STATEMENT
OF
THE AMERICAN COLLEGE OF PHYSICIANS
BEFORE THE
HOUSE ENERGY AND COMMERCE
SUBCOMMITTEE ON COMMERCE, TRANSPORTATION AND TOURISM
March 11, 1983

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

The American College of Physicians (ACP) is pleased to have this opportunity to appear before you today to outline our views on the reauthorization of the Federal Trade Commission (FTC). My name is Daniel D. Federman, MD, FACP, and I am the President of the American College of Physicians; in addition, I am presently a Professor of Medicine and the Dean for Students and Alumni at the Harvard Medical School. Accompanying me today are Richard J. Reitemeier, MD, FACP, President-elect of the ACP, and Edwin P. Maynard, III, MD, FACP, the Chairman of the College's Health and Public Policy Committee. Dr. Reitemeier is Professor of Medicine at the Mayo Medical School in Rochester, Minnesota; Dr. Maynard serves as Assistant Clinical Professor of Medicine at the Harvard Medical School and is a practicing internist at the Massachusetts General Hospital in Boston. We also have with us John R. Dall, MD, JD, the Associate Executive Vice President for Health and Public Policy of the ACP.

The College was founded in 1915 to uphold high standards in medical education, medical practice, and medical research. Today the College represents over 56,000 doctors of internal medicine, related non-surgical specialists, and physicians-in-training. Approximately one third of our
members are Fellows of the College (FACP), a designation based upon their having met the standards of a national credentials committee in the areas of scholarship and contribution to the science and practice of internal medicine. The ACP membership includes private practitioners providing primary health care; medical specialists in such fields as gastroenterology, endocrinology, oncology, and cardiology; medical educators and researchers. It is the largest organization of general internists and allied subspecialists in the world.

The statement that we present today outlines the College's views on the relationship between the Federal Trade Commission and the medical profession and reflects months of careful review and discussion by the policy-making bodies of the College, culminating in its approval by the Board of Regents late last year.

In its essence, this position holds that the FTC has a legitimate role in monitoring the business aspects of health care delivery. The College believes that the Commission has clear responsibility for ensuring the protection of business competition and the protection of the American consumer, and it appropriately should act to prevent unfair methods of competition and unfair or deceptive practices affecting commerce. We believe that to prevent FTC scrutiny of those aspects of health care delivery which are directly linked to the business of health care would be inappropriate. Additionally, we believe that exempting the medical profession from all FTC review would create a special privileged class and is therefore inequitable.
We also believe that the medical profession has a legitimate role and an ethical responsibility in ensuring the quality of care and the quality of medical education and training. Such activities include the necessary credentialing by the profession of individuals and institutions through a variety of testing and accreditation processes. Continued recognition and preservation of the medical profession's leadership role in quality assurance, education, and accreditation activities is required not only by the Federal Trade Commission, but also by the Congress and by government at all levels. A key component of such recognition includes understanding and acknowledging the legitimate and proper role of voluntary associations in quality assurance, education, and accreditation.

Lastly, the College believes that the administrative processes of the Federal Trade Commission must adhere to basic principles of fairness and due process, and all necessary actions must be taken to ensure conformance to these principles.

We are here today because we believe that a full discussion of these issues is critical and that the debate must be begun in a manner of honest and forthright discussion of the respective responsibilities of the Federal Trade Commission and of the medical profession. It is our belief that if the profession fails to enter into this discussion in a productive fashion and fails to educate the Congress and the FTC as to our own perception of these respective roles, that the right and responsibility for self-regulation in the areas of credentialing, accreditation, and quality assurance will be placed in jeopardy.
Jurisdiction of the Federal Trade Commission

It is the position of the American College of Physicians that the courts have clearly held that the professions are subject to antitrust law. It is our further view that the courts have also upheld the applicability of the Federal Trade Commission Act to the professions. This committee is well aware of the case law on these points and we will not attempt to recapitulate the pertinent cases.

