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14 Attorneys for Plaintiff

15 UNITED STATES DISTRICT COURT  
16 SOUTHERN DISTRICT OF CALIFORNIA

17 ALEXANDER ROSENSTEIN, M.D., )  
18 Individually and on Behalf of All Others )  
Similarly Situated, )

19 Plaintiff, )

20 vs. )

21 AMERICAN BOARD OF )  
22 ORTHOPAEDIC SURGERY and )  
AMERICAN BOARD OF MEDICAL )  
23 SPECIALTIES, )

24 Defendants. )

Case No. **'19CV1754 GPC WVG**

CLASS ACTION

COMPLAINT FOR VIOLATIONS OF  
THE SHERMAN ANTITRUST ACT  
AND CALIFORNIA BUSINESS &  
PROFESSIONS CODE §§16700, *et*  
*seq.* AND 17200, *et seq.*

DEMAND FOR JURY TRIAL

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27  
28

1 Plaintiff Alexander Rosenstein, M.D. (“plaintiff”), individually and on behalf of  
2 all those similarly situated, brings this action for treble damages and injunctive relief  
3 against defendants for violations of the Sherman Antitrust Act (“Sherman Act”),  
4 California’s Cartwright Act (“Cartwright Act”) and California’s Unfair Competition  
5 Law (“UCL”).<sup>1</sup> Based on counsel’s investigation, research and review of publicly  
6 available documents, on plaintiff’s personal knowledge, and upon information and  
7 belief, plaintiff alleges as follows:

### 8 NATURE OF THE ACTION

9 1. For years ABMS and its member boards, including ABOS, have abused  
10 and continue to abuse their dominant position within the American medical  
11 community, receiving massive, illegally obtained revenue through anticompetitive  
12 means. Not only has their conduct been at the expense of physicians nationwide, it  
13 has sharply curtailed, if not eliminated, fair competition in the field of medical  
14 specialty certification maintenance.

15 2. In addition to obtaining a license to practice medicine from the states in  
16 which they practice and other state-mandated requirements, physicians obtain one or  
17 more industry-specific certifications in a particular specialization within the field of  
18

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19 <sup>1</sup> Defendants include the American Board of Medical Specialties (“ABMS”) and the  
20 following certifying medical specialty board that ABMS encompasses: the American  
21 Board of Orthopaedic Surgery (“ABOS”). In addition to this board, ABMS also  
22 consists of 23 more certifying medical specialty boards that are also co-conspirators  
23 with defendants. These ABMS member boards include: the American Board of  
24 Obstetrics and Gynecology; the American Board of Dermatology; the American  
25 Board of Allergy and Immunology; the American Board of Colon and Rectal Surgery;  
26 the American Board of Family Medicine (a/k/a American Board of Family Practice);  
27 the American Board of Internal Medicine; the American Board of Medical Genetics  
28 and Genomics; the American Board of Neurological Surgery; the American Board of  
Nuclear Medicine; the American Board of Ophthalmology; the American Board of  
Anesthesiology; the American Board of Emergency Medicine; the American Board of  
Otolaryngology - Head and Neck Surgery; the American Board of Pathology; the  
American Board of Pediatrics; the American Board of Physical Medicine and  
Rehabilitation; the American Board of Plastic Surgery; the American Board of  
Preventive Medicine; the American Board of Psychiatry and Neurology; the American  
Board of Radiology; the American Board of Surgery; the American Board of Thoracic  
Surgery; and the American Board of Urology. ABMS and all of its member boards  
are collectively referred to herein as “ABMS.”

1 medicine. This is called Initial Board Certification (“board certification” or “IBC”).  
2 The purpose of IBC is to indicate that, beyond meeting state licensing requirements, a  
3 board certified doctor also has demonstrated the skill, knowledge and ability to  
4 practice the medical specialty for which he or she is certificated.

5 3. More than 29,000 licensed physicians are members of ABOS, and  
6 approximately 90% of the over 880,000 licensed physicians in the United States are  
7 board certified in at least one medical specialty by ABMS, which, as the dominant  
8 seller of IBC through its member boards, including ABOS, has monopoly power in  
9 the IBC market.

