INTRODUCTION FOR ARIZONA LEGISLATORS TO
THE ACS 2014 LEGISLATIVE INFORMATION
PACKAGE AND PROPOSAL
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Arizona Chiropractic Society (ACS)
December, 2013

We have distilled thousands of pages of documents into seven separate short documents this year for your convenience. We would respectfully request that you take the time to read each one. Here are the titles with brief descriptions:

1 -- Conservative Care First -- A Strategy to Reduce the High Cost of Health Care: The main driver of health care inflation is high technology medicine and in-patient care. When patients are first seen by chiropractors compared to MDs or DOs, the frequency of MRIs, CTs, surgeries and hospitalizations is lower and this reduces the overall cost of health care.

2 -- Chiropractic -- A Low Cost Solution to High Cost Healthcare: Back pain is the second most common reason that patients consult doctors. When patients see chiropractors rather than MDs or DOs, the overall costs of care are 20-40% less expensive, thus reducing the nation’s health care tab.

3 -- Wilk v. AMA Permanent Injunction Order: In 1987, a Federal District Court Judge issued a Permanent Injunction against the AMA banning it from continuing its effort to conduct an “illegal boycott and conspiracy” to “contain and eliminate the profession of chiropractic” because it was an economic competitor. The injunction was issued because there were still “lingering effects” of the boycott. The AMA convinced insurers not to cover chiropractic and that is the root of our problem today since it continues.

4 -- Wilk v AMA 25 Years Later Why It Still Is Not Over: Evidence that the AMA’s effort to “contain and eliminate” the chiropractic profession is ongoing. The most recent example is found in 2010 when AMA House of Delegates voted to have the AMA lobby to repeal the provider anti-discrimination clause in the Affordable Care Act, Sec. 2706, which protects chiropractic from discrimination. Nothing has changed since 1987. The AMA wants existing discrimination against chiropractors to continue. That is why the Arizona chiropractic insurance equality law is necessary.

5 -- Cato Analysis Executive Summary: The conservative Cato Institute conducted a thorough analysis and concluded that the more types of health care providers in the marketplace, the more competition there would be with the result being lower prices. They found that certain segments of the medical profession seek to use unfair advantages to squeeze out competition and maximize their own incomes through licensure and other laws.
6 – Proposed Arizona Fair Copayment Bill: Most chiropractic and physical therapy patients need about 20-30 treatments over a 2-3 month period of time. When copayments are at specialist levels of $40-$60 per visits, the average patient is not able to afford the care. While chiropractors and physical therapists are clearly not primary care physicians (PCPs), and nothing in this bill confers that privilege to them, they most certainly are not specialists either. Specialists complete medical school and then attend 3-7 years of post-graduate training. Chiropractors and physical therapists graduate from the equivalent of medical school and then go into practice with no additional training. It is clearly false to compare the education and training of a chiropractor or physical therapist to, for example, an MD neurologist or orthopedic surgeon. Practically speaking, patients simply are not getting the chiropractic care or physical therapy they need with copayments at specialist levels. Oftentimes, the copayment is close to or exceeds the total amount reimbursable for an entire visit and so the insurer actually pays nothing. Copayments for chiropractic care and physical therapy must be set at PCP, not specialist levels. Also, chiropractors don’t get paid anything near what actual specialists get on reimbursement -- insurers want to classify chiropractors as specialists only when it is advantageous to do so. This bill also covers occupational and respiratory therapy.

7 – Provider Non-Discrimination Act: The existing Arizona chiropractic insurance equality law/freedom of choice law. This law must be moved from the Unfair Claim Settlement Practices Act which can only be enforced by the Arizona Department of Insurance (ADOI). In recent litigation, the courts have affirmed that ADOI has no duty to enforce this law even if there are clear violations. In the past six years, ADOI has refused to enforce the law and has misinterpreted the law compared to the way it was interpreted from the time it was passed in 1990 to 2007. The law must be moved elsewhere in Title 20 where it will be subject to the same legal recourse as all of the other 2,500 laws in Title 20. The stricken language was added in 2004 as a last minute amendment and allows insurers to discriminate against chiropractic when applying medical necessity review. No discrimination whatsoever should be allowed and so this line must be removed.

