and 67 for non-administrative positions.

Twenty-two meetings were held to acquaint new employees with employee benefits and major policies. A new pension plan was implemented for more than 500

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eligible employees. A pension packet is being designed to provide up-to-date benefit information. Revised editions of the Employee Handbook and the AMA Services and Organization Guide were published, and a computerized system was designed for an individually tailored Employee Benefit Statement.

An orientation program was presented monthly to acquaint new employees with the history, purposes and scope of the AMA. Service recognition programs and the Crusade of Mercy Program were conducted.

A wide range of skill development programs was provided for AMA staff. A total of 50 "disadvantaged" persons received training during the year and arrangements were made with the YMCA Community College to provide college credit for certain AMA in-house programs.

A total of 4,428 visits were made to the employee health office. A heart re-screening program was conducted in cooperation with the Chicago Heart Association and the annual Group Assurance Program (Blood Bank) had a membership of 694, surpassing the required quota by 134 donors.

Of the 4,019 film reprints on 440 medical subjects available in the medical motion picture library for loan, more than 30,000 were distributed. A major portion of the Smith, Kline and French Laboratories' film distribution operation was donated to the library.

The mail unit distributed approximately 5,000,000 pieces of first class mail annually. Of the 1,300 titles of health education materials in storage, total movement of materials for the year was more than 10,000 copies.

BUILDING SERVICES DEPARTMENT

This Department is responsible for planning, constructing and operating the AMA headquarters building. With the discontinuance of the Institute for Biomedical Research, a program of reconstruction was begun on the seventh, eighth, ninth and tenth floors. In addition, office alterations were made on other floors. During this period, the Department answered 4,026 calls for custodial and decorating services, as well as for carpentry, electrical, lighting, plumbing and mechanical repairs.

AMA EDUCATION AND RESEARCH FOUNDATION

During the past fiscal year, contributions to the AMA-ERF designated for medical schools totaled $941,036. Contributions for the Loan Guarantee Fund were $160,272, while the unrestricted contributions totaled $128,130. During the period covered by this report, $955,726 were distributed to medical schools in the United States.

A total of 2,393 loans was guaranteed last year by the Foundation in the amount of $2,506,111 to medical students, interns and residents. Since 1962, when the Loan Guarantee Program began, the Foundation has guaranteed 44,855 loans worth $50,024,975. As of June 30, 1971, there were 21,873 outstanding loans worth $34,208,238 (including interest).

During the year, the AMA-ERF Loan Guarantee Program was expanded to include interest free loans to disadvantaged and deserving medical students. Contributions to this new program were $104,070.

REPORTS OF BOARD OF TRUSTEES

The following reports, A-T, were presented by Max H. Parrott, M. D., Chairman, Board of Trustees. Reports on the Distinguished Service Award and Citation of a Layman for Distinguished Service appear on pages 14 and 15.

A. STATEMENT ON SCOPE, OBJECTIVES AND FUNCTIONS OF OCCUPATIONAL HEALTH PROGRAMS

(Reference Committee H, page 277)

HOUSE ACTION: ADOPTED AS FOLLOWS:

In June 1957, and again in June 1960, the House of Delegates approved a statement on the "Scope, Objectives and Functions of Occupational Health Programs." An amended version of the statement was submitted to the House of Delegates in November 1970 but was referred back to the Board and its Council on Occupational Health for clarification.

The Council on Occupational Health has reviewed the 1970 draft, has considered the objections expressed and has explored with many physicians a variety of viewpoints regarding the proposals. A new draft is submitted which includes a preface which summarizes the purpose of the changes and incorporates suggestions from many knowledgeable sources. The proposal applies only to employees, not to their dependents. Other clarifications include newly worded (underlined) statements and omissions (lined out) from the House approved 1960 document, and do not represent changes from the 1970 amendments.

The Council and the Board submit the following revised statement to the House of Delegates for its approval:

Scope, Objectives and Functions of Occupational Health Programs

Preface

In June 1957 and again in June 1960, the House of Delegates approved a statement on the "Scope, Objectives and Functions of Occupational Health Programs."

The Council on Occupational Health believes that the following revised version will make possible innovative methods for delivery of medical care by industrial medical departments for nonoccupational injuries or diseases of employees in areas where medical care is not otherwise available and that it recognizes modern developments in supplementary health screening procedures now widely utilized in industry.

Introduction

The term "occupational health program," as used in this statement, means a program, provided usually by management, to deal constructively with the health of employees in relation to their work.

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29th Clinical
Doc. 1975

(AMA-ERF)

AMA-ERF has been able to distribute $1,016,393 directly to medical schools in 1975, which is slightly less than was made available to assist medical education programs in 1974. However, experience in the third quarter indicates that the volume of student loans guaranteed by AMA-ERF will be up sharply by the end of this year. As of June 30, 1975, 1,816 loans totaling $2,459,100 were extended to medical students, interns and residents and guaranteed by the Foundation. Medical students accounted for 1,648 of the loans. The AMA-ERF has guaranteed 57,015 loans valued at $66,567,375 since the program began in 1962. Medical students have been the recipients of 64.2 percent of all the loans; during the first six months of 1975, 90.7 percent of AMA-ERF guaranteed loans were awarded to medical students.

During the period from October 1971 to June 30, 1975, 422 loans totaling $851,250 have been guaranteed for disadvantaged and deserving students under the Student Opportunity Loan Program. These loans are given interest-free to students during their medical school years. The AMA-ERF has paid more than $67,000 in interest subsidies in support of this program to benefit needy students since the program was initiated in 1971.

In 1974, the AMA-ERF received a bequest to establish a fund to be known as the Rock Sleyster Memorial Scholarship Fund from the Estate of Clara Sleyster, wife of Dr. Rock Sleyster, Past President of the AMA in 1939-1940. Earnings from the fund were to be awarded to medical students with a demonstrated interest in psychiatry. The fund earned enough in 1974 to provide sixteen $2,000 scholarships which have been awarded this year.

AMA-ERF received approximately $500 thousand in 1975 from the estate of Florence A. Carter through the Riggs National Bank of Washington, D. C., to advance research in the cure and prevention of leukemia. A program to award research support grants is now being planned with the assistance of AMA's Advisory Committee on Medical Science.

At the suggestion and with the support of the Audio-Digest Foundation, one of AMA-ERF's largest and most consistent contributors, a scholarship fund to encourage interest in scientific communications has been established as a memorial to Congressman Jerry L. Pettis, a founder of Audio-Digest. The first annual award of $2,500 will be presented at the 1976 Annual Convention in Dallas, Texas.

Certainly, the AMA-ERF is healthy in 1975. Yet, the support of the profession is needed more than ever. Is there anyone who is not aware that medical education is entering a period of fiscal trial? Costs are up; tuitions are up; support is down. Through AMA-ERF we can demonstrate that the private sector, America's physicians, can rise to meet the needs of our profession's future.

When you get home, please look on your desk for AMA-ERF's last appeal for funds during 1975. If you have not sent a check before, please be generous now. Thank you for your attention and continued support of the American Medical Association Education and Research Foundation.

(The Audio-Digest Foundation made a contribution of $50,000 to the AMA Education and Research Foundation)

REPORT OF AMERICAN MEDICAL POLITICAL ACTION COMMITTEE: The following report was presented by James C. MacLaggan, M. D., Chairman, Board of Directors:

In just one month the United States will begin its Bicentennial Celebration. When the United States was begun almost 200 years ago, there was a Holy Roman Emperor, Venice was a republic, France was ruled by a King, China by an Emperor, Japan by a shotgun, Russia by a Czar, and

Great Britain was a Monarchy. But today, among the world powers the only government that stands essentially unchanged is the United States — put together in 1776 by courageous patriots organized into thirteen dissimilar states.

Those ingenious patriots who became our founding fathers launched an evolution as well as a revolution. It was their decision that the nation should have the institutional means to accommodate the ever shifting demands of innovation and public opinion. Consequently, they did not draw up an unchangeable, detailed blueprint to impress on an unseen future. The total structure — involving elections, separated and balanced legislative, judicial and executive powers, and constitutional amendments — assures a continually changing national accommodation. Thus, America is a nation that will never be completed. It will always be evolving. Working within this always evolving system, the country not only survived all of the challenges brought to it but managed to produce a record of steadily rising achievements.

America's underlying idealism has motivated us to attempt simultaneously a vast number of unprecedented national reforms. Not all of the reforms have been successful. But no other country of our size and unhomogeneous population has ever tried to do as much. The scope of America's aspirations can be seen in its goals. This country's attempt at political reform is more intensive now than ever before. The 1976 elections will be run in an atmosphere of political reform that may be more stifling and repressive than reformative. Nevertheless, it is the law of the land at this time and the medical PAC movement will observe the spirit and the letter of the law.

But the campaign reform laws, as drastic and severe as they are, have not dulled the thrust and the growth of the PAC movement. For the eighth consecutive year, AMPAC has broken its all-time high membership record. In addition, fourteen states have established new all-time high membership records. They are: Alaska, Arizona, California, District of Columbia, Florida, Georgia, Illinois, Maryland, Mississippi, Nevada, New Jersey, South Carolina, Tennessee and Texas. And we take special pride in the fact that we have broken our all-time high sustaining record again in 1975. And this record was not broken by just one or two more sustaining members. We have fully 10 percent more sustaining members than we have had in any previous year.

But under the new political reform laws, membership dollars alone will not carry the day. PAC contributions must be backed up with volunteer efforts. Every member of this House is an opinion maker in his community. This asset must be applied politically if medicine is to have the result it wants in the 1976 elections. It is incumbent upon every member of this House to support the candidate of his choice in an active and participatory way, in his own congressional district in the 1976 elections. If this House would assume this voluntary and participatory leadership, it could make a terrific impact on the 1976 elections. The need for personal involvement has never been needed as much as it is needed in the 1976 elections. This will be a change from the normal political pattern of most of us here today. But the willingness to change while playing by the rules has been the key to the nation's political success.

Repressive reforms will not stand the test of time. America can always change its mind. It frequently does. It is the one central characteristic of our political system that has kept the nation strong and resilient — if not always completely or quickly successful — over nearly 200 years of unprecedented change.

I urge each of you to stand the test of change. Let each of us participate so that no one is barred from the political process. For we believe that we, as free citizens in a free land, are obligated to defend our beliefs in the way permitted to us and required of us by our form of government.

(Medical Practice)

PROJECT USA: This physician recruitment plan, established in 1972 through a HEW (National Health Service Corps-USPHS) reimbursable contract to provide volunteer physician-replacements for NHSC physicians, was continued and expanded. This year, mid-career physicians interested in long-term USPHS appointments were recruited. Staff prepared and mailed materials about NHSC and Project USA to state and local medical societies. In addition, Project USA began recruiting volunteer physicians for the Indian Health Service on a locum tenens basis. The contract has been extended for fiscal year 1976.

PUBLIC AFFAIRS DIVISION

A major reorganization occurred at the outset of the year with the elimination of the Field Service Department and the merger of portions of that Department with a new Department of Federation Affairs.

Division activity was reorganized to maintain close relationships with constituent societies. Public Affairs Division Memos were mailed to state, county and specialty societies on a regular basis and a medical society request control center was established. AMA staff were assigned as personal contacts for each state association and medical specialty society. County societies were encouraged to use a special telephone "hot line" when seeking service from the AMA.

State associations and specialty societies were contacted several times during the year through a series of legislative conference telephone calls from both Washington, D. C., and the Chicago Headquarters.

OFFICERS SERVICES SECTION: The Section is responsible for scheduling the extensive engagements of the President and the President Elect. The President gave priority to participating in AMA-sponsored meetings, national programs of pertinent interest to the profession and to state and metropolitan medical society meetings. The President and President Elect appeared before approximately 50,000 physicians during the year. The Section coordinated the Trustees State Association Visitation Program, now in its fourth year. The AMA was represented by an officer or trustee at all but three of the state annual meetings.

SPEAKERS AND LEADERSHIP PROGRAMS: Special Speakers and the Leadership Seminars were designed for state medical associations in California, Minnesota, Oklahoma, Pennsylvania and Texas. The seminars were conducted in cooperation with five county medical societies. These seminars, open to all physicians, were also conducted at the Portland Clinical and Atlantic City Annual Conventions, and three seminars were held at the O'Hare Marriott Hotel in Chicago.

Special projects were an AMA Board of Trustees-AMA Staff Seminar and two seminars for the officers of the AMA Auxiliary. The Section also helped coordinate the National Leadership Conference and the New Medical Executives School. Another special project was a seminar for the American Academy of Dermatology. The AMA Speakers Bureau on National Health Insurance placed scores of physician and staff speakers before live audiences and broadcast media. These speakers were kept informed through special briefings and a newsletter.

AMA OFFICE IN WASHINGTON

The Washington Office continued to collect, evaluate and report information on proposed legislation and regulations, while also furnishing information to the federal government, the media and Washington-based organizations and agencies. A major activity continues to be the briefing of state and specialty society representatives during their visits to the Capitol.

The Department of Governmental Relations was abolished as an economy measure. The former Department Director was designated Assistant Director of the Washington Office and has continued contact with federal agencies, particularly regarding maximum allowable cost regulations, the National Health Planning and Resources Development Act of 1974 (PL 94-641), implementation of PL 92-603 with emphasis on PSRO and physicians' reimbursement provisions, health post appointments in HEW, and national health insurance.

DEPARTMENT OF CONGRESSIONAL RELATIONS: During the period under review, some 1,000 bills relating to medical and health care were introduced into the Congress. Proposed or already enacted legislation of concern to the AMA included:

HEALTH MANPOWER: The principal activity of the Department was aimed at deleting federal licensure and relicensure provisions from the legislation; deleting federal involvement in the residency training programs; and eliminating indentured service or capitation payback provisions.

- NATIONAL HEALTH INSURANCE: The AMA's new bill (HR 6222), plus other major NHI proposals, continued to occupy the Department. There were numerous overview hearings on the subject.

HEALTH MAINTENANCE ORGANIZATIONS: The AMA opposed legislation to liberalize and further subsidize HMOs meeting federal requirements.

- PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS: The Department concerned itself with amendments to the law and with repeal measures.

- MEDICARE AND MEDICAID AMENDMENTS: The Department was involved in the legislative process relating to numerous objectionable Medicare and Medicaid amendments.

- POSTAL RATE LEGISLATION: The Deparment monitored various legislative activities intended to raise the rates for second, third and fourth class postage.

For the second consecutive year, the Department assessed the attitudes of all members of Congress on health issues in conjunction with Annual Member Contact Program.

DEPARTMENT OF COMMUNICATIONS: The Department continued to serve the media, health-related organizations and agencies, health publications, and the federal government. Speeches, news releases, news conferences, background materials and information kits were prepared. The Department continued to provide Washington and eastern U. S. reportorial coverage to the "American Medical News," "JAMA" and the "AMA Newsletter."

WASHINGTON LIBRARY: The library continued to serve staff, Congressional offices, federal agencies and other associations. Library services were reevaluated to provide more in-depth reference to staff. The library began to catalog and improve its collection and sought to establish better working relations with other libraries through professional associations.

LEGISLATIVE DEPARTMENT

The Department continued its assignment of carrying out the Association's activities concerning national and state legislation on medical and health care matters and in reviewing regulatory activities of governmental agencies. The Department reviews federal legislation, analyzes and

comments on federal regulations, develops model bills, prepares and coordinates AMA testimony before Committees of Congress, staffs the Council on Legislation and publishes "Legislative Roundup" and "State Health Legislation Report."

The Council on Legislation met seven times during the year to review federal legislation and to submit recommendations to the Board of Trustees. Representatives of national medical specialty societies were guests at one of the sessions. Legislation reviewed included health planning, health education, bonus pay for certain medical personnel in the uniformed services, professional liability, Indian health care, health insurance for the unemployed, communicable disease control, regulation and licensure of clinical laboratories, health maintenance organizations, salary increases for VA physicians, health professions education, health facility construction and amendments to Medicare and Medicaid. The Council gave special attention to regulations concerning utilization review and to maximum allowable costs for payment of drugs under Medicare and Medicaid.

Because of national interest in professional liability, portions of "Legislative Roundup" were devoted periodically to reviews of important state legislation seeking short and long-term solutions to the problem.

Through Public Affairs Division Memos, specialty societies and state associations were kept informed of proposed new regulations and changes in regulations relating to the operations of health programs.

DEVELOPMENT OF PROPOSED LEGISLATION: Many of the legislative proposals prepared by the Council for introduction in the 93rd Congress were reviewed, updated and resubmitted to the Board of Trustees for introduction in the 94th Congress. The bills concern rural health care, PSRO amendments, disabled physicians, blood banks, labeling of prescription drugs, full tax deductions for the cost of medical care and drugs, amendments to the Social Security Act to prevent malpractice claimants from receiving, as part of recovered damages, costs of health care services already paid by Social Security, and incentive pay for medical officers in the uniformed services.

The AMA's new national health insurance proposal (HR 6222) was based upon guidelines previously adopted by the Association. Features include mandated employer coverage through private insurance; employer-employee sharing of premium costs; limited subsidy for small employers; private insurance pool for indigent, uninsurable and self-employed; coinsurance determined by income level; insurance for the unemployed, and coverage for all against the cost of a catastrophic illness.

MEDICAL BILLS ENACTED INTO LAW: New enactments during the latter stages of the 93rd Congress include: National Program of Biomedical Research, PL 93-348; Medical Library Assistance, PL 93-353; Students Loans in Health Professions Education Schools, PL 93-385; Compensation of Armed Forces Physicians, PL 93-394; and National Health Planning, PL 93-641. No major health related legislation was signed into law during the first months of the 94th Congress.

AMA TESTIMONY: During the year, the AMA presented its views to Congress more than 70 times — in person or in writing — on major health legislation and proposed regulations.

PENDING LEGISLATION: During the first eight months of the 94th Congress, over 12,000 bills were introduced of which some 10 percent are of particular interest to medicine. Major

bills pending include health manpower training, national health insurance, health revenue sharing, HMO amendments, health insurance for the unemployed, professional liability, communicable disease programs and amendments to Medicare and Medicaid.

DEPARTMENT OF SPECIALTY SOCIETY SERVICES

SPECIALTY SOCIETIES: Staff-to-staff liaison was maintained with 28 specialty societies, and five legislative briefings for specialty representatives were held in cooperation with the Washington Office staff. Support was also provided for the AMA Section Councils and Association of Section and Service Delegates.