10 4. Far beyond being simply a voluntary act taken by some doctors to  
11 demonstrate a specific medical skill or to distinguish themselves from other doctors,  
12 board certification has evolved to become an essential component of a physician’s  
13 commercial practice. Indeed, it has become a *de facto* requirement for meaningful  
14 participation in the commercial practice of medicine. Fully licensed doctors  
15 authorized to practice medicine cannot expect to maintain a commercial practice,  
16 including the core requirements that they be able to maintain hospital admitting  
17 privileges, maintain malpractice insurance and, perhaps more importantly, treat a  
18 majority of the commercially insured patients in the United States, without being  
19 board certified. Thus, failure by physicians to maintain their board certification is  
20 likely to have devastating effects on their livelihood, income and ability to practice  
21 medicine. Defendants’ conduct also has the attendant effect of depriving patients of  
22 choice in service providers.

23 5. In addition to selling IBC, ABOS and other ABMS member boards  
24 requires that board-certificated doctors also maintain their IBC by purchasing  
25 “maintenance of certification” or “MOC” from ABOS or the ABMS member boards.  
26 Failure to purchase MOC results in loss of certification, regardless of a physician’s  
27 skill or ability within their given specialty. Indeed, purchasing MOC from a provider  
28 other than ABOS or other ABMS member boards results in loss of IBC because the





1 and Biomedical Engineering at the University of Texas. He has written numerous  
2 peer-reviewed scholarly articles and won many awards relating to the practice of  
3 medicine generally and orthopaedic surgery specifically. Throughout his career, he  
4 has both continuously practiced and held various esteemed positions, including,  
5 among others: (1) at the South Coast Medical Center in Laguna Beach, California, he  
6 was the Chief of Staff, the Director of the Hospital Governing Board, the Chairman of  
7 the Department of Surgery, and the Chairman of the Division of Orthopaedic Surgery;  
8 (2) at Texas Tech in Lubbock, Texas, he was the Chief of the Adult Reconstruction  
9 Division, an Associate Clinical Chair of the Department of Orthopaedic Surgery, and  
10 the Director of Adult Reconstruction Fellowship; (3) at Memorial Hermann Hospital  
11 in Houston, Texas, he was the Director of Adult Reconstruction, the Physician Leader  
12 for OR Orthopaedic Surgery, an Associate Chair of the Department of Orthopaedic  
13 Surgery, and the Director of the Adult Reconstruction Fellowship; (4) at the  
14 Charleston Area Medical Center in West Virginia, he was the Director of Orthopaedic  
15 Reconstructive Surgery and the Director of the Adult Reconstruction Fellowship; and  
16 (5) at the Kona Community Hospital in Hawaii, he is the Director of Orthopaedic  
17 Reconstructive Surgery. Over the course of his career, Dr. Rosenstein has taught  
18 hundreds of residents, if not more, on techniques specific to orthopaedic surgery and  
19 on being a medical professional in general. He is intimately involved with what is  
20 required to be an orthopaedic surgeon and what is required from a practice and  
21 educational standpoint to maintain a high quality standard of care. Dr. Rosenstein  
22 currently is a resident of Hawaii, but has also lived in California, West Virginia and  
23 Texas during his professional career.

24 14. Defendant American Board of Orthopaedic Surgery is a non-profit  
25 organization that became an ABMS member in 1935. With more than 29,000 Board  
26 Certified Orthopaedic Surgeons in the United States (more than a thousand of which  
27 reside in California), it has one of the largest memberships of any Board in the  
28

1 country. ABOS is headquartered at 400 Silver Cedar Court in Chapel Hill, North  
2 Carolina.

3 15. Defendant American Board of Medical Specialties is a nationally  
4 recognized non-profit organization that sets the standards for and certifies doctors as  
5 capable in specified medical specialties and subspecialties, as described herein,  
6 through its 24 member boards. ABMS is headquartered in Chicago, Illinois.