We realize that this question of jurisdiction has engendered substantial debate not only within the Congress but also within the medical profession and within other professions as well. However, we believe that further debate on this point is unwarranted, and that the findings of the courts speak for themselves. As noted earlier we have no quarrel with the concept that the Federal Trade Commission has responsibility for ensuring the protection of competition and for preventing unfair methods of competition and unfair or deceptive practices affecting commerce, and that their purview should include the health care delivery system.

However, there is a valid point for discussion: that is, whether changes should be made in this present system to restrict or alter the FTC's authority over the professions. It is our belief that such changes are not warranted nor should they be desired or sought by members of the profession of medicine. The College believes that the spectrum of the provision of health care has become both very broad and most complex. Modern health care provision is a combination of services of professionals -- such as physicians and nurses -- and products that are not inherently
professional -- such as material, equipment, and machinery. Terms of commerce -- cost containment, competition, prospective payment -- that were not even in our lexicon a decade ago are now commonly applied to health care. Therefore, health care itself is no longer solely the province of the individual practitioner but has become, in a more general sense, a significant component of our national economic life.

This committee is well aware of the litany of statistics that encapsulate the growth of the health care industry -- as a nation we presently spend over $300 billion for health care, a sum comprising approximately ten percent of our Gross National Product (GNP) -- and there is general agreement on the critical need to ensure that these expenditures are made prudently. Consequently, it is neither realistic nor appropriate for such a significant sector of the economy to be placed outside of the purview of laws governing methods of competition and unfair or deceptive practices affecting commerce. It is quite clear that health care, taken as a whole, is in fact a part of our national system of "commerce" -- in the traditional and broad sense of that term.

It may be useful to conceptualize the full range of health care activities as a spectrum -- with the clearly commercial at one end and the clearly professional at the other. The professional practice of physicians is based on an arduous training that involves college and medical school, internship, residency and sometimes fellowship, and continuing medical education. Each step is provided by publicly chartered institutions that have defined academic goals and are subject to scrupulous accreditation
mechanisms. The processes of credentialing of all sorts -- including licensure and specialty board certification -- have been painstakingly developed and honed. These are processes which we believe to be inherently professional and which should not be subject to unwarranted review by the Federal Trade Commission or others.

At the other end of the spectrum, health care delivery involves a bewildering array of products and services that are made and sold competitively, often for a not inconsiderable profit. While these elements are crucial to the provision of modern medical care, they are clearly prepared and trafficked in a commercial setting. The FTC has not only the right but also an obligation to ensure that the provision of these elements of care is free of anti-competitive restraints. This role is all the more important in an era of progressively worrisome cost increases.

The challenge arises in trying to define the boundary between the academic and professional elements at one end and the commercial processes at the other. For example, when is the criticism of alternative healers a genuine assertion of a difference in training and therapeutic potential and when is it a selfish attempt to restrain competition? When is the skepticism toward a new grouping of physicians an honest concern that their cost containment has jeopardized patient welfare and when is it an effort to protect a current pattern of fees and charges? When is an announcement of services and probable benefits a respect for the public's right to know and when is it deceptive advertising? Difficult as these distinctions may have been in the past, the current growth of the for-profit sector of health
care will compound them greatly. Any determination of the appropriateness of such activities must be based, at the least, upon a full understanding of the need for and value of the profession's assumption of certain self-regulatory responsibilities.

Responsibility of the Medical Profession

The medical profession -- as a profession -- engages in a wide variety of activities for the public good. Indeed, just as it is the individual responsibility of the physician to act for the benefit of the patient, it is the corporate responsibility of the profession to act for the benefit of the public. Parenthetically, I would be quick to emphasize that what I wish to focus on here is not a demand for the profession's right to maintain certain activities, but on its responsibility to carry them out for public benefit.