INTERSPECIALTY COUNCIL: The Council, with representatives from 32 national specialty societies and acting as an advisory body to the AMA Board of Trustees, held four meetings during the year. Discussions included medical health legislation, peer review, health education, health manpower, specialty society participation in the AMA, guidelines for housestaff contacts, professional liability, health care costs, and physician's assistants programs.

DEPARTMENT OF FEDERATION AFFAIRS

The Department is responsible for membership development programs and communication with all physicians. Encompassed in this responsibility is the nation's medical student population. The 1975 AMA dues-paying membership will surpass 1974, which was a record dues-paying membership year. This is being accomplished by the development of new pamphlets, programs and communications to all segments of the physician and medical student population. The year 1974 ended with an increase of approximately 11,000 dues-paying AMA members. This figure was double the largest dues-paying membership increase of any of the preceding twelve years. By July 1975, both medical student membership and intern and resident membership surpassed the 1974 year-end total by more than 50 percent.

The Department maintained regional offices in Massachusetts, Georgia and Illinois.

DEPARTMENT OF HOUSESTAFF AFFAIRS

The Department is responsible for all activities relating to concerns of the 60,000 interns and residents enrolled in AMA-accredited programs. The Department staffs the Annual I & R Business Session, the Clinical I & R Business Session and all meetings of the IRBS Executive Committee.

In 1974, the third year in which AMA membership was offered to Housestaff, I & R membership totaled 5,097. As of August 5, 1975, AMA Housestaff membership had set a new record of 7,750.

Priority was given to amending the Residency Review Committee structure to provide for I & R representation on each of the 23 Residency Review Committees. Other priorities included physician manpower, Housestaff representation within the AMA, national legislation affecting residency programs and young physicians, professional liability, and foreign medical graduates. Liaison was established with the Young Lawyers Section of the American Bar Association to deal with such problems as health care in penal and mental institutions.

In working within the AMA, Housestaff representatives met with the Council on Long Range Planning and Development, Council on Constitution and Bylaws, Judicial Council, Board of

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ANNUAL REPORTS

JULY 1, 1972 TO JUNE 30, 1973

The House of Delegates received the Annual Reports as information

The following Annual Reports were submitted to the House of Delegates by the Board of Trustees. Each Division and Department of the AMA was asked to prepare a comprehensive report of its activities from July 1, 1972 to June 30, 1973. These reports contain detailed information regarding the programs and contributions of the Standing Committees of the House as well as Councils, Committees and Commissions of the Board of Trustees and the AMA Education and Research Foundation.

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DEPARTMENT OF MEDICINE AND RELIGION

During the year the Board of Trustees discontinued its Committee on Medicine and Religion; however, this action did not indicate reduced interest in the Department and its programs. The Department continues to develop programs that will lead to greater effectiveness in the working relationship between physicians, clergy and chaplains for the benefit of patients and their families. The task is carried on through medical society committees, other medical groups and institutions. The Board has supported the use of consultants to provide staff with special expertise and guidance in future programs. All state committees have maintained their activities.

Four regional workshops were held for state society committee chairmen. These programs provide the chairmen with education, training and an opportunity to share their plans with each other.

The Department provides resource material to state committees that cooperate with seminaries in developing medicine and religion emphases in their courses. The purpose is to help seminarians understand their role in working with physicians in caring for patients. Medical schools are encouraged to include medicine and religion in continuing education programs. Many postgraduate departments of medical schools now offer symposia on medicine and religion.

An increasing number of state societies held interfaith prayer breakfasts at their annual meetings. This trend developed with the first breakfast at AMA's Annual Convention in 1970. The Department works with the National Congressional Committee in planning a seminar for physicians at the time of the Annual National Prayer Breakfast in Washington, D. C.

The Department newsletter continues to be of increasing interest to both physicians and clergy, and its films and exhibits have one of the largest circulations of any at AMA. Staff worked with the American Hospital Association's Committee on Chaplains and the Joint Commission on Accreditation of Hospitals in developing standards for hospital chaplaincy departments.

The Medicine and Religion program during the Annual Convention featured Father Charles Carroll, who spoke on "The Primary Community--State or Family?" John R. Schenken, M.D., gave a special presentation on "The Life of Christ in Art" at the Interfaith Prayer Breakfast.

OFFICE OF THE GENERAL COUNSEL

This report covers the activities of the Office of the General Counsel, the departments under its jurisdiction, and the following Councils and Committees staffed by the Office: Council on Constitution and Bylaws, the Judicial Council, and the National Conference of Representatives of the AMA and ABA.

The Office continued to function as a source of information on developments in the medicolegal field. Information on such subjects as abortion,

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blood transfusions, body donations, chiropractic, consent by minors, immunity for peer review committees, malpractice, physician unions, professional corporations, reportable acts and diseases, and many other topics was sent to physicians and organizations on request.

The Office advised the AMA on wage and price control developments. It negotiated the new Group Term Life and Excess Major Medical insurance plans with Provident Life Insurance Company. It maintained liaison with outside counsel in the litigation against AMA regarding Educational Council for Foreign Medical Graduates.

Cease and desist letters were written to many companies and organizations to prevent unauthorized use of the AMA's name or copyrighted materials for promotional purposes.

Council on Constitution and Bylaws: The Council held six meetings during the period and reports were submitted to the House of Delegates at the Annual and Clinical Conventions.

CORPORATE LAW DEPARTMENT

This Department handles all the business law questions of the AMA and AMA-ERF, such as contracts, leases, taxes and insurance. In addition, it advises the membership of general legal developments in the tax areas. Among other activities, the Department negotiated contracts with the Pennsylvania Medical Society regarding flood relief ERF loans, with two unions covering AMA tradesman employees, with Batelle Labs regarding a long-range planning system for AMA, with Fireman's Fund on the Members Disability Insurance Program, with Fulfillment Corporation of America regarding mailing AMA subscription publications, with Blue Cross regarding sharing time on AMA computers, and with Gittleman Film Associates, New York, regarding the Today's Health TV pilot.

The Department entered AMA as amicus curiae in Williams & Wilkins v. U. S., a case attempting to charge royalties for Xeroxing copyrighted articles in medical journals. It incorporated the National Joint Practice Commission. It successfully petitioned the IRS not to apply retroactively a ruling prohibiting withdrawal of voluntary contributions to Keogh Plans. The Department met with the direct mail houses to negotiate a new two-year contract regarding the AMA master physician lists. It met with the legal and tax committees of the Magazine Publishers Association in New York. Legal research memoranda were prepared on such subjects as AMA withdrawal from the World Medical Association, pricing policy of AMA publications, sale of goods at AMA conventions, solicitation of sales of Members Retirement Plan, and tax aspects of a subsidiary "for-profit" corporation.

DEPARTMENT OF INVESTIGATION

The Department continued activities to fight health quackery in general and deal with chiropractic in particular.

Health Quackery in General: Information was collected and disseminated on all forms of health quackery. Liaison and cooperation with federal, state and

local legal and administrative agencies brought action in a number of cases. A few examples of activities include:

1. Liaison was maintained with an ad hoc committee named by the National Institutes of Health to investigate acupuncture. The Department compiled information on legislative actions and opinions issued on acupuncture by state boards of medical examiners and attorneys general. Most opinions held that acupuncture should be performed only by licensed medical practitioners.

2. A do-it-yourself "pap check" kit offered to women in nationwide advertisements was investigated. Action by HEW halted sale of the kits.

3. Information was gathered on claims and promotions by groups headed by laymen who are selling courses in "alpha wave and biofeedback training."

4. Several schemes involving foreign promoters who offered "opportunities" for a fee to American students to receive a medical education and/or obtain a medical "degree" overseas were blocked through cooperation of the Department with the U. S. Postal Inspection Service.

Committee on Quackery: Congress passed an amendment to the Medicare law in October 1972 that added chiropractic services on a limited basis for "manual manipulation of the spine (to correct subluxation demonstrated by x-ray to exist) which he is authorized to perform." The limitation resulted primarily through successful efforts by medicine to obtain reconsideration of amendments that had included a broader provision. Regulations and standards for the new law were announced by HEW in June. While the regulations and standards were being drafted, the Department provided HEW with information and materials pertaining to chiropractic. After announcement of the proposed standards and regulations, the AMA urged reconsideration because a "minimum standard" was set and there was a lack of specificity in the published regulations. The AMA expressed "extreme concern" that the proposed regulations would grant "point-of-entry status" under Medicare to chiropractic services.

The Committee Chairman testified in March 1973 before the Advisory Committee on Accreditation and Institutional Eligibility of the U. S. Office of Education, opposing two applications by different chiropractic groups for recognition as the accrediting agency for chiropractic schools. The Office of Education denied both applications, subject to review hearings requested by both chiropractic groups.

The Committee resumed conferences dealing primarily with federal and state legislative problems relating to chiropractic. A poll by mail of state medical societies showed the majority favored resumption of regional conferences rather than national conferences at the time of AMA conventions. One national conference already scheduled at the 1972 AMA Clinical Convention was well attended.

A claim published by chiropractors that chiropractic services are required in health maintenance organizations was called to the attention of HEW by the Committee, and an HEW official refuted the claim.

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DEPARTMENT OF MEDICAL ETHICS

The Department provides staff support to the Judicial Council. In addition, it works closely with the staffs of state and county medical societies when questions of medical ethics (solicitation of patients, advertising, fee splitting, excessive fees, etc.) or bioethics (clinical investigation, genetic engineering, mercy death/euthanasia, behavior control, test tube babies/artificial insemination) arise.

The Department also answers inquiries on ethical subjects presented by physicians, the public, governmental departments and the media. It prepared a series of three articles on the Supreme Court opinion on abortion for the "Law and Medicine" section of JAMA. It cooperated with two specialty societies that were drafting supplements to Opinions and Reports of the Judicial Council for their own memberships. A paper on "Group Legal Services to Medical Societies and Their Members" was prepared, and a paper on "The Time Lag Between Advances in Medicine and Law" was presented at the annual meeting of the American Association for the Advancement of Science.

Judicial Council: The Judicial Council held its Fourth National Congress on Medical Ethics in Washington, D. C. The philosophical aspects of ethical issues were emphasized. The Council answered a number of inquiries and completed the 15th annual distribution of Opinions and Reports to all senior medical students. In statements, the Council said that physicians should not withhold signatures on insurance claim forms as a means of collecting unpaid bills and that it is demeaning to the profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises.

LEGAL RESEARCH DEPARTMENT

The Department developed and made available to members and to medical societies a variety of informational and instructional materials. Twenty-four issues of The Citation, the newsletter of the Office of the General Counsel, were published and 52 articles were written or reviewed for the "Law and Medicine" section of JAMA.

Thousands of copies of the 500 items of medicolegal information available from the Office of the General Counsel were distributed. A revised and enlarged edition of the Medicolegal Forms book was published. A third book in the Best of Law and Medicine series was begun.

The Department assisted C. A. Hoffman, M. D., in his work as a member of the HEW Commission on Medical Malpractice, including assistance in the preparation of separate and dissenting statements for publication with the Report of the Commission. It worked with the staff of the Commission in an attempt to improve its studies and prepared a point-by-point analysis and critique of the Commission's Report. It provided staff assistance to the planning committee which decided to establish the Medical Liability Commission. The membership of this independent organization is limited to national organizations representing medical care providers.

National Conference of Representatives of AMA and ABA: This Conference covers the activities of the AMA Liaison Committee to the American Bar Association and the ABA Committee to Cooperate with AMA. The Conference met twice. It presented the 1973 National Medicolegal Symposium at Las Vegas, Nevada, in March. The Proceedings of this Symposium are being prepared for publication. The site for the 1975 Symposium will again be Las Vegas. The Conference established liaison with the National Conference of Commissions on Uniform State Laws so that both associations can be kept advised of proposed legislation. In cooperation with the American Hospital Association, it assisted in the development of a medicolegal film on hospital safety, titled The Best of Care, produced by Richardson-Merrell.

Ad Hoc Committee on Blood Grouping Tests for Determination of Questions on Disputed Paternity: The Committee, which was appointed to cooperate with the Committee on Paternity of the Section on Family Law of the American Bar Association in the development of a model law, recommended that a compilation of data on blood grouping tests be undertaken by AMA. The compilation is being prepared.

CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT

The Center for Health Services Research and Development is continuously engaged in conducting and encouraging socioeconomic research on the environment within which medicine is practiced. The Center consists of the Department of Survey Research, the Department of Economic Research and the Department of Systems Research. The three departments seek to: (1) evaluate experimental health care delivery systems; (2) identify cost-effective models for the financing, organization, and delivery of health services; (3) provide AMA with research reports and data to assist in the formulation of its policies; (4) facilitate participation by medical societies in health services research and development; (5) provide a link between AMA and other sectors of the health services research community; and (6) conduct research on the supply and distribution of health manpower.

Economics of Medical Practice: In June 1973, the Center completed the third year of a research project with the University of Southern California. Early phases concentrated on development of methodologies and collection of data for the comparative evaluation of the economics of alternative forms of medical practice. The two surveys -- one of 2,000 group practices and one of 10,000 physicians -- completed a data base for purposes of analysis.

Research papers completed or in progress concern factors affecting employment and utilization of allied health personnel; the impact of allied health personnel on productivity of primary medical care; efficient classification of medical practice; effect of the use of allied health personnel on the prices of medical services, physicians' incomes and hours worked by physicians; and cost and utilization experiences in prepaid group practice. Preliminary research into the productivity of medical practices was completed. Further effort is underway to extend the study of physician productivity as a means of gaining insight into the relative efficiency of larger scale (group) practices.

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Staff is engaged in a joint study with faculty members of the University of Florida. Three projects are progressing: (1) an analysis of physicians' pricing decisions; (2) a study of hours worked by physicians; and (3) non-price rationing by physicians. A paper on pricing was presented at a seminar of the Center for Health Administration Studies, University of Chicago, in May 1973. Another joint study involves Center staff and faculty of the Center for Health Administration Studies at the University of Chicago. This effort focuses on physicians' referral patterns. Data collection has been completed and analysis is underway. A collaborative study with the Rand Corporation analyzes factors affecting the location of physicians in rural and urban areas. This project is funded by HEW.

Public Affairs Research: Staff provided assistance and research support to the AMA representative to the Health Services Industry Committee of the Economic Stabilization Program. Staff assisted in revising AMA's Medicredit proposal and worked on revised cost estimates for that bill. Proposals were submitted to HEW for the development of both a clearinghouse for information on professional standards review organizations and a proposed academy to train PSRO administrators.

Health Manpower Research: The Center is engaged in nine major health research projects. Among these are:

A project on comprehensive health manpower strategy, focusing on the supply and distribution of physicians, was initiated at the request of the HEW Secretary. A report to be published in the summer of 1973 will include research papers on the measurement of the supply of physicians' services, distribution of physicians by both geographic and specialty characteristics and the supply of foreign medical graduates.

A long-term study of physicians' specialty and practice-site decisions will make full use of AMA's current and historical data on physicians' locational, professional, and practice characteristics. The analysis will focus on changes in physician characteristics over time, permitting the identification of determinants of trends in a variety of aspects of medical practice. Results of this analysis will provide sound statistics for the formulation of future public policy.

Research Clearinghouse: At the 1971 Clinical Convention the House of Delegates directed the Center to establish and maintain a central clearinghouse for information on research, development, and demonstration projects being conducted by medical societies. Examples of the types of projects that are included in the clearinghouse are: HMO planning and development programs, Experimental Medical Care Review Organization projects; research projects on such issues as medical education, quality of care, health care costs, and health manpower. Some benefits already resulting are:

1. Societies studying similar problems or issues have been identified and brought together to share information.
2. An annual report of the research and development activities of organized medicine is prepared and disseminated to all participants in the clearinghouse and to selected private medical organizations.

3. Organized medicine is provided with the latest research findings for policy making and legislative efforts.

To ascertain what research and development activity was being conducted and planned by medical societies, the Center surveyed executive officers of state, county and specialty medical societies. Responses indicate that continuation of this activity is desired.

Data Requests: Each year the Center responds to numerous requests for information, usually in the form of data from the AMA Physician Masterfile. These requests are carefully screened. The integrity of the AMA data base and protection of the individual physician are paramount considerations. In supplying data, the Center collaborated with the National Medical Association on a project to identify all black physicians in the U. S.; worked with Columbia University researchers who are doing a major study of physicians' attitudes on various aspects of the health delivery system; assisted the National Center for Health Statistics in selecting a sample for the National Ambulatory Medical Care Survey; worked with the National Health Service Corps in developing procedures for determining areas which have a shortage of physicians.

Updating the AMA Data Base: The Center conducted the triennial census of the entire physician population to obtain information for the "current activity, specialty and employer" sections of the AMA Physician Masterfile; maintained quality control and review of the weekly update procedures for assuring that information on the AMA Physician Masterfile is current; conducted the AMA-Rand Survey of 1965 Medical School Graduates, a major survey of all 1965 graduates of American medical schools to obtain information on the location choice of young physicians; conducted the American Medical News readership survey and prepared a market analysis of the survey; analyzed the Weinhotten Survey of 1960 Medical Graduates of American Medical Schools; conducted the second AMA Membership Opinion survey under the direction of the AMA Committee on Membership Opinion Polls; conducted a survey of U. S. jails to collect data on the health facilities and services available; conducted the eighth Periodic Survey of Physicians to collect information on practice characteristics of physicians, including hours worked, volume of patient visits, income, expenses, fees, employment of allied health personnel; designed a fourth survey of group practice that will become the initial data for the newly designed permanent data file on group practice; conducted a survey to collect information on frequency of prescribing certain types of drugs, physicians' opinions of certain information sources, and other data related to prescribing patterns of physicians.

AMA National Advisory Committee on Physician Data: This Committee was established to assist the Center in maintaining and improving the AMA data base. The Committee includes representatives from major organizations concerned with physician data, including government agencies, the academic community, and various medical associations and other health related organizations.

Publications: The Center published the following volumes: Distribution of Physicians in the U. S., 1971; 1973 Reference Data on Socioeconomic Issues of Health; 1973 Reference Data on the Profile of Medical Practice; Towards a Comprehensive Health Manpower Strategy; 1973 Opinion Survey of the AMA Membership; Medical Care in U. S. Jails--A 1972 AMA Survey. Numerous articles and reports also were published.