CONCLUSION

When you are fighting the forces of the monolithic medical monopoly, it is never too soon to begin the effort. Therefore, we would like to ask you now to commit to being a sponsor or cosponsor of two bills: one to move the chiropractic insurance equality law outside of the Unfair Claim Settlement Practices Act and strike the one designated single line at the same time, and the other to pass a law requiring copayments for chiropractic, physical therapy, occupational and respiratory therapy be at the same level as they are for primary care physicians (PCPs). Please contact me at 602-368-9496 or ACS@AZChiropractors.org or our lobbyist Timothy LaSota at 602-515-2649 or TAL@tlaw.com to discuss your thoughts. Thank you very much in advance for your attention to this matter.

Alan M. Immerman, D.C.
President and Executive Director
ISSUE BRIEF

Conservative Care First:
A Strategy to Reduce the High Cost of Health Care

The cost of health care is becoming an ever-larger portion of the federal budget. In 2011, $2.7 trillion was spent on health care in America and $551 billion was spent on Medicare alone. We cannot sustain these rapidly increasing costs. The number of Medicare patients are growing as baby boomers enter retirement age and the care of patients with chronic conditions continue to drive increasing costs of health care. The average health care cost for all Medicare patients in 2006 was $8,344, but the average cost for the top 10 percent of Medicare patients was $48,200\(^1\). In May 2013, the Medicare Board of Trustees revealed the Medicare trust fund, as currently configured, will run out of money by 2026.

The rapidly increasing prevalence of chronic conditions is an important factor. In 1987, 31 percent of Medicare patients were treated for five (5) or more chronic conditions. In 1997, that number jumped to 40 percent and by 2002 the number had increased to more than 50 percent. An estimated 96 percent of Medicare spending in 2006 was for patients with multiple chronic conditions; 79 percent for those with 5 or more chronic conditions\(^2\).

The incidence of obesity doubled between 1987 and 2002, along with diabetes, hyperlipidemia and hypertension\(^3\). Obesity and diabetes are increasing in all age groups including children and adolescents. Seventy-two million Americans are obese, with estimated annual health care costs of $147 billion\(^4\). There are also more that 100 million chronic pain patients in the US according to the Institute of Medicine, with costs exceeding $635 billion annually\(^5\). These numbers continue to rise, showing a deterioration of Americans' health status, even as we continue to spend more and more on "health care." The truth is that we spend very little in the U.S. on "health care;" what we call health care is mostly "disease care" with services and expenditures largely focused on very expensive illness and symptom treatment. This focus must change to promote the use of safer and less expensive conservative care interventions first. We must encourage increased patient education and counseling on risk avoidance and health promotion strategies, including lifestyle modifications that are necessary to avoid or mitigate costly and debilitating chronic illnesses and diseases\(^6\).

Our health care system is overloaded and medical providers are stretched to see increasing numbers of patients. There are growing shortages in Primary Care Providers (PCP). We must change our approach to patient care. Provider shortages are predicted to increase dramatically but can be safely and effectively mitigated by using all available physician level health care providers at the top of their licenses\(^7\). Chiropractic Physicians are educated as conservative primary care providers who serve as portal of entry\(^8\) and perform many PCP services\(^9\) safely, efficiently and effectively. The full inclusion of doctors of chiropractic (DCs) in America's health care system can help to reduce health care costs, while maintaining excellent clinical outcomes and patient satisfaction levels and without rationing care, reducing access or excluding large segments of America's population.

Changing health care to the conservative-care-first (CCF) approach of Chiropractic Physicians, and increasing the nation's focus on health promotion, prevention and wellness, will achieve major reductions in health care costs – but this will require significant changes in America's health care delivery and the culture of our health care system. With the decline in Americans' health status, the increase in chronic conditions, the worsening shortage of primary care providers, and rapidly escalating health care costs, significant changes are critical. Authors Marvasti and Stafford note there is a need for "transformational change," a "fundamental reordering of our health care system" and "reengineering prevention into health care"\(^6,10\). But how can this be done?