Of the host of such valid professional activities, the American College of Physicians wishes to emphasize three: board certification, hospital accreditation, and medical education. Each is carried on for the purpose of ensuring the competence of individuals in medicine or of the quality of institutions within which medical care is provided. Each is also carried on for the purpose of assuring the public that physicians and hospitals meet essential standards, that people have information that will enable them to make responsible choices of a physician and of a hospital. Assuring the public of essential competence and providing valid public information are professional activities of basic value to society.
Certification. "Credentialing" is a generic term relating to a set of different activities by which society grants certain individuals the right to provide health care or certifies their qualifications as meeting specified standards. The most basic credential is a license to practice, granted by the state on the basis of an individual's having met standards determined by the state to be appropriate and to be those minimally acceptable. A license confers the right to practice; the unlicensed practice of medicine is a criminal offense in every state.

In contrast to the license, which is the state-granted entry into what has been termed the "health care market," most other credentialing mechanisms are carried on by the profession, or the private sector. The most important -- and most common -- professional credentialing mechanism is board certification. The purpose of board certification is to encourage excellence -- to encourage the young physician to pursue knowledge and educational experience beyond that minimum required for licensure. Further, the purpose of certification is publically to recognize the attainment of that knowledge and experience and to assure the public that higher, professionally recognized, standards have been met. Thus, board certification can and does serve valid public purposes.

Certification by boards in the medical specialties was initiated as a voluntary credentialing mechanism. The first examining board was established in 1916, as the American Board of Ophthalmology. It had two basic activities: examining candidates for cognitive and practical competence, and developing requirements for graduate medical education for candidates desiring admission
to the examination. Most subsequent boards followed this model, to a greater or lesser degree. Professional societies have been in the forefront of the development of specialty boards in order to ensure the competence of the individuals claiming special expertise. The American College of Physicians, for example, was instrumental in the formation, in 1936, of the American Board of Internal Medicine. In 1933, the four boards then in existence (ophthalmology, otolaryngology, obstetrics and gynecology, and dermatology and syphilology) formed the Advisory Board for Medical Specialties, including as associate members the American Hospital Association, the Federation of State Medical Boards, the Association of American Medical Colleges, and the National Board of Medical Examiners. Today there are 23 recognized specialty boards, comprising the membership of the (now named) American Board of Medical Specialties (ABMS), which also consists of Associate Members -- non-physician organizations concerned with graduate medical education and specialty practice.

Board certification plays an increasingly vital role as health care has grown more complex. Although the physician's competence has always been of critical importance to the patient, other institutions -- including hospitals and federal agencies -- increasingly have begun to need both valid measures of competence and the assurance that specific physicians meet appropriate standards. Hospitals, for example, have in the last decade or so been held by the courts to be responsible for the quality of care provided within them. The yardstick of licensure is inadequate to the task the hospital faces in its determination of what privileges to grant individual physicians. For example, in most states the license to practice medicine, once granted, provides no limitations on a physician's practice. Hospitals have a valid
concern, for example, that surgeons are qualified to perform surgery, a fact that medical licensure alone does not address. Board certification, while clearly not the only measure a hospital may use, provides some assurance that the physician being considered has achieved a specified level of cognitive and experiential competence.

Just as board certification is a most appropriate encouragement of excellence and measure of competence, the participation of physicians in developing board examinations and criteria for sitting for those examinations is vital. Only physicians have the technical competence for writing examination questions and for determining what constitutes the appropriate level of competence deserving certification. This is not the vulgar demand for an exclusive right; it is the recognition by the profession of a public responsibility. Who else can perform this valid and increasingly necessary activity? How else can it be done? The medical profession, in the development of specialty boards and in the writing and grading of board examinations, serves to ensure the competence of practitioners, and to inform and assure the public of the standards which the board certified specialist has met.

Accreditation. Just as "certification" may be applied to individuals and their qualifications, accreditation is the process by which institutions are measured. These institutions may be intangible (e.g., training programs in graduate medical education) or tangible (e.g., hospitals).

As indicated a moment ago, one role performed by many specialty certification boards was the development of requirements for graduate medical education for
those candidates who desire to sit for the board examination. In 1940, the American Board of Internal Medicine (ABIM), the American College of Physicians, and the Council on Medical Education of the American Medical Association formed the Conference Committee on Graduate Training in Internal Medicine, delegating to it the responsibility for accrediting residency programs in internal medicine. The Committee became the Residency Review Committee in Internal Medicine in 1953. There are now 23 such residency review committees, all of which are cosponsored by the appropriate specialty board and the AMA Council on Medical Education, and 14 of which have a specialty society as a third sponsor.