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DIVISION OF SCIENTIFIC PUBLICATIONS

The Division continued its efforts to make The Journal of the American Medical Association and the 10 AMA specialty journals eminent periodicals in the medical field, both in content and style.

Two supplements to JAMA were published. For the first time continuing education courses appeared in supplementary form (August 13, 1972) rather than in the body of The Journal. The Primer on the Rheumatic Diseases, a supplement to The Journal of April 30, 1973, was acclaimed as a valuable contribution to the literature.

Special numbers of JAMA published were: Olympic Issue, August 28, 1972; Clinical Convention Number, October 16, 1972; Education Number, November 20, 1972; Book Number, April 2, 1973; Annual Convention Number, April 16, 1973.

In June 1973 the Board of Trustees announced that Robert H. Moser, M. D., will assume the editorship of JAMA and become Director of the Division of Scientific Publications on October 1, 1973. Hugh M. Hussey, M. D., will become editor emeritus and will continue in full-time employment.

SPECIALTY JOURNALS

Eight of the ten specialty journals (Archives of Dermatology and Archives of Internal Medicine excepted) now have covers which are uniform in style. The objective is to establish the appearance of a family of journals. Different colors are assigned to specific journals.

DIVISION OF SCIENTIFIC ACTIVITIES

The Division of Scientific Activities comprises seven departments and the Division Office. It is responsible for staffing four councils and ten committees of the Association.

The Division Office provided staff services for the following: the Advisory Committee on Medical Science, the Advisory Committee on Cancer, the Committee on Hypertension, the Committee on Maternal and Child Care, the Committee on Transfusion and Transplantation, and the Committee on Human Sexuality.

Advisory Committee on Medical Science: This Committee considered the problems of AMA scientific journals and proposed organizational and operational changes to improve scientific communication in AMA media.

Advisory Committee on Cancer: This Committee closely followed the activities of the National Cancer Institute which was established under the National Cancer Act of 1971. The Committee advised the Board of Trustees on tumor registries and supported the development of a new book on cancer based on a series of articles published in JAMA under the heading "Current Concepts in Cancer Therapy." The book is being prepared for publication.

Committee on Hypertension: A report to the Board of Trustees, subsequently endorsed by the House of Delegates, was initiated to establish policy recommendations to all physicians on the discovery and therapy of hypertension. To facilitate implementation of the policy, the Committee authored for JAMA a scientific article on the office management of hypertension. The Committee maintained close liaison with the national effort against hypertension led by the U. S. Department of Health, Education, and Welfare.

Committee on Maternal and Child Care: This Committee advised the Board of Trustees on a variety of matters including abortion, smallpox immunization, and vaccination for rubella. It has participated in an ad hoc committee effort to establish guidelines for the implementation of Report J (C-71) regarding centralized perinatal intensive care. Also participating were the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Physicians, and the National Foundation-March of Dimes.

Committee on Transfusion and Transplantation: This Committee advised the Board on federal activities relating to blood banking and transfusion facilities and services. It initiated a report, which after approval by the House of Delegates, was presented to the federal study panel group engaged in developing a national blood policy. A revised edition of General Principles of Blood Transfusion was published, and the Committee completed its work on a national survey of blood banking activities.

Committee on Human Sexuality: This Committee published a book titled Human Sexuality. The first edition was sold out in a short time and a revised edition was developed for the second printing. The Committee was discharged in June 1973.

DEPARTMENT OF SCIENTIFIC ASSEMBLY

Clinical Convention, Cincinnati, November 26-29, 1972: There were 18 half-day sessions, with three presented simultaneously. Physician registration was 2,214, almost 700 lower than last year, an indication that physicians may prefer a warmer climate for December meetings. Once again, the three postgraduate courses were sold out. The 13 luncheon roundtables also were well attended.

Annual Convention, New York, June 23-27, 1973: Physician registration was 8,756. There were 66 half-day sessions developed by the 26 Section Councils. A highlight of the program was a Symposium on Acupuncture, featuring a film from the People's Republic of China and a panel of experts. The reduced attendance at some sessions reflected the lower total physician registration as well as the separation of meeting rooms from the Coliseum. Because of strong physician interest in continuing education, as demonstrated by full attendance at postgraduate courses during previous conventions, the number of courses was increased to 15. Approximately 1,100 physicians registered for courses presented by the Council, and five courses were sold out.

The Scientific Awards Dinner was addressed by Edward H. Rynearson, M. D., emeritus, Mayo Graduate School of Medicine. The Scientific Achievement Award was presented to Edith Hinkley Quimby, Sc. D., and the Distinguished Service

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Award was presented to George Hoyt Whipple, M. D. The Citation of a Layman for Distinguished Service Award was presented to Leslie Townes (Bob) Hope at the opening session of the House of Delegates, instead of at the Awards dinner because Mr. Hope had a previous commitment on that date.

Two new Section Councils have been added: Cardiovascular Disease and Plastic and Reconstructive Surgery. One step was removed to facilitate the organization of new Section Councils. It is no longer necessary for the permanent Section Councils to review the final petition submitted by the sponsoring organization of a new Section Council. This will eliminate a second vote and save at least six months' time.

Scientific Exhibits: New York was the site of the first AMA-sponsored self-evaluation area at an Annual Convention. New technology for self-evaluation was demonstrated. Corporate-educational exhibits were incorporated in both the Annual and Clinical Conventions with good attendance shown in these areas. Special exhibits initiated by the Council on patient-management problems were well received.

Medical Motion Pictures and Television: Motion Picture Symposiums on Infertility and on the Treatment of Breast Cancer were the best-attended events on the film programs at the conventions. Staff assisted in selecting films for international and domestic festivals and aided other medical groups in planning motion picture programs. Staff processed 5,500 requests for information about films on specific subjects or for general film information. Almost 22,000 films were distributed by the film library to hospitals, medical schools and medical societies.

DEPARTMENT OF ENVIRONMENTAL, PUBLIC, AND OCCUPATIONAL HEALTH

The Department of Environmental, Public, and Occupational Health continued its combined activities in these related fields and provided staff for the newly named Council on Environmental, Occupational, and Public Health.

Environmental Health: Liaison was maintained with the Environmental Protection Agency, the Council on Environmental Quality, other governmental agencies and non-governmental associations, and particularly with the Public Health Service Center for Disease Control.

The tenth Annual Congress on Environmental Health, held in Chicago in April, featured "Energy, the Environment, and Human Health." The papers presented at this meeting will be published in book form by a commercial publisher. The biennial Air pollution Medical Research Conference was held in Chicago in October 1972.

By action of the Board of Trustees, the Council on Environmental and Public Health was given added responsibilities in the field of occupational medicine and was re-designated the Council on Environmental, Occupational, and Public Health. The Council held the last two of a series of environmental and public health planning regional meetings for representatives from medical societies, state health departments, state environmental protection agencies, and regional and federal governmental agencies. The Council and the Department cooperated

with the Union of Medical Societies of Yugoslavia in developing the program for an International Conference on Environmental Health in Primosten, Yugoslavia, in October 1973.

The Department continues to publish a monthly newsletter, Environmental and Public Health News, for distribution to medical societies, physicians and allied health professionals. Physician's Guides to Pollution (air, water, noise and odor) were published.

Occupational Health: The former Council on Occupational Health sponsored its 32nd AMA Congress on Occupational Health in Chicago in September 1972. The monographs, "Occupational Dermatoses" and "Health Hazards in Farming and Gardening," were published under the direction of the former Council's Committee on Occupational Toxicology. The Council also published revisions of "Guide to the Development of an Industrial Medical Records System" and "Guide to the Significance of Occupational Exposure Limits."

Although the Board of Trustees terminated the Council on Occupational Health and its three committees (Occupational Toxicology, Aerospace Medicine, and Mental Health in Industry) in October 1972, programs in occupational health are continuing under the re-designated Council on Environmental, Occupational and Public Health. The 33rd AMA Congress on Occupational Health is scheduled for Philadelphia on September 17-18, 1973.

AMA consultants, ad hoc committees, and staff are assisting the National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration in toxicology-standards development, record keeping, and advice on medical services under the Occupational Safety and Health Act.

DEPARTMENT OF DRUGS

The staff of the Department was reorganized and consolidated following the termination of the Council on Drugs. Staff effort was devoted principally to completing the second edition of AMA Drug Evaluations. Contractual arrangements were made for publication by Publishing Science Group, Inc., Acton, Massachusetts.

Departmental publications in JAMA included three monographs on new drugs, five editorials, and one statement. The nomenclature section published 12 listings of new nonproprietary names and two new editions of the nomenclature printout.

The Department sponsored a conference attended by representatives of the FDA and 15 major medical organizations to consider alleged overutilization of antibiotics; appropriate follow-up studies are underway. Staff worked closely with the Legislative Department in preparing AMA testimony and responses to proposed FDA rule-making and regulations.

Liaison was maintained with many governmental agencies and medical organizations. Staff answered 5,000 inquiries from physicians and the public, mailed 37,000 reprints and pamphlets, and staffed 11 exhibits at scientific meetings.

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Committee on Cutaneous Health and Cosmetics: The Committee met twice. A significant portion of both meetings was devoted to discussions of proposed legislation and regulations dealing with the safety of cosmetic products. The Committee sponsored a Symposium on Environment and the Skin in Cincinnati and a Conference on Hair Growth in Chicago. Committee members and staff gave eight talks to various groups and supplied data for a large number of magazine and newspaper articles. A new public exhibit on acne was constructed. Four scientific articles and two new pamphlets were published.

DEPARTMENT OF FOODS AND NUTRITION

Concerned about potential hazards to health, the Council on Foods and Nutrition published a detailed critique of low carbohydrate ketogenic weight reduction regimens and, in particular, the book Dr. Atkins' Diet Revolution.

The Goldberger Award in Clinical Nutrition was given to Clement Finch, M. D., for his outstanding contributions in the research of hematology, iron metabolism, biophysics and clinical pathology. Fifteen medical students were awarded research fellowships in honor of the Goldberger Award recipient. AMA Lectures in Medical Sciences were given at 84 colleges by 17 lecturers. This program presents AMA on campus to inform the audience of current concepts in the medical sciences and to stimulate careers in the health professions.

The Council's Subcommittee on Total Parenteral Nutrition, which was organized to study and evaluate the safety and composition of the TPN solutions and delivery systems, developed recommendations for the nutrient composition of large-volume parenteral solutions that is the basis of FDA regulations. A resource conference was held on the technical and clinical aspects of intravascular catheters and related devices.

The Council, with the AMA Food Industry Liaison Committee, sponsored a research Conference on the Physicians' Guide to Processed Foods which provided an opportunity for physicians and industry representatives to discuss current concepts in clinical nutrition, processed food, and the responsibilities of both physicians and industry in nutrition. A Symposium on Fats and Carbohydrates in Processed Foods is scheduled for October. The Council evaluated the newer techniques of food processing and published a definitive monograph with recommendations for safe and effective management of processing problems.

Five books based on recent conferences are being published. Audiotape cassettes of a number of Council symposia have been completed, as well as a clinical teaching videotape-film on Absorption and Digestion: Normal and Abnormal. A pilot community nutrition educational program at the Daniel Hale Williams Health Center in Chicago has been underway since the first of the year. Plans are being developed for the Western Hemisphere Nutrition Congress IV in Florida next year.

OFFICE OF CURRENT MEDICAL TERMINOLOGY

The Office of Current Medical Terminology, in cooperation with the Division of Medical Practice and consultants from specialty societies, and under the

direction of an editorial board, produced the third edition of Current Procedural Terminology. This edition includes approximately 500 new terms and related definitions for "new" procedures, an expanded index, and a new format. CPT utilizes a five-digit coding system and is computer oriented to facilitate a variety of statistical applications, including peer review.

Staff has begun work on the fifth edition of Current Medical Information and Terminology which will include many new terms and definitions of diseases and conditions. CMIT employs random numbers for coding its entries. The fifth edition will provide code numbers for symptoms, which will allow reporting for therapy in cases where a final diagnosis has not been determined.

DEPARTMENT OF MENTAL HEALTH

Council on Mental Health: The theme of the 19th Annual Conference of State Mental Health Representatives, held in April, was the right to treatment of patients who are involuntarily committed.

As part of its commitment to monitor the comprehensive community mental health centers program, the Council presented a progress report to the Board of Trustees outlining some of the major problems, such as staffing, funding and community participation.

The Council's statement on physicians with psychiatric disorders was adopted by the House of Delegates at its 1972 Clinical Convention. A revision of the Handbook on Mental Retardation is in progress.

Committee on Alcoholism and Drug Dependence: The Committee advised the FDA in the development of new regulations on the use of methadone. The Committee and the FDA, with the assistance of the government's Special Action Office for Drug Abuse Prevention, issued a series of 24 questions and answers on the methadone regulations, seeking to clarify some of the provisions. This clarification was sent to state and county medical society executives, members of state medical society mental health and drug abuse committees, state medical society journal editors, and directors of methadone treatment programs.

Testimony was given on barbiturate abuse before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare. A Conference on Medical Complications of Drug Abuse, held under AMA sponsorship in December, highlighted non-psychiatric sequelae of drug-taking and the relationship of drug abuse to disease.

Council and Committee representatives and staff took an active part in two international drug abuse research projects -- the Japan-United States Cooperative Science Program on Drug Abuse Research and a bilateral exchange on drug abuse initiated at the request of the President of Mexico.

The Department wrote to the deans and heads of several departments of all U. S. medical schools urging that instruction on alcoholism be incorporated in the curriculum. Accompanying the letter was a reprint of the Council and Committee statement "Medical Schools Education on Abuse of Alcohol and Other Psychotropic Drugs," published in the March 27, 1972 issue of JAMA.

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DEPARTMENT OF HEALTH EDUCATION

Major areas of Department activity are health education of the public, school and college health safety education and administration, medical aspects of sports, physical fitness, automotive safety and voluntary health agencies.

Staff answered nearly 50,000 requests for information from the public and 10,000 inquiries from health professionals. Updated publications include Birth Control, Blood Tests, Allergies and Why Girls Menstruate. Ten issues of Health Education Service for Schools and Colleges (circulation 20,000) and 12 issues of More Life for Your Years (circulation 44,000) were published. A VD Education kit was prepared for physicians, health educators and civic groups.

Committee on the Medical Aspects of Sports: The 14th National Conference on the Medical Aspects of Sports was held in Cincinnati in November. Committee representatives testified on the use of drugs in athletics before the Senate Subcommittee on Juvenile Delinquency. A Guide for the Medical Evaluation of Candidates for School Sports was revised. Liaison was maintained with 29 national health and safety agencies.

Committee on Exercise or Physical Fitness: A Symposium on Exercise and the Heart was sponsored in September 1971 in cooperation with the Washington State Medical Association, the Washington State Heart Association and the President's Council on Physical Fitness and Sports. The Committee has completed "Evaluation for Exercise Participation--The Apparently Healthy Individual," a section of its Guide to Prescribing Exercise Programs. A new pamphlet, Physical Fitness, and a statement, "Ethical Considerations Regarding Referral Services for Cardiac Rehabilitation," are being developed.

Joint Committee on Health Problems in Education of the National Education Association-American Medical Association: Resolutions were adopted on improving nutrition education in schools, legal immunity for school personnel reporting battered children, alcohol and health education, the cycle of life and health career education. These statements were distributed to education accrediting agencies, state departments of health, state departments of education, state medical societies and their journals, appropriate federal and state government agencies, PTAs, educational publications and the mass media. The pamphlet Why Health Education and the book Health Education were revised.

AMA-American College Health Association Liaison Committee: This Committee considered problems related to college entrance medical examinations, consumer participation in college health activities and higher education's responsibility for student health. A questionnaire to survey the activities of state medical associations in the area of college health was completed.

A program to upgrade the medical understanding of lay driver examiners has been launched in cooperation with the American Association of Motor Vehicle Administrators. The program has been conducted in three states and plans are underway for 15 more states to participate. Physician's Guide for Determining Driver Limitation has been revised. The theme of the AMA-American School Health Session was "Driving Safely--A Critical School Health Problem."

Patient education programs of 11 voluntary health agencies were discussed by agency and AMA representatives at the October 1972 meeting of the former Committee on Continuing Professional Education Programs of Voluntary Health Agencies. In February 1973, the Department sponsored an exploratory meeting on patient education with representatives from medicine, hospitals, universities and insurance companies participating.

DIVISION OF MEDICAL EDUCATION

Five additional medical schools accepted their first classes during the year, bringing the number with students enrolled to 113. First-year enrollment exceeded 13,500, and graduates exceeded 10,000 for the first time. "Essentials" were approved by the House of Delegates for three new allied health occupations, bringing to 24 the number of occupations for which the Council on Medical Education has accreditation responsibility. The field of continuing medical education grew rapidly. Eighty-one additional institutions were accredited, bringing the total to 248. Thirteen state medical societies are functioning as accrediting agencies for intra-state programs, under AMA supervision. In graduate medical education, "Essentials" were approved by the House of Delegates for the new specialty of nuclear medicine.

The newly established Coordinating Council on Medical Education and Liaison Committee on Graduate Medical Education held their first meetings. These bodies, with representation from American Medical Association, Association of American Medical Colleges, American Board of Medical Specialties, American Hospital Association, and Council of Medical Specialty Societies, will coordinate and supervise accreditation activities at the medical school, internship and residency levels. Staff services are provided by the Division.

The 69th Annual Congress on Medical Education was held in Chicago in February. It was attended by 1,603 physicians, educators, students, residents, administrators and licensure representatives.

Publications and Reports: The Division published reports that form the major national informational bases. The Medical Education Number of JAMA, the AMA's 72nd annual report on this subject. Directory of Approved Internships and Residencies was the 45th annual report on graduate medical education. Continuing Education Courses for Physicians was the 18th annual listing of such courses and was published for the first time as a supplement to JAMA, permitting broader distribution. Medical Licensure Statistics for 1971 was the 70th annual report on this subject. Allied Medical Education Directory was published in its third edition.

DEPARTMENT OF ALLIED MEDICAL PROFESSIONS AND SERVICES

The House of Delegates adopted "Essentials" for the approval of educational programs for the operating room technician, electroencephalographic technician, electroencephalographic technologist, and a two-year program for the radiation

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therapy technologist. Revised "Essentials" were approved for the medical technologist and occupational therapist programs. The AMA now cooperates with 27 allied health and medical specialty societies for the approval of educational programs for 24 allied medical occupations.