### 7 **FACTUAL ALLEGATIONS**

8 16. To practice medicine in the United States, physicians and surgeons are  
9 required to have obtained an MD degree, pass the U.S. Medical Licensing  
10 Examination (“USMLE”), and obtain a license granted by their individual state  
11 licensing board. The USMLE uniformly serves the function for all states of assessing  
12 physician readiness and ability to practice medicine (as the USMLE describes it, the  
13 “ability to apply knowledge, concepts, and principles, and to demonstrate fundamental  
14 patient-centered skills, that are important in health and disease and that constitute the  
15 basis of safe and effective patient care”)<sup>2</sup> and “ensur[ing] that all licensed MDs . . .  
16 pass[] the same assessment standards – no matter in which school or which country  
17 they had trained.”<sup>3</sup>

18 17. In addition, all but five states have a minimum continuing medical  
19 education (“CME”) requirement for physicians to maintain their licenses “in order to  
20 ensure the continuing competence of licensed physicians and surgeons.”<sup>4</sup>

21 <sup>2</sup> *About USMLE*, USMLE, <https://www.usmle.org> (last visited Sept. 11, 2019).

22 <sup>3</sup> *Why One National Examination?*, USMLE, <https://www.usmle.org/about/> (last  
23 visited Sept. 11, 2019). The USMLE’s purpose is to provide “high-quality  
24 assessments across the continuum of physicians’ preparation for practice,” including  
25 “provid[ing] to licensing authorities meaningful information from assessments of  
26 physician characteristics – including medical knowledge, skills, values, and attitudes.”  
27 *USMLE Mission Statement*, USMLE, <https://www.usmle.org/about/> (last visited Sept.  
28 11, 2019).

<sup>4</sup> *See, e.g.*, Cal. Bus & Prof. Code §2190; *see also, e.g.*, Title 22 Tex. Admin. Code  
§166.2 (2019); Oregon Medical Board, Ch. 847, Div. 8, 847-008-0070, Continuing  
Medical Competency (Education), [https://secure.sos.state.or.us/oard/viewSingleRule.  
action?ruleVrsnRsn=238932](https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=238932) (last visited Sept. 11, 2019).

1 18. Alongside state licensing of physicians, board certification is an industry-  
2 centric private process whereby physicians can obtain one or more certifications in a  
3 particular specialization within the field of medicine from a group of experts in that  
4 specialization. For example, in addition to being a licensed physician, a doctor might  
5 be certified in internal medicine, medical oncology, geriatric medicine and/or any one  
6 of a number of additional specialties and subspecialties. The purpose of IBC is to  
7 indicate that, beyond meeting state-mandated licensing requirements, a physician has  
8 also demonstrated distinct skills, knowledge and abilities to practice a medical  
9 specialty in a particular field of medicine.

10 19. Currently, approximately 90% of all licensed physicians in the United  
11 States – over 880,000 doctors – are board certified in at least one medical specialty.<sup>5</sup>  
12 ABMS is the dominant provider of IBC in the United States.

13 20. The value of specialty certification initially stems from its information-  
14 providing function, something particularly helpful in an industry like healthcare in  
15 which consumers may largely have incomplete information concerning doctor quality  
16 and skills, as well as its potential pro-competitive effects. As the U.S. Department of  
17 Justice (“DOJ”) states, “certification can signal that a practitioner has distinct skills,  
18 knowledge, and abilities to practice a specialty that go beyond licensing.”<sup>6</sup> The DOJ  
19 continues, explaining:

20 That signal can promote specialization, choice, and competition. For  
21 example, a consumer with specialized needs can more efficiently search  
for providers who have signaled expertise in the relevant specialty. In

22 <sup>5</sup> See Trisha Torrey, *What Is Medical Board Certification?*, <https://www.verywellhealth.com/what-is-medical-board-certification-2615005> (last visited Sept.  
23 11, 2019); see also ABMS News Release, *American Board of Medical Specialties  
24 Releases Updated Board Certification Report* (Oct. 3, 2017) (“More than 880,000  
25 physicians are board certified . . .”). The remaining non-certified but licensed  
doctors generally engage in research or academia, or treat cash-paying or government  
insured patients.