Although the residency review committees accredit graduate medical education programs, residency requirements (the "essentials" or standards to be met by the programs) require review and approval by a separate body, the Accreditation Council for Graduate Medical Education (ACGME). The sponsors of the ACGME are the ABMS, the American Hospital Association, the AMA, the Association of American Medical Colleges, and the Council of Medical Specialty Societies. The standards used in the accreditation process relate to the quality of the educational program, the capability of the teaching staff, and the availability of resources necessary for the effective conduct of the program.

A separate example of the accreditation process is that of the Joint Commission on Accreditation of Hospitals (JCAH). The medical profession has a long history of leadership in establishing standards for, and encouraging excellence in, the nation's hospitals. In 1918, the American College of Surgeons (ACS), through its Hospital Standardization Program, instituted
the first national, voluntary, program of hospital review. The ACS program, for three and a half decades, was a major force in upgrading hospital facilities, and was the institutional and conceptual ancestor of the JCAH. The JCAH, founded in 1951 by the American College of Surgeons, the American College of Physicians, the American Medical Association, the American Hospital Association, and the Canadian Medical Association, has for three decades now established the standards by which hospitals are measured.

The JCAH accreditation process is a voluntary one. Yet approximately 80% of the nation's acute care hospitals, viewing the JCAH standards as the benchmark, apply for accreditation in each accreditation cycle. JCAH accreditation is the measurement, by written response and field survey, of the hospital's facilities and services against predetermined JCAH standards. Those standards, revised six times between 1951 and 1966, have been revised annually since 1970, and are updated more often if new data become available. The standards themselves have evolved over the years: from those that reflected minimal acceptability to those that are optimally achievable; from those that focused on the hospital's physical plant and facilities to those that focus on its services; and from those that were prescriptive to those that allow flexibility.

In addition, the process of standards development has become an open one. For each of the accreditation programs of the JCAH (the hospital program is but one; others are long term care, ambulatory care, and hospice), there is a Professional and Technical Advisory Committee, with representatives from a wide variety of non-physician professional groups, business, and the
public, as well as individuals with technical expertise. A Policy Advisory Committee, again comprised of individuals outside the medical and hospital professions, provides policy advice to the JCAH Board of Commissioners. The Board itself has a public member. Each proposed revision of the standards is sent to at least 3,000 interested institutions and individuals for review and comment. The openness of the standards development process is quite likely unique among all accreditation activities in any professional field.

The JCAH standards and the accreditation process are viewed by the American College of Physicians as a responsibility of the medical profession, a responsibility physicians have shouldered and which has had, as its clear outcome, the excellence of this nation's hospitals. Indeed, Congress has recognized both the value of JCAH accreditation and the strength of its standards in providing by statute that any hospital accredited by the JCAH is deemed to have met the Department of Health and Human Services' Conditions of Participation in the Medicare and Medicaid Programs.

The accreditation of institutions, like the certification of individuals, is a demanding process that tests the recipient against rigorous standards. The process itself demands highly technical input and the expenditure of huge amounts of volunteered time. Institutional accreditation, like certification, meets the vital need of the public to be assured that health care institutions meet essential and trustworthy standards of quality.

Medical Education. A final, and briefer, word must be said about medical education. Here, perhaps even more than in the fields of certification and
and accreditation, has the profession seen and carried out a responsibility to ensure excellence. At three levels -- undergraduate medical education (the medical schools), graduate medical education (residency programs), and continuing medical education -- the profession and professional societies such as the American College of Physicians and the American Medical Association have been involved in developing educational programs and in separately developing the standards by which programs are measured.