The Department worked closely with the U. S. Office of Education in preparing revised applications for recognition of the AMA Council on Medical Education and the 27 collaborating organizations to accredit educational programs for the 24 allied medical occupations. A study Committee on Accreditation is investigating ways to reorganized accreditation for allied health occupations. The AMA, Association of Schools of Allied Health Professions and National Commission on Accrediting are represented.

Four regional workshops were conducted in Chicago, San Francisco, New Orleans, and Hot Springs, Virginia, to prepare a cadre of personnel to evaluate programs purporting to educate assistants to primary care physicians. The seminars were supported by a grant from the National Institutes of Health. A special publication, Educational Programs for the Physician's Assistant, includes information on the accreditation effort and lists approved programs.

Requests for Department publications increased. Allied Medical Education Newsletter has a monthly circulation of over 4,600, and 10,000 copies of the 1973 edition of the Allied Medical Education Directory were printed.

More than 2,700 educational programs for allied medical occupations have been approved by the Council on Medical Education. Basic information on these and other allied health education activities is maintained in the Department's National Information Center on Allied Medical Education.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Eighty-one institutions and organizations were granted accreditation by the Council on Medical Education, after review by the Advisory Committee on Continuing Medical Education. On June 30, 1973, there were 248 accredited institutions — 70 medical schools, 89 hospitals, 55 specialty societies and 34 others, including medical societies, voluntary health and governmental agencies, etc. The list of "Continuing Education Courses for Physicians" includes 2,441 courses offered by 697 institutions and organizations.

The AMA Physician's Recognition Award, established in 1969, is now in its second three-year cycle. During this time 40,501 physicians qualified for the Award, of whom about 40 percent were in residency training programs. Revision of the criteria for the Award has given added emphasis to the AMA accreditation program.

Seven state medical societies now require continuing medical education as a condition of membership. They are Arizona, Florida, Massachusetts, New Jersey, North Carolina, Oregon and Pennsylvania. Three states — Kansas, Maryland and New Mexico -- have permissive legislation giving their medical licensing agency authority to require continuing medical education as a condition for re-registration of the license to practice. Both New Mexico and Maryland are implementing this provision of their laws.

More than half of the state and territorial medical societies have expressed interest in carrying out accreditation programs as an extension of the national AMA accreditation program. Thirteen state medical associations, an increase of eight over last year, have had their accreditation programs approved by the Council, and state associations are implementing these programs.

A Self-Assessment Resource Center has been established by the Department in cooperation with the Center for Educational Development of the University of Illinois School of Medicine. A Second Biennial Workshop was organized and conducted for representatives of the specialty societies. A large variety of physician self-assessment instruments was developed with the Center for Educational Development and was demonstrated in the workshop, as well as at the AMA Annual Convention. Data were obtained for preparing a second edition of the Directory of Self-Assessment Programs for Physicians. Fourteen national medical specialty societies now have self-assessment programs in operation. A continuation grant from HEW was requested and funded for the work at the Center.

The Continuing Medical Education Newsletter has a mailing list of about 3,000.

The third National Conference of State Medical Association Representatives on Continuing Medical Education was held in Chicago in October 1972. Plans for an Institute on the status and future of continuing medical education in the U. S. are being developed by the staff and a subcommittee of the Advisory Committee on Continuing Medical Education. It will be sponsored by the American Medical Association and the Association of American Medical Colleges.

The Department continues to work with plans for a proposed data system that would utilize a name-imprinted card for automating the recording of continuing medical education activities. A pilot project, utilizing such a card, was carried out at the Annual Convention.

DEPARTMENT OF GRADUATE MEDICAL EDUCATION

The Liaison Committee on Graduate Medical Education met three times. It developed proposed bylaws and determined the procedures for annual rotation of officers through each of the sponsoring organizations. It will develop a document for submission to the U. S. Commissioner of Education requesting recognition as the accrediting body for programs in graduate medical education.

A Residency Review Committee for Nuclear Medicine was established, the "Essentials" of a residency program in nuclear medicine was adopted by the House of Delegates, and a guide for program directors is being developed. Residency review committees have been engaged in developing new or revising existing guides for directors of residency programs.

The emphasis placed on family practice by the AMA is being reflected in hospitals, in clinics, and in federal support. The number of institutions developing or expanding family practice programs is increasing as are the number of training opportunities offered. Approved residency programs increased from 103 on September 1, 1971, to 151 one year later, and to 164 as of June 30, 1973. Residents on duty increased from 632 on September 1, 1971, to 1,041 one year

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later, and to 1,601 as of July 1, 1973. Responses to a survey made by the American Academy of Family Physicians in late July 1973, received from 152 of the 164 approved programs, indicated that of the 1,601 family practice residents on duty in July, 683 were in the first year of training, 591 in the second, and 327 in the third.

Eligibility of foreign medical graduates for participation in undergraduate and graduate medical education continues to be misunderstood or misconstrued, creating serious difficulties for candidates, institutions, organizations and state and federal governments. A memorandum on May 23, 1973, on the "Policy on Eligibility of Foreign Medical Students and Graduates for Admission to American Medical Education" states clearly the five routes that can be taken by students in or graduates of foreign medical schools. It will help answer some of the questions that arise and will guide program directors as well as students and graduates. Problems continue to exist, however. The "fifth pathway" and COTRANS have relieved the situation of a small number of U. S. citizens studying medicine abroad. The diversity of responsibility, however, among governmental and non-governmental agencies, as well as the diversity of institutional and personal aims, will continue to make graduate education in the U. S. difficult for students and graduates of foreign schools.

DEPARTMENT OF UNDERGRADUATE MEDICAL EDUCATION

The rapid expansion in the number of American medical schools, and the rising number of applicants, greatly increased the activity of this Department during the year. Five additional schools opened, for a total of 113 with 13,570 first-year places. As many as 43 additional schools are under consideration.

Through the Liaison Committee on Medical Education, accreditation surveys were made of 33 schools, including five Canadian. In addition, consultation surveys were made of eight prospective new schools. In half of the surveys, the secretary of the team was an AMA staff member.

With nearly 40,000 applicants to American medical schools, more than three for every available place, many applicants sought guidance from the staff, especially in regard to study abroad. Some 4,200 Americans are estimated to be studying abroad. Attention was devoted to aiding the return of these students, especially through the development of "fifth pathway" programs, now in operation at 12 medical schools, including two in Canada.

Revisions were made in the document Functions and Structure of a Modern Medical School. It was approved by the House of Delegates in June 1973.

The Advisory Committee on Undergraduate Medical Education met three times. Studies of the teaching of team management and of ethics in medical school and the development of family medicine programs, were undertaken. Steps towards the final preparation of a document concerning the Functions and Structure of Schools of Basic Science were made. Other projects included a study of the retention of minority students in medical schools and participation in the coordination of longitudinal studies in health professional education.

DEPARTMENT OF INTERNATIONAL MEDICINE

In addition to its AMA responsibilities, the Department continued to provide administrative assistance to the National Council for International Health, the Vietnam Medical School Project and the Volunteer Physicians for Vietnam Program.

National Council for International Health: This Council met four times and its Committees and Subcommittee held 18 meetings. The NCIH sponsored an International Health Conference in Washington, D. C., in April. At this Conference a steering committee was elected to work closely with the NCIH in developing the next conference and to evolve a plan for formation of a general assembly to relate to the NCIH.

Vietnam Medical School Project: The AMA's project to support medical education in South Vietnam, funded by the Agency for International Development, is now in its seventh year. Of the 19 counterpart departments in 15 U. S. medical schools, eight hold active sub-contracts and the remainder provide voluntarily in the form of department chairmen interchange and in their willingness to train Vietnamese participants in the United States. During this seven-year period, the AMA has been able to provide support to the University of Saigon Faculty of Medicine in the form of 62 long-term personnel (visiting faculty and administrative personnel), 124 short-term faculty, as well as books, supplies and equipment. Thirty-six Vietnamese faculty participants have returned to Vietnam after receiving advanced training in the U. S.; 32 are currently in training in the U. S.; and approximately 30 are enrolled in graduate training programs supported by the Project in Saigon.

A Colloquium on Medical Education, sponsored by the AMA's project for the faculty of Medicine in Saigon during July of 1972, proved successful in defining the role of the physician in that country and in stimulating cooperation among the ministries of the government as well as consideration of changes in the medical curriculum.

Volunteer Physicians for Vietnam: The contract with the Agency for International Development for the AMA to administer the Volunteer Physicians for Vietnam Program was scheduled for termination at the end of Fiscal Year 1973. All operations related to the program ceased in Vietnam on June 30. This humanitarian program initiated as Project Vietnam in 1965, became the responsibility of the AMA on July 1, 1966. Since the inception of the program, a total of 774 American physicians have served 1,029 tours in provincial hospitals in South Vietnam. Seventeen percent of these served multiple or extended tours. These American physicians have contributed more than 150 man-years of voluntary service to the civilian population of war-torn South Vietnam. They have served at 33 provincial hospitals and assignment sites in Vietnam.

The Department developed the AMA's first meeting outside the United States. In late February and early March, the first AMA International Health Conference was held in Israel. It was co-sponsored with the Weizmann Institute of Science in cooperation with the Israel Medical Association, the Sackler School of Medicine of the Tel Aviv University, the Hebrew University-Hadassah Medical School, and the Abe Khoushy School of Medicine in Haifa. The scientific portion of the

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conference included three and a half days of presentations by professors from the Israeli institutions. A second AMA International Health Conference is planned in Australia, March 23-April 7, 1974. This Conference will be co-sponsored with the Australian Medical Association in cooperation with the New South Wales Branch of the Australian Medical Association, the Australian Post-Graduate Federation of Medicine and the Post-Graduate Committee of the University of New South Wales and the University of Sydney Medical Schools and the Royal Australian College of General Practitioners.

The Department hosted an increasing number of foreign physician visitors to the AMA headquarters and the Annual Convention. Among the visiting groups was a delegation of physicians from the People's Republic of China for three weeks in October. The Department increased its liaison with organizations, agencies and individuals involved with international health activities in the U. S. and abroad. Until withdrawal of the AMA from the World Medical Association, the Department staffed the AMA's work for that organization. Through the Doctor-to-Doctor Program, physicians in developing countries were matched with U. S. physicians who indicated their willingness to contribute journals and to establish communications. Assistance to American medical missionaries continued, primarily through distribution of medical journals and textbooks.

DIVISION OF MEDICAL PRACTICE

The Division focused on the organization, delivery and financing of health care.

New Projects: The Division completed development of a national health insurance claim form; carried out a series of ten regional conferences to provide training for medical directors and administrators of long-term care facilities; sponsored seven practice management workshops for new physicians and has scheduled 20 additional workshops to be held across the country during the next year in conjunction with state medical societies. The Division is working with the American Bar Association's Commission on Correctional Facilities and Services to establish a national health and medical certification program and develop medical standards to stimulate improvement of medical and health care services in the nation's jails, prisons and juvenile detention facilities. The Division's Project USA has so far assigned 20 physicians as short-term, voluntary replacements for National Health Service Corps physicians on vacation or leave. The Division also developed plans to organize a national commission to conduct certification of the physician's assistant, and has planned an experimental financial management workshop for established physicians.

Publications: New pamphlets were Project USA, Community Health Delivery Programs, Education and Utilization of Allied Health Manpower, Education and Use of Physician's Assistants and Survey of Medical Care in U. S. Jails. New statements published include Priorities for Increasing Availability of Health Services in Rural Areas, prepared jointly by the Councils on Health Manpower and Rural Health; Statement on Health Outreach, Statement on Free Clinics; 1972 and Committee on Health Care of the Poor Progress Report, all developed within the Department of Community Health; and a comprehensive report entitled "National

Certification of Physicians' Assistants by Uniform Examinations." A Statement on Home Health Care was also printed. A textbook on practice management is being prepared for publication.

Publications revised and reprinted were Peer Review Manual, Horizons Unlimited, What Do You Know About Your Physicians' Placement Service?, Finding a Place to Practice, Health Care Delivery in Rural Areas, and the Division's booklet listing publications, conferences, councils and committees and topics of current interest.

Conferences: Conferences sponsored by Division Councils included the 26th National Conference on Rural Health, the seventh National Congress on the Socio-Economics of Health Care, a PSRO Conference held in conjunction with the 1972 Clinical Convention and a Conference on Home Health Care preceding the 1973 Annual Convention. The Division participated actively in AMA's National Leadership Conference held in February 1973.

Physicians' Placement Service: The Physicians' Placement Service continued its trend over the past several years of increased registrations, processing a total of 7,608 applications, of which 4,434 were for physicians seeking locations and 3,174 were for practice opportunities, resulting in an increase of 485 registrations over last year. The number of physicians utilizing the Service rose by 9 percent and location registrations increased by 3 percent. The Service maintained contact with 47 organizations that locate physicians outside the United States, and 152 physicians applied to the Service for information on positions abroad. The Service staffed a placement room at the 1972 Clinical and 1973 Annual Conventions and at the April 1973 Annual Meeting of the American College of Physicians.

Practice Management: The Section on Practice Management devotes a large amount of its time to answering inquiries and developing resource information. Liaison is maintained with various associations and firms that provide services on all aspects of practice management. Two major brochures on this subject, The Business Side of Medical Practice and A Planning Guide for Medical Facilities, are being revised. Work is progressing on a program in cooperation with the American Institute of Architects to award cash prizes to student architects who design or plan medical facilities as a part of their academic program, and an experimental project designed to provide physicians with video-cassette players for patient education, practice management, training for medical assistants, scientific programs, and entertainment for children in the reception room is in progress.

Government Medical Services: Activities consist of maintaining Medicare data, handling correspondence concerning government programs and maintaining liaison with the Veterans Administration, Public Health Service, the Medical Services Administration and the Social Security Administration. Additional activities included updating and reprinting the booklet HMOs as Seen by the AMA and providing staff assistance to the Advisory Committee on PSRO Task Force on Rules and Regulations. Staff also assisted the Committee on Government Medical Services.

Computer Systems in Medicine: A program in computer systems in medicine was begun. The program will provide a foundation for continued AMA activity

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in the computers and medicine area. A newsletter, Computers and Medicine, was initiated to inform physicians of practical applications of computers in medicine. In a brief time the newsletter gained a readership of over 1,300 and is continuing to grow. An exhibit on the use of the computer in medicine was developed and has been shown at many conventions and meetings. Staff spoke at many medical meetings, and developed and presented a computers in medicine program at the 1973 Annual Meeting of the American Academy of Neurology. Staff also assisted in the preparation of the third edition of Current Procedural Terminology, and prepared for the Committee on Computer Systems in Medicine a national medical data base feasibility study.

Committee on Computer Systems in Medicine: The Committee's attention during the past year was divided between meetings on revision of CPT, site visits to medical data processing programs and development of a sound computers in medicine program. The Committee also initiated development of magnetic computer tapes for CPT-3. The Committee provided direction and support for a portion of the seventh National Socio-Economic Congress.

Council on Medical Service: Council reports submitted to the House of Delegates concerned a wide variety of subjects -- home health care, health outreach, public involvement in health services review, medical society peer review activities, free clinics, Veterans Administration medical care and the private physician, a health care of the poor progress report, notification of physicians by Medicare carriers of payments made directly to patients, claims practices of Aetna Life and Casualty Company, continuing education in long-term care, PSRO report, guidelines for medical directors in long-term care facilities, certificate of need laws, uniform claim form, Council structure, Medicare and Medicaid, confidentiality of medical information, the American Hospital Association's Quality Assurance Program, and renal dialysis and transplantation under Medicare and Medicaid.

The seventh National Congress on the Socio-Economics of Health Care, sponsored by the Council in April, was addressed to increasing the productivity and efficiency of the physician's office practice.

The Council reduced the membership of each of its six committees. Membership was increased by one with election of an intern-resident member in accord with the House's June 1973 action. Tenure was changed to three three-year terms.

Committee on Aging: The Committee continued its program of continuing education for physicians and allied health professionals in the field of long-term care and sponsored seminars in each of the ten HEW regions on the role of the medical director in the long-term care facility. A meeting was sponsored at the 1973 Annual Convention to expand physicians' concern for both preventive and well-care and rehabilitation and long-term care. The Committee designed guidelines for medical directors in long-term care facilities and is working with the Gerontological Society to develop education activities in mental health care of the elderly and with the American Hospital Association to design better environmental facilities for the aged.

Committee on Community Health Care: The Committee met with representatives from federal agencies, congressional staff and national organizations to formulate

recommendations for an AMA position on Community Health Planning renewal legislation. Guidelines on certification of need were developed, and the Committee also monitored health planning agency improvement efforts undertaken by the federal government and private organizations. Recommendations were developed on renewal legislation for Regional Medical Programs and other sections of the Public Health Service Act.

The Committee was responsible for the development of an AMA policy statement on Home Health Care and inclusion of home health care benefits in Medicredit and collaborated with the AMA Committee on Health Care of the Poor in developing position statements on free clinics and health outreach. The Committee helped sponsor a conference on home health care at the Annual Convention and sponsored several meetings of national organizations concerned with the future of neighborhood health centers. Committee representatives served on boards of national home care organizations, participated in regional and national home care and homemaker conferences and served as consultants on the AAMA-NHCO Advisory Committee as well as the AAMA Local Community Health Projects Review Committee.

Committee on Government Medical Services: The Committee met with representatives of the Veterans Administration to complete a detailed report on VA health activities. It met with representatives of the Bureau of Disability Insurance, Social Security Administration, to discuss the disability benefit program and the new Supplementary Security Program. With representatives of the Medical Services Administration, it conducted a review of the impact of PL 92-603 on Medicaid, the results of which were reported at the 1973 Annual Convention. The Committee conducted a continuing review of proposals for health maintenance organizations. It met with staff of HEW's NCHO office and with Department of Defense officials. It reviewed the CHAMPUS program and the impact of the shift to a volunteer army and projected base-closings. The Committee met with Indian Health Service officials and began preparation of a report on the IHS and its problems.