The major cost drivers in health care are largely related to our approach to treating chronic pain and diseases. We can effectively reduce expensive, high risk cost drivers by reducing the use of unnecessary and/or excessive services\(^11\): surgeries (e.g. spine surgeries\(^10,12\)), invasive procedures (e.g. spinal injections)\(^10,13\), hospital admissions and readmissions\(^14,15\), prescription drugs (e.g. opioids and NSAIDS)\(^14,16,17,18\), diagnostic imaging (e.g. MRIs and
and other diagnostic testing, as well as related hospital infections, surgical/hospital mistakes, prescription drug adverse events, and follow-up care necessitated by mistakes and adverse events. Considerable cost savings will accrue with maximum elimination of the unnecessary and/or excessive portion of these major cost drivers. This can be facilitated by transitioning to a conservative-care-first model of health care. This model will focus patient care first on conservative diagnostic testing and treatment, offered in an out-patient setting, directed toward whole-person wellness — providing an appropriate trial of conservative care (non-drug, non-surgical approach) and incorporating health promotion and wellness counseling (and coaching) from the start of care.

CCF providers must be placed on the front line of health care wherever practical; it is here that these providers can have the greatest impact on changing the focus of patient care — from symptom and disease treatment to promotion of lifestyle modification, chronic disease prevention and whole-person wellness. CCF providers deliver essential services, as defined by §1302 of the Patient Protection and Affordable Care Act (PPACA); they examine, diagnose and set care plans that employ the best conservative options and refer to other providers when patients present with acute medical emergencies or when conservative options are not readily available or appropriate. Optimal savings will be achieved by employing more conservative, less risky and less expensive options - first. The logical first step to jumpstart this important transformation to a CCF approach is to fully employ well established and broadly available CCF providers on the front line of health care.

The CCF approach will not be the only change necessary to improve health care and reduce related costs but this change alone will offer a significant step in the right direction. The use of broadly available Chiropractic Physicians as CCF providers can foster significant improvements in patient-centered care and can significantly reduce health care costs. This approach will ensure more patients receive a trial of conservative care before more costly and higher-risk procedures and interventions are attempted. This approach will also help to reduce the burden on PCP and specialty provider resources, improving access to these valuable resources for patients who truly require more invasive and/or expensive interventions.

Providing patients with the opportunity to choose a CCF provider, and indeed encouraging and directing patients to make this choice, will have a swift and definitive impact on how care is delivered — effectively changing the focus and reducing the cost of health care. Engaging patients earlier, and more often, with good health habits and whole-person health care strategies can improve patients' short and long term health and the viability of our health care system in America.

The Institute of Medicine has estimated that approximately 75 percent of our health care dollars are spent to treat patients with chronic conditions; $635 billion is spent on chronic pain patients alone. The National Center for Chronic Disease Prevention and Health Promotion (CDC) has noted that a large number of chronic conditions are lifestyle related — due to poor health habits — perhaps as many as 80 percent. These chronic conditions can be avoided or mitigated by modifying a patient's lifestyle and teaching them good health habits. As physician level CCF providers, DCs are well educated and experienced to fill this transformational role safely and effectively. Some DCs may be used as PCPs for spine care or musculoskeletal conditions, while others may be used as conservative/CAM PCPs for general health counseling and coordination of care. These strategic uses of Chiropractic Physicians will ensure the maximum application of a conservative-care-first approach and result in significant cost savings and will begin to make much needed changes in the focus of America's health care.