United States medical schools, with their unique combination of teaching, patient care, and research, are the envy of the world. The medical profession, through the Liaison Committee on Medical Education (LCME), cosponsored by the Association of American Medical Colleges and the AMA, accredits undergraduate medical education programs in this country and Canada. All state medical practice laws recognize the accreditation status conferred by the LCME on medical schools, and holders of the M.D. degree awarded by them are eligible to sit for state licensure examinations. The LCME has avoided dictating curriculum content, but has encouraged institutions to go beyond established minimal standards and approach the education of physicians in a variety of ways. Each medical school's faculty is responsible, for example, for establishing the criteria for evaluating student performance, promotion, and graduation. Thus the LCME accreditation program, far from narrowing the range of educational programs, has enhanced diversity.

In the area of graduate medical education, the activities of the Residency Review Committees and the AMA Council on Medical Education were outlined earlier. What is important conceptually to note in those activities as,
Indeed, in all those of the profession, is the continual testing of professionals and institutions against continually updated high standards.

Continuing medical education (CME) programs are diverse. Professional societies, individual hospitals, and academic health centers are among the most important groups in the development and presentation of continuing medical education, and the variety of subject matter and media is immense. An Accreditation Council for Continuing Medical Education (ACCME), sponsored by several organizations interested in the quality of CME, accredits individual programs of CME.

The American College of Physicians, approximately every four years, produces the Medical Knowledge Self-Assessment Program, a comprehensive update of new knowledge in internal medicine in syllabus form that also includes a computer-scored examination in general internal medicine. The present version, MKSAP-VI, in its first six months has had over 30,000 physician subscribers.

The point of this selective review of specific activities of the profession in standards-setting and evaluation is to emphasize, however briefly, the depth of commitment of the medical profession to its responsibility to ensure the quality of medical care in this nation. Professional activities in credentialing, accreditation, and medical education are varied and many, allowing diversity at every level while encouraging excellence. The review is selective and relates primarily to the corporate activities of the profession. It should not be forgotten that individual physicians, making individual clinical decisions, participating in local hospital quality assurance
activities and utilization review committees, and working in local medical society grievance committees, among many other activities, also participate in the profession's effort to assure the public that the quality of health services is worthy of confidence.

Areas of Misunderstanding

It is clear from the preceding that the profession has a highly developed sense of its own responsibility for self-regulation. However, our experience indicates that these professional activities are not always fully understood nor fully appreciated by either the FTC or by the Congress. Conversely, it is also quite clear that the profession's knowledge of the activities of the FTC are equally as sketchy or subject to misunderstanding. I would like to briefly note some of the ongoing problems caused by this misunderstanding.

Mr. Chairman, it was noted earlier in this statement that the failure of the profession to educate fully both the Congress and the Federal Trade Commission as to the legitimacy of certain clearly professional activities will ultimately jeopardize the profession's ability to carry out its responsibilities in those areas of self-regulation. Let me provide an example of what we perceive to be this type of misunderstanding.

On December 1, 1982 during the House of Representatives consideration of legislation regarding the Federal Trade Commission, there was substantial debate on the issue of the so-called professions exemption. In the context
of extensive remarks on that subject, the distinguished Chairman of the full Committee, Congressman Dingell, made the following comments:

The American Medical Association, the American Dental Association, and the American Optometric Association are trying to get out from under the FTC.

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At the same time, the Joint Commission on Accreditation of Hospitals (JCAH), working hand in glove with the AMA, is seeking to eliminate State and Federal supervision of medicare and medicaid in America's hospitals and substitute their own privately owned commission, totally exempt from all public supervision and accountability, as the only source of accreditation for hospitals receiving Federal funds.

As previously noted, the American College of Physicians is one of five corporate sponsors of the JCAH. We can assure you that the JCAH is not working to substitute its own method of accreditation for that of the federal government. For thirty years, the JCAH has provided voluntary accreditation of the nation's hospitals. It is the Social Security Act which permits facilities that are accredited by the JCAH to be "deemed" to have met the federal conditions of participation in Medicare and Medicaid. In fact, it is generally accepted that traditionally the JCAH standards have provided the model for the federal standards and are indeed more stringent than those standards set by the federal government. Institutions that fail to meet JCAH standards may well still meet federal standards and thereby be eligible for payment under Medicare and Medicaid.