Committee on Health Care Financing: Under the Committee's sponsorship, the AMA Work Group on Attending Physician Report Forms developed a computer-adaptable uniform claim form designed to satisfy the needs of most health insurance organizations and agencies, reduced the total cost of claims processing and simplify physician reporting and third-party processing. The Committee is continuing its investigation of problems related to the confidentiality of medical records. Practice solutions are being sought with representatives of the health insurance industry, managers of large group employer self-administered programs, and firms serving insurance companies, business and industry in an investigatory capacity. The Committee is continuing its efforts to encourage health insurance for mental illness on the same basis as coverage for any other illness

Committee on Health Care of the Poor: The Committee held two regional meetings in areas where the Appalachian poor and American Indians reside. The meetings provided poor people and concerned providers an opportunity to express their views directly to the AMA. Another Committee meeting to emphasize AMA's concern with the special problems of the poor was held with government officials representing the Appalachian Regional Commission, Regional Medical Programs, ACTION, Indian Health Service, Migrant Health Service, Community Health Service, Office of Economic Opportunity and Model Cities Program.

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The Committee also (1) developed an educational film depicting the lifestyles and health problems of the Appalachian poor, with a similar film on the American Indian in the process of development; (2) initiated a pilot school health program with the Mount Sinai Department of Community Medicine; (3) supervised an AMA contract with HEW to develop a "Guide for Professional Health Provider Participation in Early and Periodic Screening, Diagnosis and Treatment"; and (4) provided assistance to the Student American Medical Association Local Community Health Projects Review Committee.

Committee on Private Practice: The Committee continued its work on the revision of the 1964 Report on Physician-Hospital Relations and directed the development of a survey to collect information on the observance of AMA policy in this regard. The Committee reviewed the Quality Assurance Program of the American Hospital Association and a report on this subject was submitted by the Council on Medical Service to the House at the 1973 Annual Convention. The Committee also reviewed AHA's "Patient Bill of Rights" and the TAP (Trustee, Administrator, Physician) Institute of the Joint Commission on Accreditation of Hospitals.

Representatives of the Committee attended a Pilot Conference on Community Hospital Residency Programs and an HEW Conference on Norms of Lengths of Stay in Nursing Homes. The Committee continued liaison with the Federation of American Hospitals, the American Hospital Association and the Joint Commission on Accreditation of Hospitals. The Committee maintained liaison with the Student American Medical Association through a SAMA representative who attended its meetings.

Joint Liaison Committee of American Association of Medical Clinics, American Medical Association, Medical Group Management Association: A large portion of the Committee's activity has been directed to developing a better liaison and coordination in research projects concerning medical group practice. The Committee developed a new definition of group practice and has been studying the growing trend towards profit-sharing plans and has requested the Judicial Council to reevaluate its statements on pension and profit-sharing plans. The Committee recommended increased emphasis on socio-economic training for young physicians in residency programs and has given attention to seeking more exposure to group practice by both medical and health administration students. The Committee continued to consider pertinent legislative proposals, accreditation programs, media coverage of group practice and peer review programs.

DEPARTMENT OF COMMUNITY HEALTH

The Department provides staff support for the Board of Trustees' Commission on Emergency Medical Services, the Committee on Community Emergency Services and three Committees of the Council on Medical Service: Committee on Community Health Care, Committee on Health Care of the Poor and Joint Liaison Committee of the American Association of Medical Clinics, American Medical Association and Medical Group Management Association. Staff also assisted the Boards's ad hoc Task Force on Hospital Emergency Department Services.

Staff prepared a new publication, Topics: Information on Significant Programs and Issues in Health Care, which provides information on a broad range

of AMA activities and concerns, and published a revised edition of Community Health Delivery Programs: Task Force Report. The newsletter Emergency Medicine Today was published throughout the year.

Staff coordinated arrangements for the Conference on Home Health Care preceding the Annual Convention and continued to work closely with the Emergency Medical Services triage program at O'Hare Airport. Training classes in medical self-help for fireman and other airport personnel were conducted by a member of the Committee on Community Emergency Services. Under an HEW contract, AMA staff and members of the Committee on Health Care of the Poor will develop a "Guide for Professional Health Provider Participation in Early and Periodic Screening, Diagnosis and Treatment" of children under the Medicaid Program. Meetings at the national, state and local levels will be held with representatives of a number of medical organizations to develop recommendations and a pilot demonstration project.

Staff also assisted in preparation of a legislative proposal on emergency medical care, testimony for AMA representatives appearing before Congressional committees and critiques of a number of manuscripts for AMA publications.

Commission on Emergency Medical Services: The Commission was reorganized and re-established under new "Rules of Procedure." The Commission now elects its own officers and executive committee. The Commission is revising the booklet "Guide for Program Planning--Emergency Medical Service Technician" and has recommended development of a standard ambulance report form.

More than 4,000 copies of the Commission newsletter, Emergency Medicine Today, are distributed monthly. Future activities of the Commission include review of the Model Ambulance Ordinance, development of a list of essential emergency medical services supplies for the physician's office and automobile, establishment of guidelines for an emergency medical technician career ladder, and development of model legislation to allow emergency medical technician use of IV fluids and defibrillation equipment.

Committee on Community Emergency Services: Major activities were development of an AMA legislative package, work on a model airport disaster plan, a listing of state and county medical society committees on emergency medical services and a study of the communications needs for emergency medical services.

An AMA bill was introduced into the 92nd Congress. Another bill was introduced and passed by the 93rd Congress and is now awaiting action by the President. This bill, while not in total agreement with the AMA-sponsored bill, is an acceptable package and could do much to improve emergency medical services. In recognition of the need from the medical community for a single voice concerning long-range emergency medical services communications needs, the Committee is in the process of developing recommendations on this subject for submission to the Federal Communications Commission.

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DEPARTMENT OF HOSPITALS AND HEALTH FACILITIES

The Department provided staffing for the Board of Trustees' Committee of AMA Commissioners to the Joint Commission on Accreditation of Hospitals and for two Committees of the Council on Medical Service: Committee on Aging and Committee on Private Practice. The Department also coordinated analyses of proposed standards for inclusion in the JCAH's hospital and long-term care facility accreditation programs. Other departmental activities included preparation of an analysis of the American Hospital Association's Quality Assurance Program, development of a questionnaire to measure the degree of observance of AMA policy in hospital-physician relationships, a survey to determine which state medical and hospital societies have formed joint committees to mediate physician-hospital disputes and sponsorship of a series of regional seminars on "The Role of the Medical Director in the Long-Term Care Facility."

Staff helped develop a program for the 1974 Quality of Life Congress and participated with the AHA and the JCAH in developing a proposal to conduct a training program in utilization review for part-time physician consultants in HEW. Liaison was maintained with AHA, JCAH, specialty medical societies, component and constituent associations and a variety of organizations concerned with health care of the aged.

Committee of AMA Commissioners to the Joint Commission on Accreditation of Hospitals: The JCAH Board of Commissioners approved new standards for hospital outpatient departments, hospital-based home care programs and respiratory therapy services; considered drafts of standards for non-hospital healthcare facilities and adopted a statement that Joint Commission philosophy does not preclude change in the composition of the Board and/or corporate membership, provided such a change would result in the improvement of health and medical care. This statement was approved by the Committee of AMA Commissioners to the JCAH and by the AMA Board of Trustees.

The JCAH conducted accreditation surveys in 2,221 hospitals and 423 free-standing and long-term care facilities during 1972. Of the hospitals surveyed, 1,766 were granted full two-year accreditation, 390 were provisionally accredited for one year and 65 were not accredited. Of the long-term care facilities surveyed, 333 received full accreditation, 46 provisional accreditation and 44 non-accreditation. As of January 1, 1973, there were 5,200 accredited hospitals and 1,800 accredited long-term care facilities. This is a decrease of seven accredited hospitals and an increase of 196 accredited long-term care facilities since January 1972. The decrease in hospitals accredited is predominantly due to mergers during 1972.

DEPARTMENT OF HEALTH INSURANCE

A large part of the Department's activity concerned Professional Standards Review Organizations. The Department staffs the AMA Advisory Committee on PSRO and four of the Advisory Committee Task Forces, and has participated in various other meetings on this subject. The Department also publishes a twice-monthly newsletter, PSRO Report, and has completed plans for a series of eight AMA-sponsored regional conferences on PSRO.

A survey of medical society peer review activities was presented to the House of Delegates in November 1972. Two PSRO reports were prepared for the 1973 Annual Convention. Staff surveyed state and county medical societies to determine their experience with Aetna Life and Casualty Company claims-processing practices, and as a result of that survey Aetna is seeking to resolve differences with the profession.

In cooperation with the AMA Interspecialty Council, a Conference on Guidelines for Use in Peer Review was held in September 1972. A consensus was reached that each national specialty society should be responsible for the development of its own guidelines, with AMA coordinating development of such guidelines.

The Department prepared three separate updates to the Peer Review Manual and continues to serve as AMA's clearinghouse for receipt and dissemination of correspondence and publications concerning peer review. It also is responsible for AMA liaison with foundations for medical care, and provides staffing for AMA representatives serving on the Board of Directors of the American Association of Foundations for Medical Care. The Council on Medical Service's Committee on Health Care Financing, the Joint Conference Committee of AMA-NABSP and the Committee of AMA representatives on the NABSP Board of Directors are also staffed by the Department.

Joint Conference Committee of American Medical Association National Association of Blue Shield Plans: The Committee met twice during the past year in an attempt to resolve matters at issue between the Medical Society of the County of Erie and Blue Shield of Western New York, Inc. A third meeting has been planned.

AMA Representatives on NABSP Board of Directors: AMA representatives participated in discussions concerning NABSP bylaws changes, Federal Employee Program costs, no-fault automobile insurance, Current Procedural Terminology, reimbursement of physician's assistants, National Blue Shield Index and continuation of the development of nationwide computer system.

DEPARTMENT OF MILITARY MEDICINE

The Department has been primarily concerned with Department of Defense activities governing health and environment, the three military medical services, the Selective Service System and the National Health Resources Advisory Committee. With dissolution of the Council on National Security by the House of Delegates, the functions of the Council's involvement with medical and health aspects of national security were assigned to staff.

The Department maintains an information service designed to provide guidance and assistance on military medical matters, and also is a clearinghouse for information concerning recruitment and retention of military physicians, military medical legislation, medical reserves, career incentives, utilization, improved professional programs through academic affiliations and military medical facility planning. Staff was instrumental in developing AMA's Project USA and medical care in prisons and jails programs.

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DEPARTMENT OF RURAL HEALTH

Improvement in the health care delivery system for the rural population, community organization for health services and liaison efforts with national organizations interested in improving the quality of rural life continue to be major goals of the Department. The Department staffs the Council on Rural Health and its Advisory Committee.

Manuscripts were prepared on health care in rural areas, rural development and health services, guidelines for medical association committees on rural health and rural health care delivery programs. The Department is preparing a research report on a survey of 1960 medical school graduates regarding factors which influenced their selection of a practice location. Another report is being prepared on a similar survey of 1965 graduates, and the Department is also conducting a review of research in rural health services.

Council on Rural Health: The Council, in cooperation with the Washington State Medical Association, is continuing to provide assistance and direction to a rural health project in a ten-county area in northeastern Washington where health providers and community leaders are working to establish an effective health delivery system. AMA-ERF has provided a third-year $15,000 grant for this project.

Council reports were "Statement on Voluntary Health Planning for Rural America," "Pilot Project in Comprehensive Health Care Delivery in the State of Washington," "Health Services: An Essential Component of Rural Development" and, with the Council on Health Manpower, "Increasing Availability of Health Services in Rural Areas: A Progress Report."

The Council's 26th National Conference on Rural Health, "Rural Health--Innovation to Implementation," held in Dallas in March, had an attendance of 751 from 44 states. Other meetings were the 27th meeting of the Council's Advisory Committee; the Tenth Seminar for Extension Specialists in Health Education and Related Fields; a meeting with state medical association rural health committee chairmen; and a joint meeting with representatives of the American Public Health Association and American Dental Association on the subject of two-way communication on programs of mutual concern. The Council is cooperating with the American Bankers Association to arrange a half-day program on rural community health services for four Regional Community Banker Workshops.

DEPARTMENT OF HEALTH MANPOWER

The Department staffs the Council on Health Manpower and its five Committees on Certification, Registration and Licensure, Emerging Health Manpower, Manpower Utilization, Liaison with Related Health Professions, and the Ad Hoc Advisory Committee on the Physician's Assistant, established to advise the Council and the National Board of Medical Examiners on developing a national certification program for primary care physician's assistants.

Last year the Department assumed expanded responsibility for development and distribution of health careers information, including revision of Horizons

Unlimited and Project FIND. Staff assisted the National Health Council in a project to improve manpower distribution and a study of institutional licensure in Illinois, and developed a seminar for the AMA National Leadership Conference.

Department activities on the subject of certification of physician's assistants included a survey of health care functions performed by currently employed physician's assistants, a survey of numbers enrolled and graduated from training programs and, with the Bureau of Health Manpower Operation, developed a list of all known training programs in operation or planned.

Section on Nursing: This section staffed the Committee on Nursing and its Panel of Consultants, the Inter-Agency Liaison Committee of the AMA-ANA-NLN and the National Joint Practice Commission between Medicine and Nursing. Staff participated in a number of meetings with national nursing organizations, provided consulting assistance to nine of these groups and represented the AMA on several others. Staff also handled numerous requests for information on nursing and nursing careers.

Council on Health Manpower: With the Committee on Nursing, the Council sponsored a workshop in January for reorganized medical specialty societies to discuss coordination of activity in surveying manpower needs and developing new physician-support occupations. The Council also made recommendations on AMA involvement in accrediting training programs for surgeon's assistants, corrective therapists, ophthalmic assistants and electroencephalographic assistants.

The Council prepared policy statements or reports on the subjects of physician distribution by medical specialty, describing the role of the primary care physician, status and utilization of health professionals in hospitals, temporary licensure for volunteer physicians, physician's assistants, institutional licensure in relation to physicians and nurses, emergency medical personnel and increasing the availability of health services in rural areas (with the Council on Rural Health).

Committee on Nursing: The Committee has supported, encouraged and guided the National Joint Practice Commission through its early stages. The NJPC, with financial assistance from the AMA, the American Nurses' Association and the National Commission for the Study of Nursing and Nursing Education, sponsored a meeting of representatives from 41 state medical societies and nursing associations to encourage the establishment of state joint practice committees. A number of states have now created such committees.

The Committee held its first joint meeting with the Council on Health Manpower in January. Reports developed jointly with that Council were "Institutional Licensure in Relation to Physicians and Nurses" and "Status and Utilization of New or Expanding Health Professionals in Hospitals." The Committee, with the Inter-Agency Liaison Committee, American Nurses' Association and National League for Nursing, also co-sponsored a meeting for representatives of national nursing organizations and student nurses.

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Inter-Agency Liaison Committee of the American Medical Association-American Nurses' Association-National League for Nursing: Meetings were held to discuss education, credentialing and utilization of the physician's assistant. Other topics were national health insurance, peer review, accreditation of health education programs, credentialing, licensure in health occupations and the extended role of the nurse.

PUBLIC AFFAIRS DIVISION

DEPARTMENT OF FIELD SERVICE

The Officers Services Department was merged with the Department of Field Service during 1973. This activity has become an additional priority to the existing emphasis on federal health legislation, political education and AMA membership retention and growth.

Legislative Activities: Each of the 12 field representatives provided close liaison between component and constituent medical societies and the AMA's Legislative Department. The field representatives served as consultants to the states on legislation and became the catalyst for developing field activity on federal health legislation of interest to the profession. Staff mounted a strong effort in opposition to health maintenance organization (contract practice) legislation and helped developed membership education programs on national health insurance for state and county medical societies. An educational program to combat efforts to repeal state anti-substitution statutes and regulations was conducted.

Leadership Consulting Service: A special "hot line" telephone service linking the Department in Chicago with state and county medical societies was installed during 1973. Medical society executives requiring a quick response on a matter of urgency used this special telephone line when they did not know who to contact directly at AMA headquarters.

Political Education: The field representatives worked closely with state political action committees by providing direct assistance in the development of membership programs, political education workshops and campaign management expertise. Membership in AMPAC set a new record. This political education program was supported by the creation of numerous audio-visual materials and manuals on PAC and campaign organization.

Speakers and Leadership Services: Nineteen speakers and leadership training seminars were conducted in 13 states reaching more than 700 key physician leaders. The AMA Speakers Bureau on National Health Insurance placed key physician speakers before lay and professional audiences.

AAMSE Regional Meetings: During the year, six American Association of Medical Society Executives regional meetings were held on the subject of management training. Although the meetings were the responsibility of the AAMSE

Board, the Department of Field Service provided staff backup for this series of meetings. The subject material was developed and coordinated by the Department in conjunction with outside management experts.

1973 AMA-AMPAC Public Affairs Workshop: The Department planned and conducted the AMA-AMPAC Public Affairs Workshop in Washington, D. C. Conducted in conjunction with the AMPAC Board of Directors, a record 800 participants attended the meeting from all parts of the country.

AMA National Leadership Conference: The first AMA National Leadership Conference was held early in 1973 at the Marriott Hotel, Chicago. A registration of more than 800 far exceeded estimates. The meeting was designed to provide technical skills and information on priority subjects to physicians and staff in leadership positions in constituent, component and specialty medical societies. A post-meeting survey produced an extremely favorable response to this type of program. The multimedia presentation shown at the opening session of this Conference was duplicated for use by medical societies. Titled Three Days in February, the film has been seen by more than 5,000 physicians since the Leadership Conference.

General Service: The Department conducted three invitational surveys of the organizational structure, administrative policies, membership programs and services and community posture of constituent societies. The assistant directors assisted members of the Board of Trustees during visitations to annual state medical meetings, arranged numerous speaking engagements for AMA spokesmen and promoted use of AMA literature, including the AMA Quick Reference Guide, Sharing a Common Goal, Current National Health Insurance Proposals and the AMA Congressional Directory. The assistant directors continued to attend regular meetings of state governing bodies and annual state meetings. Report of the principal actions at state meetings were distributed to each state association. The Department planned and conducted the New Medical Executives Conference in conjunction with AAMSE. Twenty-nine new medical executives attended the 1973 meeting.