A 15-20 percent reduction in America's health care costs would result in $400-500 billion in annual savings. Such significant savings may be achieved with the CCF approach. Studies have shown large savings with use of DCs as first contact doctors. Patients were given the choice of consulting a DC or MD as their Primary Care Provider in AMI studies, those who chose a DC were assured a CCF, whole-person, non-drug, non-surgical approach when appropriate, and referral when necessary. The AMI studies showed 40-50 percent savings on prescription drugs, surgeries, hospital admissions and hospital stays for patients who chose DCs as their PCPs. Another study on a large population of patients in Tennessee showed 20 percent reduction in cost of care for patients with low back pain when they chose to see a DC first, compared to those patients who saw an MD first. The CCF approach is patient-centered, rational and doable and it holds great potential for reducing America's health care costs. Current access and coverage restrictions placed unilaterally on non-MD/DO providers (and their services) reduces patient choice and increases costs overall.
TALKING POINTS

Chiropractic Physicians: A Low Cost Solution to High Cost Healthcare

Numerous studies have shown that services delivered by doctors of chiropractic (DC) are cost effective and safe. The following are excerpts from several of these studies. By examining the research which demonstrates the cost savings associated with the services delivered by doctors of chiropractic, you will find that these services offer tremendous potential in meeting today’s health care challenges. The results suggest that insurance companies that restrict access to doctors of chiropractic may, inadvertently, be paying more for care than if they removed these restrictions.

✓ A 2012 study published in the Annals of Internal Medicine found that patients with acute and subacute neck pain found spinal manipulation therapy provided by DCs more effective than medication in both the short and long term.  

✓ A 2010 study evaluating data from Blue Cross Blue Shield of Tennessee found that risk-adjusted costs for low back pain episodes of care initiated with a DC were 20 percent less costly than episodes initiated through a medical doctor.  

✓ A 2010 study at the University of British Columbia found that guidelines-based care which included spinal manipulation provided by a DC was significantly more effective than “usual care” provided by medical physicians for patients with lower back pain of less than 16 weeks duration.  

✓ A 2009 Milstein and Choudhry report stated “...when considering effectiveness and cost together, chiropractic physician care for low back and neck pain is highly cost effective, [and] represents a good value in comparison to medical physician care...”  

✓ A study published in 2004 showed that patients enrolled in an HMO network using DC’s as primary care physicians experienced significantly fewer hospital visits, spent less time in a hospital for care, underwent fewer surgeries and used far fewer pharmaceuticals than other HMO patients who received traditional medical care. These findings were confirmed in a 2007 follow up study.  

✓ A 2004 study published in the British Medical Journal concluded that spinal manipulation would be “a cost-effective addition to ‘best care’ for back pain in general practice.”  

✓ According to a 2004 article in the Spine Journal, spinal manipulative treatment for both chronic and acute lower back pain was more effective in providing short-term relief than many other types of care, including prescription drugs, physical therapy and home exercise.  

3 Bishop PB, Quon JA, Fisher CG, Dvorak MF. The Chiropractic Hospital-based Interventions Research Outcomes Study: a randomized controlled trial on the effectiveness of clinical practice guidelines in the medical and chiropractic management of patients with acute mechanical low back pain. Spine Journal, 2010  
Millions of patients can significantly reduce the cost of their health care with the CCF approach, while achieving excellent clinical outcomes and high patient satisfaction. Using Chiropractic Physicians and the CCF approach to patient care presents a significant solution strategy for America’s health care challenges.