26 <sup>6</sup> Letter from Robert Potter, Chief Competition Policy & Advocacy Section, U.S.  
27 Department of Justice, to Dan K. Morhaim, M.D., Maryland House of Delegates, at 10  
28 (Sept. 10, 2018), [https://mhcc.maryland.gov/mhcc/pages/home/workgroups/  
documents/moc/DOJ\\_Letter.pdf](https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/moc/DOJ_Letter.pdf) (last visited Sept. 11, 2019).

1 turn, a provider may attract more consumers or charge a premium  
2 reflecting the value of the specialized service, and that premium may  
3 encourage other providers to pursue that specialty and offer services in  
4 that narrower market. Certifications can also signal enhanced quality,  
5 perhaps by certifying that a provider has demonstrated a certain level of  
6 training, testing, or experience over and above other providers. That  
7 signal can help consumers distinguish among providers for the same  
8 service based on the quality of service they expect to receive. This  
9 ability to distinguish may provide higher quality providers an incentive  
10 to invest in higher quality care.<sup>7</sup>

11 21. However, in the context of IBC, the DOJ has expressed specific  
12 competition-related concerns:

13 Private certifying bodies . . . can raise competition concerns under  
14 certain circumstances. Certifying bodies are frequently governed by  
15 active market participants. Because, like other forms of professional  
16 standards-setting, certification can become a de facto requirement for  
17 meaningful participation in certain markets, a certification requirement  
18 may create a barrier to entry. In such circumstances, certification may  
19 function more like licensing requirements – establishing who can and  
20 cannot participate in a market – rather than voluntary certification that  
21 can help patients and others distinguish on quality among a range of  
22 providers.<sup>8</sup>

23 22. The DOJ continues:

24 The more certification comes to resemble licensing, the more such  
25 industry self-regulation raises similar concerns. For example, as the U.S.  
26 Supreme Court has explained, though market participants offer important  
27 and needed experience and expertise about their practice and profession,  
28 such professionals, when empowered to set licensing requirements  
without meaningful review, “may blend [ethical motives] with private  
anticompetitive motives in a way difficult even for market participants to  
discern.” Similarly, competitive concerns can arise when private  
standard-setting processes become “biased by members with economic  
interests in restraining competition.” The governing members of a  
dominant certifying body may have incentives to set certification  
requirements more stringently than is necessary to certify that providers  
have the relevant knowledge and skills. In situations where one  
certifying body has become dominant, such that physicians cannot turn  
to alternative bodies for a similar certifying function, market forces  
might not constrain the dominant body from acting on these incentives.  
If requirements artificially constrain the supply of certified providers and  
raise their costs, certification may limit competition among providers and

<sup>7</sup> *Id.*

<sup>8</sup> *Id.* at 10-11 (citing, e.g., *ABMS Board of Directors*, Am. Bd. of Med. Specialties (last visited Aug. 29, 2018), <https://www.abms.org/about-abms/governance/abms-board-of-directors/> (vast majority of board members are medical doctors); *Board of Directors*, Am. Bd. of Internal Med., <https://www.abim.org/about/governance/board-of-directors.aspx> (last visited Aug. 29, 2018) (same).

1 allow for providers to raise prices paid by payers and consumers. As this  
2 letter discusses further below, if competition among bona fide certifying  
3 bodies were to develop, that could provide a meaningful check on such  
4 incentives. Moreover, even where there is no effective competition  
5 among certifying bodies, incentives to raise barriers for physicians to  
6 practice medical specialties by setting unnecessarily stringent  
7 certification requirements could be circumscribed to the extent a  
8 certifying body has procedures in place to ensure that input is available  
9 from, and decision-making is vested in, groups that represent a balance  
10 among the various relevant stakeholders, including not only doctors, but  
11 also, potentially, hospitals, insurers, and patient advocacy groups.<sup>9</sup>

12 23. Implicating the very concerns raised by the DOJ, ABMS certification has  
13 become a foundational component of the practice of medicine in the United States. It  
14 is so essential, in fact, that a doctor who is fully licensed by their state and authorized  
15 by law to practice medicine but who is not also a board certified physician in their  
16 given specialty cannot expect to maintain a commercial practice, including  
17 maintaining hospital admission privileges, and, most significantly, treat a majority of  
18 the roughly 217 million commercially insured U.S. residents.<sup>10</sup>