LEGISLATIVE DEPARTMENT

The Legislative Department continued its primary assignment of reporting on national legislative activities of medical interest. Three new activities were undertaken this year. The Department began a surveillance of state legislation of medical interest. The second activity concerns the staffing of the Task Force on Rules and Regulations of the AMA's Advisory Committee on PSRO. The third new program is an expansion of services to medical specialty organizations. A legislative attorney has been assigned in the Washington Office with the specific responsibility of monitoring medical legislation and regulations of particular interest to specialty societies. This is expected to enable the specialty societies to more easily keep abreast of events in Washington and to respond to issues of particular significance to them.

An ever-increasing volume of health bills were analyzed as introduced in Congress, as modified in Congressional committees, conferences and floor actions, and as finally enacted into law. The analyses, as well as summaries of lengthy

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bills, were distributed to appropriate committees, councils and departments of the American Medical Association, and state and specialty medical societies. Comments on these bills were encouraged in order to provide the Council on Legislation with the most complete information upon which to base its recommendations.

Another major activity has been the monitoring of proposed regulations, rules, and final regulations published in the Federal Register. In addition to a distribution to AMA councils, committees and staff within the AMA, a substantial distribution is made to state and specialty medical societies. Comments received from these societies are considered in any decision which the Association makes in submitting comments on these proposals and in the position which is taken.

Council on Legislation: The Council met six times. It reviewed legislation of medical interest and made appropriate recommendations to the Board of Trustees. Representatives of the specialty societies and the Student American Medical Association attended and participated in one of the meetings. Legislation studied included the major national health insurance bills; expiring health programs under the Public Health Service Act; health maintenance organizations; health services for migrant workers; research on aging; drug abuse; children's dental health; medical library assistance; family planning; lead-based paint poisoning prevention; catastrophic illness insurance; cosmetic safety; national standards for blood banks and tax incentives for blood donation; creation of a cabinet level Department of Health; training programs for physician's assistants; emergency medical care; veterans' drug and alcoholism treatment programs; Social Security amendments; protection of human subjects in medical experimentation; bill of rights for the mentally retarded; hospital accreditation; and occupational safety and health amendments.

General Services: Publication of Legislative Roundup continued with a weekly distribution of approximately 4,500. New federal regulations and changes, as proposed and as finally promulgated, were disseminated. Proposed regulations included such subjects as cosmetic product safety; cosmetic ingredient labeling; use of mercury in cosmetics; shipment of etiologic agents on passenger-carrying aircraft; registration of blood banks and other firms collecting, manufacturing, preparing or processing blood; conditions of participation of hospitals in Medicare; fairness doctrine as it relates to broadcasting; state program for licensing administrators of nursing homes; medical services in hospitals for persons unable to pay; disclosure of certain Medicare reports and records; proposed special requirements for the use of methadone; modification concerning safety and health records and reporting requirements under the Occupational Safety and Health Act of 1971; legal status of approved labeling for prescription drugs.

Development of Proposed Legislation: Legislative bills prepared by AMA were reviewed for introduction in the 93rd Congress. They included:

— Medicredit, a national health insurance proposal, which provides comprehensive protection against ordinary and catastrophic expenses of illness for all persons and families, regardless of

income levels, through a system of voluntary health insurance. The benefits are comprehensive, including full hospitalization, all physician services, outpatient care, home health services, skilled nursing home services, and specified dental care. The program is financed through the use of tax credits on a sliding scale with the greater financial assistance being provided to low-income individuals and families. The cost of the catastrophic coverage would be paid by the government for all persons.

— Emergency Medical Services. This bill would establish a comprehensive emergency medical service system throughout the country. While direction and financial assistance would be provided at the federal level, the program is focused at the community level. Communities would be assisted in establishing and operating an emergency medical service program as a part of an overall state program.

— Blood Bank Legislation. The AMA bill would amend the anti-trust laws to provide that the refusal of nonprofit blood banks and of hospitals and physicians to obtain blood and blood plasma from other blood banks would not be deemed to be acts in restraint of trade.

— Establishment of a U. S. Department of Health. Created within the Executive Department, at the Cabinet level, would be a separate Department of Health which would be headed by a Secretary of Health who would be a doctor of medicine, appointed by the President, with the consent of the Senate. This Department would administer all programs relating to health now under the jurisdiction of HEW.

— Labeling of Containers of Prescription Drugs. The AMA draft bill would amend the Federal Food, Drug, and Cosmetic Act to require that the label of drug containers, as dispensed to the patient, would carry the established or trade name, the quantity and the strength of the drug dispensed, except when otherwise specified by the prescribing physician.

— Social Security Cash Pension Benefits for Physician. This draft legislation would amend the Social Security Act to change the qualifying dates so that physicians would receive equitable treatment under Social Security in order to qualify for cash benefits.

— Free Choice of Physicians and Hospitals for Veterans. This proposal gives to the veteran the choice of receiving his hospitalization either in a VA hospital or a local community hospital.

— Amendment to the Internal Revenue Code to Permit Individuals to Deduct Expenses for Medical Care. This AMA bill would remove the 3 percent and 1 percent limitations on medical and drug deductions and would permit a taxpayer to deduct the full amount of medical expenses and drug expenses.

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Medical Bills Enacted into Law: Among the new enactments in the 93rd Congress are: PL 93-12, Federal Rules of Evidence Study; PL 93-14, The Solid Waste Disposal Act Extension, PL 93-15, The Clean Air Act Extension; PL 93-28, Economic Stabilization Act Extension; PL 93-29, The Older Americans Comprehensive Services Amendment of 1973; PL 93-45, The Public Health Service Assistance Extension Act of 1973.

During the final months of the 92nd Congress, the following bills were enacted: PL 92-345, Extension of Title V Programs under Social Security; PL 92-426, Uniformed Services Medical School; PL 92-449, Communicable Disease Act; PL 92-573, Consumer Product Safety Act; PL 92-585, Emergency Health Personnel Act; PL 92-603, Social Security Amendments.

AMA Testimony: The AMA testified on emergency medical services; the Clean Air Act and the Solid Waste Disposal Act extensions; the Economic Stabilization Act; Federal Employes Health Benefits Program; human experimentation; federal rules of evidence concerning the physician-patient privilege in federal court actions; national blood policy; cosmetic product experience; the Veterans Health Care Expansion Act; the Health Programs Extension Act; registration of practitioners in narcotic treatment programs; barbiturate abuse; control of methaqualone; prescription drugs used in the treatment of coughs and allergies; Drug Education Act extension; Emergency Health Personnel Act Amendments; and medical education.

The AMA also presented its views on the following informational subjects: Republican and Democratic Convention Platform Committees concerning health priorities; cost of educating various health professionals; financial assistance for medical education; proposed "Walk A Mile For Your Health Day" observance; project and formula grants under Title V of the Social Security Act to extend maternal and child health and crippled childrens' services; physicians for penal institutions; drug use in amateur athletics; national blood policy; and tax incentives to encourage practice in rural areas.

Pending Legislation: At midyear 1973, about 13,000 bills had been introduced in the 93rd Congress, some 1,000 being of medical interest. Several important measures are awaiting action by either or both Houses. Among them are several national health insurance bills; establishment of an Office of Rural Health Care in HEW; creation of a cabinet level Department of Health; restructuring of the Public Health Service Act; health maintenance organization enabling bills, the Rehabilitation Act of 1973; the Veterans Medical Care Act of 1973 which provides expansion of medical care to veterans and improves recruitment of career personnel; the Emergency Medical Service Systems Development Act of 1973; child abuse prevention; continuation of programs for the elimination of lead-based paint poisoning; Narcotic Addict Treatment Act of 1973 which provides for registration of practitioners conducting narcotic maintenance programs; and the Medical Devices Safety Act.

AMA OFFICE IN WASHINGTON

The Washington Office continues its operation of collecting, evaluating and reporting information and observations concerning proposed legislation and regulations, as well as supplying a fast and accurate flow of information

between the AMA and the federal government and all Washington-based health related organizations and agencies. Day-to-day informational services to national communications media also continued to expand. Much of the Office's activity was related to clarification of PSRO and to proposed HMO and NHI legislation.

A major activity of the Office continues to be the briefing of state and specialty society representatives during their visits to Washington. Some 30 briefings were conducted by Washington staff during the report period. In addition, some 35 speaker requests from medical and non-medical groups were fulfilled.

Department of Congressional Relations: During the period of this report, more than 1,000 bills relating to medical and health care were introduced in Congress. Among the bills of interest to the AMA are:

— National Health Insurance: AMA's "Medicredit" has 181 sponsors, more than all other proposals combined.

— Health Maintenance Organizations: The Department worked closely with members of Congress, relating AMA's position of opposition to any HMO legislation involving large federal involvement in health care delivery.

-- Health Appropriations: Extensive efforts were made to assure adequate funding for health programs passed by Congress.

The Department also covered Congressional hearings, assisted AMA witnesses and obtained Congressional speakers for various groups.

Department of Governmental Relations: The three major areas of activity during the year involved the Economic Stabilization Program, health maintenance organization legislation and Professional Standards Review Organization. In the first few months of 1973 there was a complete change in top personnel at the Department of HEW, followed by a series of reorganizations in both the Department and the White House. These changes necessitated the development of numerous new contacts.

Other activities included arrangements for meetings between AMA representatives and key government officials, including a meeting between the Chairman of the Board and the President of the United States; a close watch on the implementation of Public Law 92-603 (HR 1); Commission on Medical Malpractice; arrangements for visitations by Russian and Chinese medical delegations; and the securing of appointments to permanent positions and advisory committees in the federal agencies.

Department of Communications: Support was provided to all operations of the Washington Office. Broadened day-to-day services were furnished national news media, private health related organizations and agencies, and the federal government. Speeches were produced; radio and television interviews arranged; news releases prepared and placed; press room services provided; public relations advice and counsel given; topics researched; background material assembled; information kits prepared; and statements and testimony written. The Department also continued to provide Washington reporting services to AM News and JAMA.

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Washington Library: More than 6,700 inquiries were answered, some 800 of these originated directly or indirectly from members of Congress. Another 540 inquiries came from governmental agencies, 557 from private health related organizations and 387 from the medical community. Public inquiries numbered 4,239 and were concerned with such issues as health careers, financial assistance for medical education, various diseases, euthanasia and acupuncture. A revised edition of publication listings was produced and more than 450 copies distributed. The working relationship for the exchange of information was continued with more than 50 libraries, publication officers, and statistical offices of various agencies and organizations.

DEPARTMENT OF SPECIALTY SOCIETY SERVICES

The Department coordinates the AMA's activities for specialty societies, medical students, and interns and residents. Staff continued its general liaison program with 26 national specialty groups. Five legislative briefings for specialty group representatives were scheduled during the year in cooperation with the Washington Office staff.

Staff support for the Section Councils continued, and new Section Councils on Plastic and Reconstructive Surgery and Cardiovascular Disease were formed. Convention arrangements for the Association of Section and Service Delegates were also handled. The Department staffed the Task Force on Communications and Education of the AMA Advisory Committee on PSRO.

Interspecialty Council: Four meetings were held and recommendations were made to the Board of Trustees. Primary topics of interest to the Council were specialty representation in the House of Delegates, expiring health legislation, physician distribution, and nursing practice. New societies added to the Council were the American College of Cardiology, American College of Chest Physicians/American Thoracic Society, and the American College of Gastroenterology/American Gastroenterological Association.

Intern and Resident Business Meetings were held just prior to the Clinical and Annual Conventions, and new officers were elected at the 1972 Clinical. Special programs on topics of interest of physicians-in-training followed each business meeting. Representation within the AMA structure was increased by the House of Delegates' action to add house officers to the Council on Long Range Planning and Development, the Council on Medical Service and the Council on Medical Education. To better identify house staff interests, the Board of Trustees authorized a special think session in June 1973. Participants included 15 medical leaders and 15 interns and residents. As one result of the meeting, the Board authorized the establishment of a Committee on House Staff Affairs, which will advise on issues of concern to interns and residents and which will complement the participation of the Intern and Resident Officers.

A membership mailing and four issues of an Intern and Residents' Newsletter were produced and mailed. The membership effort produced 2,400 requests for information. Membership increased from 1,650 in 1972 to 2,100 in mid-1973. A regular membership for medical students was offered for the first time in 1973, and approximately 1,000 students joined the AMA during the first six months of the year. The first Medical Students Business Meeting was held just prior to the 1973 Annual Convention.

DEPARTMENT OF MEMBERSHIP DEVELOPMENT

The responsibility of the Department is to increase the percentage of AMA dues-paying members proportionate to the physician population. This Department staffs the Board of Trustees Committee on Membership, the Staff Committee on Membership Growth and Retention, the Staff Committee on Insurance, and the AAMSE Ad Hoc Committee on Membership.

Until May 1973, the Department also staffed the Council on Long Range Planning and Development, and arranged open hearings in Detroit, Cincinnati, and Washington, D. C. The purpose of the hearings was to receive comments, constructive criticism and ideas for future planning from the membership.

The AAMSE Ad Hoc Committee on Membership met three times and took action to encourage local society membership programs, bylaw revisions, billing systems, and state and county cash incentives programs.

The Department, in its responsibilities to the Board Committee on Membership, has uncovered and researched many of the roadblocks to membership growth. Several bylaws revisions, approved by the House of Delegates will aid in improving membership communications, growth and retention. They are:

1. A physician can now become a member of AMA upon certification, prior to the delivery of his dues to AMA.
2. AMA will now have the option of doing its own billing under certain circumstances.
3. A physician who has dropped AMA may now rejoin without the penalty of one year's dues.
4. Dues exemptions in AMA will be consistent with the exemption of each state medical society.
5. State societies have been encouraged to "reduce the period of provisional membership."
6. April 30 has been established as the new membership delinquency date.

A cash incentives program was approved for state societies which will pay the state one-half percent above prime interest rate on Certificates of Deposit for early reporting of physicians' dues dollars. In addition, the AMA will pay a county society one-half of a physician's AMA dues if the physician is a new member or a dropout of at least 24 months.

The Department has initiated numerous other membership projects. It provided assistance to 30 local societies, through the Department of Field Service, in establishing regular membership programs. Assistance included counseling, and providing computer printouts and resource materials. Two of these societies have shown a 20 percent increase in AMA membership. Special membership programs

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were presented at the 1972 Clinical Convention and the 1973 National Leadership Conference. More than 100,000 copies of the pamphlet Sharing A Common Goal were distributed to physicians. Nine advertisements for insert in the publications of AMA and state and county medical societies were designed. More than 100 computer printouts of physicians' names, addresses, and membership status have been supplied to local medical societies for support of membership identification and program implementation. Twenty-four membership awards were presented to state society presidents at the National Leadership Conference. In 1972, these states exceeded their 1971 total dues-paying memberships in AMA.

The Department published an "Intern and Resident" pamphlet which was sent to all interns and residents in the nation. Responses requesting more information have exceeded 2,400. The Department also designed new publications on medical student membership and benefits of membership. The latter will be sent to 242,000 eligible members late in 1973. A reception was held at the Annual Meeting of the Medical Society of the State of New York, where 16 AMA staff members discussed issues with physicians who chose to attend. A special 1973 supplemental dues statement was sent to 29,997 physicians who are members of state and county societies but not AMA. As a result, 398 physicians rejoined the AMA. (The Department continues to receive responses from this mailing.) Another special mailing was sent to 396 Texas physicians who dropped their AMA membership in 1973. A total of 62 physicians, 16 percent of those asked to reconsider, have rejoined.

The Department has responded, by letter, to more than 3,000 letters received from physicians who expressed an area of concern or criticism about AMA. Non-AMA physicians who registered at the 1973 Annual Convention have received special membership invitations. Of the 25,000 AMA-ERF loan recipients, 12,000 have been identified. A total of 6,900 of these non-members have been contacted with a membership solicitation. The Department arranged for a meeting between the Board Committee on Membership and representatives of HEW, Department of Defense, Public Health Service, and the Surgeons' General of the three military branches.

COMMUNICATIONS DIVISION

In the area of general, non-clinical information the Communications Division serves as an important link between the AMA and physicians, the press and the general public.

The most significant achievement of the year was the publication of Prism, a monthly magazine devoted to exploration and discussion of the socioeconomic issues of medicine. Published in a unique format (11 x 11), with a strong emphasis on graphics, the magazine quickly established itself as a major new voice, with early indications of a predominantly positive response from physicians.

A second major area of activity was a dispute with the National Broadcasting Corporation regarding a documentary entitled What Price Health? which was broadcast on December 19, 1972. Following an exchange of letters and the filing of a protest with the Federal Communications Commission, NBC offered the AMA an opportunity to appear on the Today show to discuss Medicredit and other health care issues. The AMA-NBC dispute generated considerable attention in the press, with considerable support for the AMA position.

NEWS BUREAU

Press Relations: This staff coordinated media coverage of the three-week six-city tour of the United States by physicians from the Peoples Republic of China, a tour co-sponsored by the AMA. As part of its regular duties, Press Relations handled many requests from newspapers, wire services and radio-TV networks and stations for information and assistance on stories about the socioeconomics of medicine. Staff also assists officers and AMA departments by serving as liaison with the press, and it operates press rooms at the Annual and Clinical Conventions and other AMA events.

Science News: This section, which maintains contact with science writers and media representatives, added a new weekly column, "Health Tip from the American Medical Association." It offers basic information on maintenance of good health and has been widely used, particularly by news magazines. Staff distributed some 400 news releases on AMA programs and on newsworthy papers published in JAMA and other Association journals; answered more than 1,200 queries from writers and staffed press rooms at the Conventions. Press arrangements for 14 other meetings also were handled. The section conducted the annual AMA Medical Journalism Awards Program which drew more than 500 entries.

Magazine Relations: This staff alerts editors and writers to story ideas and assists in story development. It handled 93 requests for editorial assistance during the year. A number of stories were prepared specifically for national publications, including the National Observer, Good Housekeeping and Parade. A total of 83 manuscripts were reviewed for medical accuracy and 120 requests for library research were answered. A 20-minute slide presentation on rural health was prepared and shown at the national meeting of the Agricultural Editors Association and will be given before other interested groups. The section also handled publicity for the Quality of Life Congress, arranging national TV and press coverage, and continued a program of personal contact with editors of consumer magazines.

Speakers Services: Staff assisted AMA officers and members of the Board of Trustees in the research and preparation of 81 speeches on various socioeconomic topics. Other writing projects included several newspaper and magazine articles and initial copy for a pamphlet on the AMA's revised Medicredit plan. Staff also wrote summaries of House of Delegates actions at the Clinical and Annual Conventions.