References Cited:
2. Responding to the Growing Cost and Prevalence of People with Multiple Chronic Conditions, Gerard Anderson, PhD, Johns Hopkins Bloomberg School of Public Health, 2007
5. Relieving Pain in America—A Blueprint for Transforming Prevention, Care, Education and Research, Institute of Medicine, June 2011
7. Patient Protection and Affordable Care Act (ACA); Sec. 2706, Non-Discrimination in Health Care
8. Educational Standards; Council on Chiropractic Education (CCE); 2013
9. Practice Analysis of Chiropractic; National Board of Chiropractic Examiners; 2010
11. Squandering Medicare’s Money, Rita F. Redberg, Editor Archives of Internal Medicine, San Francisco, May 2011
12. MRI Abundance May Lead to Excess in Back Surgeries (Study Shows), Welsh J, Stanford University School of Medicine, Oct. 14, 2009.
15. Adverse Events in Hospitals: National incidents among Medicare beneficiaries, Department of Health and Human Services, Office of Inspector General, Daniel R. Levinson, November 2010
18. Epidemic: Responding to America’s Prescription Drug Abuse Crisis, Executive Office of the President, 2011
21. Hospital Incident Reporting Systems Do Not Capture Most Patient Harm, Daniel J. Levinson, Department of Health and Human Services, Office of Inspector General, January 2012
23. Incidence and Preventability of Adverse Drug Events Among Older Persons in the Ambulatory Setting, Gurwitz J. H., JAMA 289 (9): 1107-1116
24. Patient Protection and Affordable Care Act (ACA); Sec. 1302, Essential Health Benefits Requirements
25. National Center for Chronic Disease Prevention and Health Promotion (CDC); The Power of Prevention-Chronic Disease... the Public Health Challenge of the 21st Century; 2009
26. A Hospital-Based Standardized Spine Care Pathway: Report of a Multidisciplinary, Evidence-Based Process, Ian Palkowski, DC, Michael Schneider, DC, PhD, Joel Stevans, DC, John Ventura, DC, and Brian D. Justice, DC, JIMT February 2011.

Other References:
34. Chiropractic Summit Partners; American Chiropractic Association, Association of Chiropractic Colleges, Congress of Chiropractic State Associations, International Chiropractors Association, et al; Consensus Document-Doctors of Chiropractic Can Improve the U.S. Primary Care Workforce Challenge; 2010
PERMANENT INJUNCTION ORDER AGAINST THE AMERICAN MEDICAL ASSOCIATION AUGUST 27, 1987

Susan Getzendanner United States District Judge August 27, 1987
Permanent Injunction Order against AMA
IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION
AMERICAN MEDICAL ASSOCIATION, et al., Defendants.
No. 76 C 3777

The court conducted a lengthy trial of this case in May and June of 1987 and on August 27, 1987, issued a 101-page opinion finding that the American Medical Association ("AMA") and its members participated in a conspiracy against chiropractors in violation of the nation's antitrust laws. Thereafter on opinion dated September 25, 1987 was substituted for the August 27, 1987 opinion. The question now before the court is the form of injunctive relief that the court will I order.

As part of the injunctive relief to be ordered by the court against the AMA, the AMA shall be required to send a copy of this Permanent Injunction Order to each of its current members. The members of the AMA are bound by the terms of the Permanent Injunction Order if they act in concert with the AMA to violate the terms of the order. Accordingly, it is important that the AMA members understand the order and the reasons why the order has been entered.

A. The AMA's Boycott and Conspiracy

In the early 1960s, the AMA decided to contain and eliminate chiropractic as a profession. In 1963 the AMA's Committee on Quackery was formed. The committee worked aggressively -- both overtly and covertly -- to eliminate chiropractic. One of the principal means used by the AMA to achieve its goal was to make it unethical for medical physicians to professionally associate with chiropractors. Under Principle 3 of the AMA's Principles of Medical Ethics, it was unethical for a physician to associate with an "unscientific practitioner," and in 1966 the AMA's House of Delegates passed a resolution calling chiropractic an unscientific cult. To complete the circle, in 1967 the AMA's Judicial Council issued an opinion under Principle 3 holding that it was unethical for a physician to associate professionally with chiropractors.

The AMA's purpose was to prevent medical physicians from referring patients to chiropractors and accepting referrals of patients from chiropractors, to prevent chiropractors from obtaining access to hospital diagnostic services and membership on hospital medical staffs, to prevent medical physicians from teaching at chiropractic colleges or engaging in any joint research, and to prevent any cooperation between the two groups in the delivery of health care services. (Note: The AMA also tried to persuade insurers, especially BCBS plans, not to cover chiropractic.)

The AMA believed that the boycott worked -- that chiropractic would have achieved greater gains in the absence of the boycott. Since no medical physician would want to be considered unethical by his peers, the success of the boycott is not surprising. However, chiropractic achieved licensing in all 50 states during the existence of the Committee on Quackery.

The Committee on Quackery was disbanded in 1975 and some of the committee's activities become publicly known. Several lawsuits were filed by or on behalf of
chiropractors and this case was filed in 1976.