19 24. ABMS is well aware of these requirements, acknowledging that:

20 Hospitals and health care groups . . . use a credentialing process  
21 that involves checking a physician’s Board Certification, education,  
22 training, experience, and other background information before granting  
23 practice privileges. Insurance companies, law firms, recruiters, and  
24 research organizations also regularly check Board Certification status for  
25 their particular purposes.<sup>11</sup>

26 25. Insurance companies place significant weight on, if not requiring or  
27 effectively requiring, board certification. By way of example, as relevant here, in

28 <sup>9</sup> *Id.* at 11-12 (citing *N.C. State Bd. of Dental Exam’rs v. FTC*, 574 U.S. 494, 135 S.  
Ct. 1101, 1111, 1115 (2015) (“State laws and institutions are sustained by this  
tradition when they draw upon the expertise and commitment of professionals.”); and  
*Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 501, 509 (1988)  
(noting that “private standards can have significant procompetitive advantages” if  
“procedures . . . prevent the standard-setting process from being biased by members  
with economic interests in stifling product competition”)).

<sup>10</sup> See Edward R. Berchick, *et al.*, *Health Insurance Coverage in the United States:  
2017*, U.S. Census Bureau, at 4, Table 1 (Sept. 2018), [https://www.census.gov/  
content/dam/Census/library/publications/2018/demo/p60-264.pdf](https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf) (last visited Sept.  
11, 2019).

<sup>11</sup> *Verify Certification*, ABMS, <https://www.abms.org/verify-certification> (last visited  
Sept. 11, 2019).

1 order to be considered for becoming an Anthem-credentialed healthcare provider,  
2 doctors are required to “have current, in force board certification (as defined by the  
3 American Board of Medical Specialties (‘ABMS’) . . .) in the clinical discipline for  
4 which they are applying.”<sup>12</sup> ABMS certification is also a central consideration of  
5 being credentialed for Aetna’s doctor network.<sup>13</sup> Cigna, likewise, requires board  
6 certification for application to its Medical Network Credentialing.<sup>14</sup>

7 26. The dominant entity providing specialty IBC to doctors in the United  
8 States is ABMS. ABMS was originally established in 1933 by a small organization of  
9 medical specialty boards and groups of physicians and medical educators. Its purpose  
10 was to develop “a national system of standards for recognizing specialists and  
11 providing information to the public.”<sup>15</sup> ABMS developed and oversees a uniform  
12 system for the administration of examinations designed to assess physician education,  
13 knowledge, experience and skill in given medical specialties.

14 27. In the years since its inception, ABMS has grown in the number of  
15 specialties for which it provides certification, as additional specialty boards were  
16 added to ABMS. All but six of the ABMS member boards joined ABMS by 1949.<sup>16</sup>

17  
18 <sup>12</sup> *Anthem Provider Administration – Credentialing and Maintenance*, Anthem Blue  
19 Cross and Blue Shield – Provider Manual (July 2016), [https://www11.anthem.com/  
20 provider/noapplication/f0/s0/t0/pw\\_b154811.pdf?refer=ahpprovider](https://www11.anthem.com/provider/noapplication/f0/s0/t0/pw_b154811.pdf?refer=ahpprovider) (last visited Sept.  
21 11, 2019).

22 <sup>13</sup> *Medical Credentialing, What does the Aetna doctor credentialing process involve?*,  
23 Aetna, <http://www.aetna.com/docfind/cms/assets/pdf/MedicalCredentialing.pdf> (last  
24 visited Sept. 11, 2019).

25 <sup>14</sup> *Cigna Medical Network Credentialing*, Cigna, [https://www.cigna.com/health-care-  
26 providers/credentialing/join-medical-network](https://www.cigna.com/health-care-providers/credentialing/join-medical-network) (last visited Sept. 11, 2019).

27 <sup>15</sup> *ABMS History of Improving Quality Care*, ABMS, [https://www.abms.org/about-  
28 abms/history](https://www.abms.org/about-abms/history) (last visited Sept. 11, 2019).