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AMA News Features: This service, begun in August 1972, provides in-depth stories on AMA activities as well as the entire medical scene. More than 100 daily newspapers regularly carry the articles in full or in part. Although aimed at medium and smaller dailies, News Features have been picked up by many larger papers as well as news magazines, news services and professional journals.

AMA Update, aimed at opinion makers such as editorial writers and editors, continued to be quoted frequently by the media. A highlight was a special issue devoted to debunking in detail allegations contained in an NBC television documentary on health care, which was criticized not only by physicians but by lay press editors and TV columnists for its bias.

AUDIO VISUAL DEPARTMENT

This Department serves both the media and constituent societies. During the past fiscal year it assisted in the creation and production of a pilot television program, Today's Health. The program, designed for commerical syndication, is produced in cooperation with Today's Health magazine.

Other activities: Public service announcements produced for television were broadcast by more than 600 stations, and the "instant radio news service," offering pre-recorded news and health messages, was used by more than 500 major radio stations each week. More than 18 million people saw AMA films during the year; audio cassette highlights were produced for every major AMA meeting and more than 15,000 cassettes were sold; two films dealing with problems in the health care delivery system were completed.

TODAY'S HEALTH

"Your magazine is appreciated by myself, and many others like me, and fills a great need in a day when nearly everybody considers himself an expert on matters of human health." That letter, from an Oklahoma man, was just one of many received during the year by TH. It reflected the magazine's continuing effort to improve the quality of the physical-mental health and consumer-oriented information it presents to the public. Today's Health marked its 50th anniversary with a special issue focusing on the next 50 years in medicine.

SPECIAL PROJECTS DEPARTMENT

During the past year, this Department, in cooperation with the Scientific Assembly staff, launched major promotional programs to encourage attendance at the Annual and Clinical Conventions. Special efforts also were made to promote participation in a variety of conferences and seminars.

Today's Health subscription promotion got special attention through installation of a new, more thorough "source information system," a concentrated Christmas-gift subscription campaign and a new subscriber marketing test. In addition to an increasing number of pamphlets, booklets, mailers, books, posters and other materials produced for various AMA departments, Special Projects was involved in preparing promotional and advertising materials for two major projects -- (1) AMA Membership Drive and (2) VD Educational Kits for physicians and counselors.

DEPARTMENT OF PROFESSIONAL COMMUNICATIONS

This Department is responsible for the AMA Newsletter, American Medical News, JAMA Medical News, the Annual Report published in the Clinical Convention Handbook and Proceedings, the Daily Bulletin and the 535 Reporter. The Department also staffs the Sheen Award Committee and performs various editorial services for the Office of the Executive Vice President.

AMA Newsletter: Bulk shipments of the "Green Sheet" are now sent to 123 state, county and specialty medical societies for distribution to their officers. In Brief, a new monthly publication of short items, is being distributed to medical society editors for reprinting in journals and bulletins.

American Medical News: A readership survey by the Center for Health Services Research and Development during the summer of 1972 revealed that 88.6 percent of the physicians responding spend some time reading AM News. Only 9.5 percent replied that they do not read it. The survey was based on a 3,196 physician random sample with a 53 percent response rate. Eight-six percent of office-based MDs said they spend some time reading the paper, and only 2 percent of the interns who replied said they do not read AM News.

Emphasis during the year was placed on reporting in depth, and on interpreting, subjects of major interest to the profession. Subjects included health maintenance organizations and professional standards review organizations; efforts to attract more women, blacks and other minorities to medicine; price controls; physicians in politics, and the controversy between AMA and NBC News over the documentary What Price Health? A new column, "AMA Report," was introduced to inform readers regularly about AMA activities.

JAMA Medical News: This weekly section has continued to stress comprehensive stories on such subjects as transplantation, psychosurgery, old age and the medical uses of transfer factor, as well as coverage of scientific meetings. Emphasis was also placed on feature articles of general physician interest.

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MANAGEMENT SERVICES DIVISION

BUILDING SERVICES DEPARTMENT

Building alterations were made in the basement and on floors 1, 2, 3, 4 and 8. The Department responded to 3,654 calls for custodial and decorating services, as well as for carpentry, lighting, electrical, plumbing and mechanical repairs. Security measures were enforced to insure the safety of employees and the building.

CIRCULATION AND RECORDS DEPARTMENT

This Department handles the distribution of all regularly published AMA publications and maintains the physicians' biographical and historical records and the AMA membership records. Requests for information totaled more than 2,600 per day.

Of the 19 regularly published periodicals, eight had increases in average circulation and 11 showed slight decreases. AM News, with an average circulation of 368,380 per week, led those that showed an increase. The average number of copies of the 19 periodicals distributed per month totaled 3,560,300.

CONVENTION SERVICES DEPARTMENT

The Department made arrangements for the Clinical Convention in Cincinnati and the Annual Convention in New York, with total attendance of 4,788 and 22,122 respectively. In addition 350 separate meetings and social functions were handled at the headquarters hotels during the two conventions.

During the reporting period, 232 ancillary meetings were set up. Of these, 191 were handled by the Department. In the AMA exhibit program, 269 exhibits were displayed in 123 cities for a total of 2,545 show days. They were viewed by two million persons. Twenty-four exhibit construction projects were completed. Tour programs are being developed and coordinated in conjunction with continuing education for physicians.

GENERAL SALES OFFICE

A number of changes were made in the advertising sales program. These include changes in staff personnel, specialization of sales personnel and realignment of sales territories, creation of a practical incentive program, and development of new reporting and record-keeping methods that will be computerized to provide better internal sales data.

INFORMATION SERVICES DEPARTMENT

This Department responded to more than 700 requests for services, including reports, special listings and labels. The Physicians Record System, Personnel System and Members Retirement System have been converted to an Information Management System to provide for more flexible and reliable service.

A basic study and review of the AMA data processing operation was undertaken by Arthur Young and Company. Results of this review brought new stimulus to improve AMA data processing capability through a planned action program.

OPERATING SERVICES DEPARTMENT

The Contract Printing Section and Publication Production Section renegotiated the printing contract for Today's Health. The Reproduction Section and the Processing and Distribution Section processed more than 7,000 individual "in-house" printing jobs, valued at $540,000. Over 250 tons of paper were consumed for "in-house" work. The Purchasing-Transportation Section processed 3,900 orders for materials and supplies and 3,930 requests for transportation. The Job Printing Section processed 1,215 individual jobs purchased from outside sources.

PERSONNEL AND OFFICE SERVICES

This Department services AMA personnel requirements, administers pamphlet and film distribution, and provides for telephone, mail, cafeteria and medical services.

The Employee Relations and Training Section prepared and distributed a computerized benefit statement to AMA employees. Approximately 250 newly hired employees attended orientation programs, and service recognition awards were made to 113 employees completing from five to twenty-five years of service. A "management by objectives" program was developed for selected departments. As a special consultant to AAMSE Continuing Education Committee, the section prepared several management programs and presented them at six AAMSE regional meetings. A management development program was also presented to the California Medical Association. A wide range of skill-development programs on the clerical and technical level were continued for over 200 employees of all divisions.

The mail unit distributed approximately five million pieces of first-class mail. Of the 1,500 health education titles in storage, total movement for the year was more than six million.

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(Management Services)

The Compensation and Benefits Section offered group and individual orientation programs for every non-exempt employee hired, and individual pension plan consultation for eligible AMA personnel. Various new and revised insurance plans — such as the Disability Income Replacement, Accidental Death and Dismemberment, Provident Life Insurance and the Excess Major Medical plans — were communicated to the AMA staff. Retirement counseling services were provided to 32 employees. Twelve employees, with a total of 218 years of service to AMA, retired.

A total of 4,417 visits were made to the Employee Health Office. Group Assurance Program (Blood Bank) had a membership of 448, and 143 pints of blood were obtained in a blood drive.

AMA EDUCATION AND RESEARCH FOUNDATION

The AMA-ERF received $1,698,068 in contributions during the period covered by this report. This was an increase of $261,962 over the preceding 12 months. Physicians individually accounted for $556,188 of the total contributions, and the Women's Auxiliary, individually and collectively, accounted for an additional $629,199. The remaining $512,681 came from foundations, medical organizations, corporations and laymen.

Of the total gifts, $1,041,930 was designated for medical schools, $210,892 for the regular loan guarantee program, $70,152 for interest-free loans to disadvantaged and deserving students, and $117,971 for the unrestricted fund. The total also included an additional bequest of $198,569, to the Dr. Rock Sleyster Memorial Fund, which made it possible to establish a medical student scholarship program scheduled to begin in the 1973 fall semesters.

Medical students, interns and residents obtained 3,120 loans, totaling $4,266,006 through the Foundation's Guarantee Program. Since the program's inception in 1962, the AMA-ERF has backed 50,330 loans worth $57,462,581. As of June 30, 1973, there were 19,692 loans outstanding worth $33,536,221.

Since October 1971, when the Medical Student Opportunity Loan Plan was initiated, 111 interest-free loans totaling $182,350 have been guaranteed for disadvantaged and deserving medical students. Acceptance of these loans committed AMA-ERF to approve and guarantee up to $606,000 of additional loans for the 93 students in this program during their years in medical school. Interest paid on these loans by the AMA-ERF totals $10,237, of which $9,127 came from a special grant of $12,000 for this purpose by the Alfred P. Sloan Foundation. During the period of this report, the interest-free loan program was exercised only in California. It is scheduled for expansion to Illinois and New York late in 1973.

REPORTS OF BOARD OF TRUSTEES

The following Reports, A-73, were presented by James H. Sammons, M. D., Chairman, Board of Trustees. Reports on the Distinguished Service Award and Citation of a Layman for Distinguished Service appear on pages 17 and 19.

A. AMA ACTIVITIES CONCERNING PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS: PROGRESS REPORT
(Reference Committee A, page 263)

HOUSE ACTION: FILED

Report E (C-72), a joint report of the Board of Trustees and the Council on Medical Service, as adopted by the House of Delegates, called for the AMA to provide a leadership role in the implementation of Title XI, Part B: Professional Standards Review legislation. Reports E and CC (A-73) of the Board of Trustees presented a progress report of Association activities concerning Professional Standards Review Organizations (PSRO) through late June 1973. This report summarizes Association activities from late June to October 12, 1973.

AMA Advisory Committee on PSRO

The Advisory Committee met for the fourth time on July 28, 1973 in Chicago; for the fifth time on September 22, 1973, also in Chicago. During both meetings, the Committee task forces reported on their activities. Highlights of those reports follow:

Task Force on Rules and Regulations: Reported on its continuing review of sections of the PSRO law considered most urgently in need of clarification through the formulation of appropriate regulations. Following completion of that review, the Task Force will submit a document containing recommendations for regulations to the Advisory Committee. The Task Force emphasized the development of suggested model language has spurred active debate and has generated many questions regarding the effect PSRO may have on the preservation of high quality of patient care. The Task Force is addressing those questions.

Task Force on Structure and Organization: Presented to the Advisory Committee a preliminary draft report setting forth various elements which might be included in a PSRO structure. Consideration was given in the report to organizational structure, the types of committees and appeal mechanisms necessary, and the relationship of professional review to data systems. The Task Force also presented a set of sample Bylaws and Articles of Incorporation for consideration by the Advisory Committee as possible models for use by physicians in establishing a PSRO. Modifications suggested by the Advisory Committee are now being integrated into those model instruments.

Task Force on Guidelines of Care: Reported on its July 14, 1973 Invitational Conference on guidelines development which was sponsored for representatives of

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ORIGINAL Ex. # 39

BEFORE THE FEDERAL ELECTION COMMISSION

- - - - - - - - - - - - - - -x
:
In the Matter of: :
: MUR253, et al.
AMA, AMPAC, et al. :
:
- - - - - - - - - - - - - - -x

Washington, D. C.

Friday, February 2, 1979

Deposition of

JOHN ZAPP, D.D.S.

a witness in the above-mentioned matter, called for examination by counsel for the Federal Election Commission, pursuant to notice, taken at the offices of the Federal Election Commission, 1325 K Street, Northwest, Washington, D. C., beginning at 3:11 o'clock p.m., before James R. Hunton, a Notary Public in and for the District of Columbia, when were present on behalf of the respective parties:

Milton & Greenwood Reporting Associates, Inc.
OFFICIAL REPORTERS
1601 Connecticut Ave., N.W., Suite 302
Washington, D.C. 20009
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For the Federal Election Commission:

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Federal Election Commission
1325 K Street, N. W.
Washington, D. C. 20005

For the AMPAC:

DONALD O. WILCOX, ESQ.
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Chicago, Illinois 60610

and

JOHN LEWIS SMITH III, ESQ.
WILLIAM SCHWEITZER, ESQ.
Baker, Hostetler, Frost & Towers
818 Connecticut Avenue, N. W.
Washington, D. C. 20006

For Morris A. Riley and AMA:

JACK BIERIG, ESQ.
Sidley & Austin
One First National Plaza
Chicago, Illinois 60603

Also Present:

ELENA KING

MILTON E. GRIFFITH & ASSOCIATES, INC.

C O N T E N T S

WITNESS:	EXAMINATION BY COUNSEL FOR: FEDERAL ELECTION COMMISSION (Mr. Branch)
JOHN ZAPP, D.D.S.	7

E X H I B I T S

Exhibits marked for identification and attached:	Page
No. 1 -- a document headed "American Medical Association", giving instructions how to reach congressmen, with attachment	17
No. 2 - a schedule for AMA-AMPAC Public Affairs Workshop, April 1976	26

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Thereupon

JOHN ZAPP, D.D.S.,

a witness, was called for examination by counsel for the Federal Election Commission, and, after having been sworn by the notary, was examined and testified as follows:

MR. BRANCH: At the outset, I want to note the attendance of the different counsel at the deposition. In particular, we have John Lewis Smith III; William Schweitzer; and Donald Wilcox, who are attending representing the American Medical Political Action Committee.

It is my understanding they are not representing the witness, Dr. Zapp. Is that correct?

MR. SMITH: Yes.

MR. BRANCH: As as stated in the deposition of Morris Riley, held earlier today, it is the position of the general counsel of the Federal Election Commission that in a deposition taken pursuant to an investigation such as the present deposition, only counsel for the witness may attend as a matter of right.

We are agreeing to the attendance of Messrs. Smith, Schweitzer and Wilcox with the understanding that it will be as observers and that that specifically will be that they do

not counsel the witness, Dr. Zapp, and that they do not enter objections or comments on the record during the proceeding of the deposition.

This procedure and this agreement on the part of the Commission is made without any intent to waive any position that might be taken by the general counsel or the Commission in regard to the future depositions.

And it is understood by us that no waiver of any position in future depositions is intended by counsel for AMPAC, or that by attendance of counsel for AMPAC nothing is meant to imply their acceptance with the propriety of the procedure.

In keeping with the manner which we proceeded this morning, I will permit Mr. Smith to make comments on the record now in regard to the manner in which we are proceeding.

MR. SMITH: I am John Lewis Smith, with the firm of Baker, Hostetler, Frost & Towers. I appear with William Schweitzer and Donald Wilcox. We are counsel to the American Medical Political Action Committee -- AMPAC.

We are not counsel to John Zapp, D.D.S., the witness. We do not contest or contend that we have the right to counsel

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with or advise the witness in connection with this deposition. However, we do insist upon, and continue to insist upon, our rights as counsel for a respondent in the numberous matters under review which purportedly this discovery process addresses to be both present and to make available through the record our objections to questions and potential answers to such questions we believe would violate procedurally the due process right to our clients in the capacity as a respondent.

We base that upon a reliance upon Section 437(a) of the Federal Election Campaign Act as amended. We call attention specifically to the right of the respondent, such as AMPAC in this matter, to notice of alleged violations. And in that context, the fact that AMPAC has gotten notice of two types of allefed violations, reporting violations and common contributional violations both related to alleged affiliation between AMPAC and state medical political action committees.

We particularly make not of the sparse but yet the existence of due process rights reserved to respondents in the statute to have a reasonable opportunity to demonstrate that no action should be taken against them prior to the second stage finding contemplated by the law for the Commission known as a reasonable cause to believe finding stage.

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And we submit that being foreclosed from participation in the deposition in the nature of making applicable objections, we believe by, hopefully, excluding from the record for the Commission consideration irrelevant or improper information, we are foreclosed from the exercise of our rights. We do not by being present here intend to waive either that general objection or any specific objection we might desire to make to any specific question or answer.

I would like to correct that. I was speaking from memory. Citation 437(a) was incorrect. It is 437(g), Subsection A-2 and Subsection A-4.

MR. BRANCH: We will proceed with the deposition.

EXAMINATION BY COUNSEL FOR THE FEDERAL ELECTION COMMISSION

BY MR. BRANCH:

Q Dr. Zapp, you are employed by the American Medical Association; is that correct?

A Correct.

Q What position do you hold?

A Director of the Department of Congressional Relations.

Q And is that Department of Congressional Relations part of the AMA Washington office?

A Yes.

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Q What are your responsibilities as director of the Department of Congressional Relations?

A My responsibilities as director of the department is to direct the staff that works for me and to communicate the positions of the House of Delegates to Congress.

Q When you refer to the House of Delegates, what are you referring to?

A Policy-making body from the AMA.

Q Is it from the House of Delegates you receive your directions?

A Ultimately, yes.

Q How large is the staff that works under you?

A There are four registered lobbyists and myself and three secretaries.

Q You yourself are a registered lobbyist?

A Correct.

Q What are the names of the other four registered lobbyists?

A Jim Drake; John Mahoney; Ken Benjamin; Harley Dirks.

Q Do you yourself engage in lobbying?

A Yes.

Q And you are responsible for supervising the lobbying

activities of the other four members of your staff; is that correct?

A Correct.

Q Who is your immediate superior?

A Morris Riley.

Q And he is director of the AMA Washington office?

A Correct.

Q How frequently are you in contact with your staff members in your supervision of them?

A Daily.

Q Is it likely you talk with each one of them daily?

A Not always, but most of the time.

Q How frequently are you in contact with Mr. Riley?

A Generally, I would say on a daily basis.

Q How frequently are you in contact with any officials in the AMA office in Chicago?

A Probably several times a week.

Q What officials in particular would you be in contact with during an average week?