B. Change in AMA's Position on Chiropractic

In 1977, the AMA began to change its position on chiropractic. The AMA's Judicial Council adopted new opinions under which medical physicians could refer patients to chiropractors, but there was still the proviso that the medical physician should be confident that the services be provided on referral would be performed in accordance with accepted scientific standards. In 1979, the AMA's House of Delegates adopted Report UU which said that not everything that a chiropractor may do is without therapeutic value, but it stopped short of saying that such things were based on scientific standards. It was not until 1980 that the AMA revised its Principles of Medical Ethics to eliminate Principle 3. Until Principle 3 was formally eliminated, there was considerable ambiguity about the AMA's position. The ethics code adopted in 1980 provided that a medical physician "shall be free" to choose whom to serve, with whom to associate, and the environment in which to provide medical services."

The AMA settled three chiropractic lawsuits by stipulating and agreeing that under the current opinions of the Judicial Council a physician may, without fear of discipline or sanction by the AMA, refer a patient to a duly licensed chiropractor when he believes that referral may benefit the patient. The AMA confirmed that a physician may also choose to accept or to decline patients sent to him by a duly licensed chiropractor. Finally, the AMA confirmed that a physician may teach at a chiropractic college or seminar. These settlements were entered into in 1978, 1980, and 1986.

The AMA's present position on chiropractic, as stated to the court, is that it is ethical for a medical physician to professionally associate with chiropractors provided the physician believes that such association is in the best interests of his patient. This position has not previously been communicated by the AMA to its members.

C. Antitrust Laws

Under the Sherman Act, every combination or conspiracy in restraint of trade is illegal. The court has held that the conduct of the AMA and its members constituted a conspiracy in restraint of trade based on the following facts:

*The purpose of the boycott was to eliminate chiropractic; chiropractors are in competition with some medical physicians; the boycott had substantial anti-competitive effects; there were no pro-competitive effects of the boycott; and the plaintiffs were injured as a result of the conduct. These facts add up to a violation of the Sherman Act.*

In this case, however, the court allowed the defendants the opportunity to establish a "patient care defense" which has the following elements: (1) that they genuinely entertained a concern for what they perceive as scientific method in the care of each person with whom they have entered into a doctor-patient relationship; (2) that this concern is objectively reasonable; (3) that this concern has been the dominant motivating factor in defendants' promulgation of Principle 3 and in the conduct intended to implement it; and (4) that this concern for scientific method in patient care could not have been adequately satisfied in a manner less restrictive of competition.
The court concluded that the AMA had a genuine concern for scientific methods in patient care, and that this concern was the dominant factor in motivating the AMA's conduct. However, the AMA failed to establish that throughout the entire period of the boycott, from 1966 to 1980, this concern was objectively reasonable. The court reached that conclusion on the basis of extensive testimony from both witnesses for the plaintiffs and the AMA that some forms of chiropractic treatment are effective and the fact that the AMA recognized that chiropractic began to change in the early 1970s. Since the boycott was not formally over until Principle 3 was eliminated in 1980, the court found that the AMA was unable to establish that during the entire period of the conspiracy its position was objectively reasonable. Finally, the court ruled that the AMA's concern for scientific method in patient care could have been adequately satisfied in a manner less restrictive of competition and that a nationwide conspiracy to eliminate a licensed profession was not justified by the concern for scientific method. On the basis of these findings, the court concluded that the AMA had failed to establish the patient care defense.

None of the court's findings constituted a judicial endorsement of chiropractic. All of the parties to the case, including the plaintiffs, and the AMA, agreed that chiropractic treatment of diseases such as diabetes, high blood pressure, cancer, heart disease and infectious disease is not proper, and that the historic theory of chiropractic, that there is a single cause and cure of disease was wrong. There was disagreement between the parties as to whether chiropractors should engage in diagnosis. There was evidence that the chiropractic theory of subluxations was unscientific, and evidence that some chiropractors engaged in unscientific practices. The court did not reach the question of whether chiropractic theory was in fact scientific. However, the evidence in the case was that some forms of chiropractic manipulation of the spine and joints were therapeutic. AMA witnesses, including the present Chairman of the Board of Trustees of the AMA, testified that some forms of treatment by chiropractors, including manipulation, can be therapeutic in the treatment of conditions such as back pain syndrome.