The reason for dwelling on this example is not through a desire to set the record straight, but rather to indicate the potential harm which may be done to self-regulation when it is perceived by the public as part and parcel of self-serving activities. It is precisely for this reason that the
American College of Physicians believes that the FTC must maintain the potential right to review appropriately even those activities of the profession which we have previously outlined as professional in nature. The type of publicly held misunderstanding evidenced in the quoted material would only be exacerbated by any effort to remove these activities from the purview of the law.

The hallmark of any profession is the right to set and to enforce appropriate standards affecting professional behavior. As pointed out previously, the purpose of such standards is to ensure the highest level of proficiency in training and practice of members of the profession. This right can only be maintained if it is not above valid public scrutiny, since the grant of the right is an expression of the public will.

We are concerned that any absolute exemption of professional activities from FTC scrutiny could cause unanticipated problems. First, we believe an exemption could potentially heighten public misunderstanding and public mistrust of these processes, and ultimately make all efforts at accreditation, credentialing, and other quality assurance activities suspect. Secondly, we believe that an exemption could create a potential sanctuary for those who might misuse self-regulation for improper purposes.

Let me be clear: we do not believe that any profession, including the profession of medicine, is riddled with individuals who are inherently evil or deceptive and that such an abuse of these legitimate activities is a natural corollary to their exemption from the law. However, what
we are saying is that in order to ensure that the public's faith in the legitimacy and value of these activities is maintained, we must make it quite clear that these activities are not beyond the reach of the law. We would sincerely hope that unwarranted scrutiny could be avoided, but we do not believe that creating sacrosanct enclaves is the best mechanism for either preserving these responsibilities or enhancing the public trust. We remain concerned that any exemption of these activities may carry with it a far greater liability of engendering public suspicion. In short, just as one of our most basic societal tenets is that no individual is above the law, neither is any group of individuals, be it a profession or an association of professionals.

Mr. Chairman, we have illustrated briefly the type of public misunderstanding and distrust which can develop whenever a profession, including the profession of medicine, is perceived rightly or wrongly as acting in a self-interested manner. However, we all know that the confusion and misunderstanding which has surrounded and colored all discussion of the FTC and the professions has not been limited to the public.

Discussions with the American College of Physicians have clearly revealed that many physicians are unclear as to the role and the activities of the FTC. Indeed, the profession has not been active in clarifying the misunderstandings of its members about the FTC. We believe that many physicians, if the facts were fully presented and discussed, would support actions of the type taken by the FTC. Furthermore, a review of those actions clearly indicates that the FTC is not on a full-scale rampage against
legitimate self-regulatory activities, but has taken action in instances which should be of concern to all of us, activities that have inappropriately restricted competition.

Summary and Recommendations

The American College of Physicians believes that there must be a better understanding and clarification of the respective responsibilities of the profession and of the Federal Trade Commission. We would recommend that the committee consider placing in its report on the reauthorization of the FTC language that would recognize and underscore the primary role of the profession in such activities as certification, accreditation, and medical education, and that would indicate that any activity by the FTC in these areas should be undertaken only if clearly justified by specific indications.

We believe that this underscoring of existing law and clarification of the division of responsibility between the FTC and the profession would go a long way towards easing the fears of many within the profession that the profession's ability to carry out its responsibilities is in jeopardy under antitrust law. We are hopeful that if this essential spirit of the law can be captured, it will prove unnecessary to attempt to craft and place in statute complex definitions and assignments of responsibilities which by their nature must run the risk of being either overly broad or excessively narrow.

Physicians do not always understand or agree with the FTC; neither does the FTC always understand or agree with the profession. However, that does
not mean that it is appropriate to walk away from the problem -- we do not do that in the practice of medicine, and we must not do that in the practice of public policy. I can assure you that the College stands ready to work with the committee in attempting to resolve this issue.

This concludes my prepared remarks. I would be pleased to respond to any questions that you or the other members of the subcommittee might have. Thank you.