A Generally, the members of the Department of Legislation.

Q Who directs that department?

A Harry Peterson.

Q Is that department included in the Division of Public Affairs?

A Yes.

Q Is the Division of Public Affairs a larger group of which the Legislative Division is a part?

A Yes. It is a part, and the Washington office is also a part of the Public Affairs.

Q Is there a legislative division or department in the Washington office?

A Yes.

Q Is that distinct from your Department of Congressional Relations?

A It is distinct, yes.

Q What are the activities -- what is it called? I am using the term "Legislative Department."

Does it have a particular title?

A It doesn't have a departmental status, if that is what you mean. And it actually is a part of the Office of Federal Affairs or Department of Federal Affairs.

Q Is the Department of Federal Affairs a department of the AMA Washington office?

A Yes.

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To correct that, I am advised that our chart shows that as Government Relations.

MR. BRANCH: When you are referring to a chart, it is not in front of us yet.

MR. BIERIG: Exhibit 1 from this morning. I just wanted to get the terminology squared.

MR. BRANCH: Why don't we put it in front of us. Let me show you what has previously been marked.

Off the record.

(Discussion off the record.)

MR. BRANCH: Back on the record.

BY MR. BRANCH:

Q Dr. Zapp, the department that you are in charge of is the Department of Congressional Relations?

A Correct.

Q Is there also a Department of Governmental Relations in the AMA Washington office?

A Yes.

Q What does that department do?

A That department has the general responsibility for liaison with the Executive Branch of the government.

Q You described the Department of Federal Affairs. Is

that also a separate division with departmental status in Washington?

A That would be synonymous with Governmental Affairs.

Q Governmental Relations?

A Relations.

Q When you refer to the Department of Federal Affairs, the current title is Governmental Relations?

A Correct. That is my understanding.

Q Is there a Legislative Section, Division, or whatever, within the Governmental Relations department?

A Yes.

Q How is that appropriately called? What term is used for that division?

A I am not certain that it has a distinct departmental status.

Q If I refer to it as the Legislative Division, is that sufficiently clear for you to understand my question?

A To understand your question, it would be somewhat misleading in that a division would indicate something much larger than our office.

Q How many people work in the Legislative Section?

A There are two attorneys and one secretary.

Q What kind of work do they do?

A They monitor the Congressional Record and the Federal Register, keep track of bill status. Occasionally do bill analysis.

Q Are those people ever under your supervision for any part of their work?

A No.

Q Does the work of your department and their section overlap at all?

A No overlapping. There is a certain supportive function that they form in that we get materials that they generate.

Q What kind of materials do you get from them?

A Such as a scan of what is in the Congressional Record for a day, for the Federal Register, or if they would happen to do a bill analysis.

Q Going back to the Department of Governmental Relations, how long have you been director of that department?

A Congressional Relations?

Q Yes.

A Five years, as of March 1 of this year.

Q So you took that position as of March 1, 1974?

A Correct.

Q What position or job did you hold prior to your taking your present position?

A I was Deputy Assistant Secretary of HEW.

Q How long were you in that position?

A I was in that particular position about three years.

Q Prior to your being Deputy Assistant Secretary, had you been employed by AMA in any other position?

A No. I held another position in the Department.

Q Of HEW?

A Yes.

Q What position did you hold?

A I was Deputy Secretary for Health and Manpower.

Q Returning to your present position as director of Congressional Relations for AMA, the description that you have given us so far of the duties and responsibilites of your department, has that changed at all over the five years that you have been in that position?

A The duties?

Q The duties and responsibilities.

A No, I don't think the duties and responsibilities have necessarily changed.

Q What I am interested in knowing is when you gave a description of what it is you did, is it fair to say that there has been the same general responsibilities and duties throughout the time you have held that position?

A I would say that generally the duties and responsibilities have been the same.

Q In your position as director of Congressional Relations, do you have any contacts with state medical associations?

A With state medical associations?

Q Yes.

A Yes.

Q With officials of state medical associations?

A Yes.

MR. BIERIG: Again, I am going to ask if we can clarify whether talking about officials in capacities as officials or individuals who happen to be officials of state medical societies but not acting in the capacity as such?

MR. BRANCH: I will ask you both.

BY MR. BRANCH:

Q Do you have contact with officials who are acting in their capacities as officials of state medical associations?

A If by officials you mean staff of state medical associations, the answer is yes.

Q By officials, I was thinking more in the line of physicians who are in office. But you do have contact currently with staffs of state medical associations?

A Yes.

Q What kind of contact do you have?

A Exchange of information.

Q What kind of information?

A Status of legislation.

Q What would be a typical example of the kind of information supplied to you from staff of a state medical association?

A To me?

Q Yes. Coming from the association to you, yes.

A The situation is generally reversed from that, I would think, in that we would be informing a state many times of what the status of legislation is in Congress.

Q Do you any regular system for informing the state associations' staffs of developments on legislation in Congress?

A Yes.

Q What kind of systems do you have?

A Well, not in our office, but the Chicago office publishes weekly a legislative roundup.

Q I will show you what I will mark here for identification purposes as Exhibit 1.

(The document referred to was marked Exhibit No. 1, for identification, and attached to the original of this deposition.)

(Document handed to witness.)

MR. BRANCH: A document that we had received in this investigation from the Illinois Medical Society, state medical society. There are three copies there.

BY MR. BRANCH:

Q Is this a document that you have seen before?

A Yes.

Q Can you tell me what it is?

A Well, it is a document showing within the Washington office in the Department of Congressional Relations the correct mailing and identification of House and Senate Office Buildings, with an attachment that lists the names of various members of my staff and myself, with listed below numbers of individual states.

Q On the second page those are described as state medical

society assignments.

What specifically are the individual members of your staff assigned to do in regard to the states listed here?

A They would have the responsibility for general liaison or a communication with them.

Q What kind of liaison?

In regard to what kind of matters?

A Generally on almost -- specifically, revolving around legislation.

Q And when they carry out this liaison function, who do they generally deal with in the state medical societies?

A It varies with the size of the states and the sophistication and organization of their individual staffs. In some cases, it is the cheif executive officer, which is what we call the "state exec."

Q It would be a staff member?

A It would be a staff member. Some of the larger states, they would have an individual who is given the responsibility for legislation.

Q Again, are you referring to probably a staff member?

A A staff person, yes.

Q Does their liaison role include contacts with officials?

By that, I mean physician members of the state medical association.

A I would say that it would generally not be the case as it relates to this, for these assignments. This is a very specific kind of thing. You are more communicating the status of legislation.

Q If a staff member from a state association were to call up your office with a general inquiry, would it be referred to an appropriate staff member here?

A Generally, yes.

Q Would the same apply to a physician member of a state association who called up with an inquiry for your office?

A It would depend upon the nature of the inquiry.

Q How would it depend?

A Well, if a physician member of a certain state were to call the office on an inquiry as to the status of proposed regs, for example, the operator on the switchboard would or should refer that person to somebody in the Government Operations side of the shop.

If it was simply a status or wanting a copy of a bill, as an example, he would generally be referred directly to the Legislative Section.

Q If it were the status of a bill, it would be referred to the Legislative Section?

A If just a straight status or wanting a copy of a particular bill that had been introduced.

Q Do you get inquiries ever from members of state associations as to what positions the AMA is taking on a particular bill?

A If you mean members, are you talking here --

Q Physician members. Members of a state association.

A That would be a rare instance, I would think. The policies of the AMA are set by the House of Delegates, and they are published through the weekly AMA News, and things like that.

I would think it would be infrequent that a physician member, you know, would not know what the position of the AMA was.

Q Do you ever receive inquiries at your office from physician members?

A I may have, but I really don't recall that sort of a category as happening in the office.

Q Do members of your staff ever attend state medical association functions?

A Members of my staff on occasion will attend state medical society meetings.

Q What would be the purpose of their attending such meetings?

A Generally to give -- I would say almost exclusively to give briefings on what is happening in Congress in health legislation.

Q Do members of your staff ever attend any other kinds of functions of state medical associations, such as dinners or social gatherings?

A No, not unless in conjunction with an annual or some sort of a seasonal meeting a state association was having.

Q You yourself are on this list, listed as responsible for Arizona, California, Delaware, Georgia, Idaho, Kentucky, Louisiana, Oregon and Texas.

Do you continue to have a liaison function with that group of states today?

A Yes.

Q And has that been true throughout the time that you have been director of the Governmental Relations department?

A Yes.

Q Do you yourself attend functions of state medical

associations within the area you are responsible for?

A Yes.

Q What has been the purpose of the meetings you have attended?

A The same as I described a minute ago for the lobbyists if they were to go, and that is to discuss health legislation within Congress.

Q Within the states that you are responsible for, do you know who the officers of that state medical associations are?

A On occasion. But your relationship that is listed here is generally with what we would consider to be the staff member that is responsible for legislation within the state.

Q As a general matter, you are more familiar with the staffs of associations than the physician officers?

A Well, certainly more familiar with the staff member who has the responsibility for state legislation or federal legislation.

Q Do you or your staff ever directly lobby on behalf of state assocations?

A No.

Q Do you ever solicit views of state association staff

members as to what position state associations would like to see taken on legislation in Congress?

A Not in terms of the question as you ask it.

Q Do you ever solicit views of state associations about legislation?

A We solicit their position on certain pieces of health legislation.

Q When you do that, is that done through staff members, generally, or through physician members?

A Staff members, generally.

Q Do you ever request state associations to provide you with information about positions of Congressmen on different issues?

A No.

Q Have you ever requested state associations staff members to give you positions of incoming new congressmen on legislative issues?

A Yes, of general legislative issues.

Q Has that been done on a regular basis?

Let me ask that a little more specifically. There has just been an election in 1978. Do you have any regular policy of trying to reach the various state associations and ask them

for a rundown on the general views of the incoming congressmen?

A Yes.

Q Was that done with all of the state associations?

A Yes.

Q Do you ever get inquiries from that staff of the state associations as to what positions congressmen from their states or areas are taking?

A On individual -- not positions plural, but individual legislative situations that we would have inquiries from the states.

Q For example, a staff member might say what position has Congressmen X taken on this bill?

A Yes.

Q Do you have any regular contacts in your activites with state medical PAC staffs?

A No.

Q Do you have any parallel liaison arrangments with state medical PAC staffs for your staff?

A No.

Q Have you ever made any requests for information as to the view of a candidate for a federal office from a state PAC?

A From a state PAC?

Q State PAC.

A No.

Q I am using the term "PAC." You are familiar with, or are you familiar with the term "PAC"?

A Yes.

Q When I refer to state medical, I will just refer to the Political Action Committees as state medical PACs.

In your contact with state medical associations, do you ever have occasion to meet with members of Congress here in Washington together with staff from a state medical association?

A Yes.

Q What is the purpose of such meetings when they occur?

A Well, generally most -- not most, but a number of states do hold visitations to come in and meet their member.

In some cases, they know them; in some cases, they don't know them.

And to let that member know what their positions are on a variety of health issues.

Q Do those meetings include, sometimes include members, physician members of state medical associations in addition to staff?

A Yes.

Q Do you or your staff ever have meetings with members of Congress together with staff of state medical PACs?

A No.

Q In the past or for some period of years, it is our understanding that the AMA AMPACs sponsored an annual political workshop of sorts in Washington.

Are you familiar with the workshops which were held like that in the past?

MR. BIERIG: I object to that. I don't know what you mean by "workshops," like that.

MR. BRANCH. Well, initially, I want to determine if just a reference to the AMA AMPACs jointly sponsored annual workshops has some significance to the witness.

THE WITNESS: I am familiar with the meetings. I don't think they are being held anymore.

MR. BRANCH: Let me show what I will mark here as Exhibit No. 2.

This refers to a specific workshop that was held in April of 1976, called "AMA-AMPAC Public Affairs Workshop."

(The document referred to was marked Exhibit No. 2, for identification, and attached to the original of this deposition.)

(Document handed to witness.)

BY MR. BRANCH:

Q Do you recall attending this workshop?

A Yes.

Q And you are listed on the second page as taking part in a panel discussion. Can you recall what the subject of the panel discussion was?

A It was a very broad-ranging program on legislation that was pending before Congress, and individual projections as to what might happen with some of it.

Q Can you remember what your contribution to that discussion was?

A At this time, no.

Q Did you take part in any other formal sessions in this workshop? I don't see others listed, I am just asking.

A Not that I recall.

Q Do you recall whether other members of your staff took part in any formal presentations at this workshop?

Again, I add that nothing particular referred to on the document.

A No, not that I recall.

Q Did any other members of the staff attend the workshop?

A I don't recall, but I think that some of them possibly did at certain times. I just don't recall it. It was too many meetings ago.

Q Did you or your staff have anything to do with organizing this workshop?

A If you mean by organizing in the same terminology that I would think of organizing, I would say no. By that, I would mean to devise a program to solicit attendees to make arrangments with the hotels, et cetera, no.

Q Did you presonally have any part in the planning of this workshop beyond your own presentation?

A I would assume that I may have had an involvement from the standpoint of followups on letters that were sent to members of Congress to invite them.

Q Do you recall whether your staff played any function such as that in helping to arrange members of Congress to attend?

A That may have also been involved with a followup to a request, but I honestly don't recall.

Q Do you have any recollection of who the people who attended this workshop from the states were?

A Speculation?

Q No, recollection. The knowledge that you have today

that you best can recollect.

Do you know who the people who attended the workshop were?

A No.

Q Do you know who was invited to attend?

A No.

Q Specifically, do you know if officials of state medical associations in their capacity as officials of state medical associations were invited to attend the workshop?

A I don't know.

Q Do you know if similar workshops sponsored by AMA and AMPAC were held in any other of the years that you have been director of Congressional Relations?

A There may have been one the first year that I came on board.

Q Which would have been 1974?

A Correct.

Q Do you recall any such workshops sponsored by AMA and AMPAC since 1976?

A No.

Q Have you or your staff participated in any political workshops held by state medical PACs?

A Not to my knowledge.

Q In your lobbying activities, do you or your staff ever receive requests from members of Congress for contributions to their campaigns?

A For contributions to their campaigns?

Q Right.

A Requests to us?

Q Made to you.

Let me rephrase it. Do you or members of your staff receive requests to be made of AMPAC for contributions to campaigns by members of Congress?

A On occasion we will receive an inquiry, but I would put it in the category of a member actually making a request.

Q If you receive an inquiry from a member of Congress as to whether or not AMPAC might make a contribution, how do you handle that inquiry? What do you do with it?

A Refer them back to their local physicians.

Q When you say "local physicians," their constituent physicians?

A Yes.

Q Has there ever been an occasion while you have been director of the department that you or your staff members have

relayed such inquiries on to AMPAC?

A No. If a request was ever directed toward AMPAC, the member would have been told to make a contribution himself. I mean, I don't recall one for myself, and I certainly don't recall that any of my staff have.

Q You youreslf have not relayed any requests from a congressman to AMPAC?

A For a campaign contribution?

Q For a campaign contribution.

A No. This would exclude a reception or something of that category.

Q Have you ever had inquiries from an AMPAC staff members as to a particular congressman's need for campaign funds?

A No.

Q Have you ever had inquiries from and AMPAC staff member as to a particular congressman's plans for reelection?

A No.

Q Have you had any inquiries from AMPAC staff members as to a particular congressman's views on legislation?

A On views?

Q Legislative positions of a congressman.

A Well, positions would indicate something that is a matter of record as opposed to views. I have a little problem.

Q Is the problem that "views" is vague to you as a word?

A Yes.

Q Referring to legislative positions, have you been contacted by the AMPAC staff in regard to the legislative positions taken by any member of Congress?

A I just don't recall. I mean, not an attempt to be vague on my part.

Q Let me ask the other side of that question.

Can you recall any instance in which you have given information to AMPAC staff as to legislative positions of a member of Congress?

A No.

Q Do you receive any reports from AMPAC as to who contributions are made by AMPAC?

A Directly from AMPAC to myself?

Q Yes.

A No.

MR. BIERIG: I have exercised considerable indulgence for

not objecting. But I have to say for the record at this time that the whole line of inquiry dealing with the relationship of Dr. Zapp's department and AMPAC is irrelevant to MURs.

And, as I understand the subpoena, we are here with respect to MURs that have been noted that are outstanding, and I haven't heard much at all about what I perceive is the purpose of the deposition.

So I don't want to prevent you from exercising your lawful discretion, but, at the same time, I have to object. It seems to be going far afield at this point.

MR. BRANCH: As to relevance?

MR. BIERIG: Yes. The whole things seems to be relevance.

I am not instructing the witness not to answer, but I would like to know as to the relevance, if you continue to do so.

MR. BRANCH: We have a broader sense than you do of the range of inquiry of the investigation.

Could we have the question read back.

(Record read by the reporter.)

BY MR. BRANCH:

Q Do you get the information as to whom contributions have been made by AMPAC from any other source?

A Frequently from The Washington Post.

Q Any other source than The Washington Post?

A Copies of reports are filed with the Federal Election Commission.

Q Do you receive copies of those reports from any source?

A No, not regularly.

Q Do you receive any written reports as to what contributions have been made by state medical PACs to federal candidates?

A No.

Q Do you receive that information from any source on a regular basis?

A No.

Q Do you in your duties ever attend fund-raising functions on behalf of members of Congress?

A Fund-raising?

Q Functions held to raise funds for a member of Congress.

A Occasionally.

Q Do you ever attend, for example, dinners which entail a contribution?

A Occasionally.

Q When you attend such a function, who pays or makes the necessary contribution?

A AMPAC.

Q How is a request from your office made to have such a contribution paid?

MR. BIERIG: There is an assumption in that question that is not in evidence. And I ask you to first establish if the assumption is correct; namely, that there is some kind of a request made from Dr. Zapp's office to AMPAC, which is not in the record and may not be true.

BY MR. BRANCH:

Q When AMPAC pays for such a contribution, is the contribution requested from AMPAC by your office?

A Requests of the types -- so we are both talking about the same kind of things -- that occur as a result of various fund-raising receptions generally come to the office in the form of a printed invite with all the appropriate information that is required by the Commission.

They are given to my secretary, who calls a secretary at AMPAC in Chicago, phones the information in. And later on she is notified that yes, AMPAC will contribute to the receptions or no, they won't.

Q Do you have any knowledge as to the policies used by AMPAC in making the decision which functions they will contribute