D. Need for Injunctive Relief

Although the conspiracy ended in 1980, there are lingering effects of the illegal boycott and conspiracy which require an injunction. Some medical physicians' individual decisions on whether or not to professionally associate with chiropractors are still affected by the boycott. The injury to chiropractors' reputations which resulted from the boycott has not been repaired. Chiropractors suffer current economic injury as a result of the boycott. The AMA has never affirmatively acknowledged that there are and should be no collective impediments to professional association and cooperation between chiropractors and medical physicians, except as provided by law. Instead, the AMA has consistently argued that its conduct has not violated the antitrust laws.

Most importantly, the court believes that it is important that the AMA members be made aware of the present AMA position that it is ethical for a medical physician to professionally associate with a chiropractor if the physician believes it is in the best interests of his patient, so that the lingering effects of the illegal group boycott against chiropractors finally can be dissipated.

Under the law, every medical physician, institution, and hospital has the right to make an individual decision as to whether or not that physician, institution, or hospital shall associate professionally with chiropractors. Individual choice by a medical physician voluntarily to associate professionally with chiropractors should be governed only by restrictions under state law, if any, and by the individual medical physician's personal
judgment as to what is in the best interests of a patient or patients. Professional association includes referrals, consultations, group practice in partnerships, Health Maintenance Organizations, Preferred Provider Organizations, and other alternative health care delivery systems; the provision of treatment privileges and diagnostic services (including radiological and other laboratory facilities) in or through hospital facilities; association and cooperation in educational programs for students in chiropractic colleges; and cooperation in research, health care seminars, and continuing education programs.

An injunction is necessary to assure that the AMA does not interfere with the right of a physician, hospital, or other institution to make an individual decision on the question of professional association.

E. Form of Injunction

1. The AMA, its officers, agents and employees, and all persons who act in active concert with any of them and who receive actual notice of this order are hereby permanently enjoined from restricting, regulating or impeding, or aiding and abetting others from restricting, regulating or impeding, the freedom of any AMA member or any institution or hospital to make an individual decision as to whether or not that AMA member, institution, or hospital shall professionally associate with chiropractors, chiropractic students, or chiropractic institutions.

2. This Permanent Injunction does not and shall not be construed to restrict or otherwise interfere with the AMA's right to take positions on any issue, including chiropractic, and to express or publicize those positions, either alone or in conjunction with others. Nor does this Permanent Injunction restrict or otherwise interfere with the AMA's right to petition or testify before any public today on any legislative or regulatory measure or to join or cooperate with any other entity in so petitioning or testifying. The AMA's membership in a recognized accrediting association or society shall not constitute a violation of this Permanent Injunction.

3. The AMA is directed to send a copy of this order to each AMA member and employee, first class mail, postage prepaid, within thirty days of the entry of this order. In the alternative, the AMA shall provide the Clerk of the Court with mailing labels so that the court may send this order to AMA members and employees.

4. The AMA shall cause the publication of this order in JAMA (the Journal of the American Medical Association) and the indexing of the order under "Chiropractic" so that persons desiring to find the order in the future will be able to do so.

5. The AMA shall prepare a statement of the AMA's present position on chiropractic for inclusion in the current reports and opinions of the Judicial Council with an appropriate heading that refers to professional association between medical physicians and chiropractors, and indexed in the some manner that other reports and opinions are indexed. The court imposes no restrictions on the AMA's statement but only requires that it be consistent with the AMA's statements of its present position to the court.

6. The AMA shall file a report with the court evidencing compliance with this order on or before January 10, 1988.
It is so ordered.

August 27, 1987

Susan Getzendanner
United States District Judge
Chiropractic Antitrust Suit Wilk, et al., v. AMA, et al. 39

(Emphasis added.)