29 <sup>16</sup> American Board of Dermatology (1933), American Board of Obstetrics and  
30 Gynecology (1933), American Board of Ophthalmology (1933), American Board of  
31 Otolaryngology – Head and Neck Surgery (1933), American Board of Orthopaedic  
32 Surgery (1935), American Board of Pediatrics (1935), American Board of Psychiatry  
33 and Neurology (1935), American Board of Radiology (1935), American Board of  
34 Urology (1935), American Board of Internal Medicine (1936), American Board of  
35 Pathology (1936), American Board of Surgery (1937), American Board of

1 Five member boards joined in the ten years between 1969 and 1979.<sup>17</sup> The final  
2 member board joined in 1991.<sup>18</sup> Thus, for the majority of the twentieth century and, at  
3 least, for almost thirty years, ABMS has maintained a monopoly as the provider of  
4 medical specialty IBC in the United States. Today, ABMS certifies physicians in 40  
5 specialties and 87 subspecialties.<sup>19</sup>

6 28. ABMS's initial certification occurs after a physician completes residency  
7 training and generally requires that physicians complete four years of college or  
8 university premedical education, earn a medical degree from an ABMS-approved  
9 medical school, complete a three to seven-year ABMS-approved residency, provide  
10 attestation letters from the director and/or faculty of their residency program, and  
11 become licensed to practice medicine in their state. ABMS also requires that IBC  
12 candidates pass an ABMS exam in the specialty for which the physician seeks  
13 certification. Similarly, physicians seeking subspecialty certification must also  
14 complete ABMS-approved additional training during or after their residency, as well  
15 as successfully complete additional subspecialty-specific knowledge and clinical  
16 judgment assessments.

17 29. Historically, receiving certification was sufficient for board certification  
18 for the remainder of a physician's career. By the mid-1980s, ABOS and certain other  
19 ABMS member boards had begun to issue certifications for new applicants that

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22 Neurological Surgery (1940), American Board of Anesthesiology (1941), American  
23 Board of Plastic Surgery (1941), American Board of Physical Medicine and  
24 Rehabilitation (1947), American Board of Colon and Rectal Surgery (1949), and  
25 American Board of Preventive Medicine (1949).

24 <sup>17</sup> American Board of Family Medicine (1969), American Board of Allergy and  
25 Immunology (1971), American Board of Nuclear Medicine (1971), American Board  
26 of Thoracic Surgery (1971), and American Board of Emergency Medicine (1979).

26 <sup>18</sup> American Board of Medical Genetics and Genomics (1991).

27 <sup>19</sup> *ABMS Guide to Medical Specialties*, ABMS (2019), [https://www.abms.org/media/](https://www.abms.org/media/194925/abms-guide-to-medical-specialties-2019.pdf)  
28 [194925/abms-guide-to-medical-specialties-2019.pdf](https://www.abms.org/media/194925/abms-guide-to-medical-specialties-2019.pdf) (last visited Sept. 11, 2019).

1 required retesting after 10 years in order to maintain their certification. Physicians  
2 with lifetime certifications, however, were exempt from these requirements.

3 30. By the early 2000s, ABMS required all of its member boards to  
4 uniformly agree that, with the exception of lifetime certificate holders, certification  
5 would only be granted to physicians for limited time periods followed by mandatory  
6 retesting in order to maintain certification. In the years since then, the requirements  
7 for maintaining IBC have increased. As discussed above, failure to maintain  
8 certification is devastating to a physician’s ability to treat the vast majority of patients  
9 in the United States, and certainly would spell destruction for their medical practice.  
10 Indeed, the certification renewal requirements “effectively converted the ‘voluntary’  
11 aspect of board certification to a requirement to maintain hospital privileges and  
12 insurance panel participation and profoundly impact[] a physician’s ability to earn a  
13 living.”<sup>20</sup>

14 31. The ABOS certification renewal requirements became what is called  
15 Maintenance of Certification or MOC. Similar requirements exist for all ABMS  
16 member boards.

17 32. ABOS and all other ABMS board MOC began in the latter part of the  
18 twentieth century as a voluntary retesting. Very few physicians participated. In or  
19 around 2005, however, ABMS added more requirements to MOC for re-certification.  
20 MOC then required a minimum number of “MOC points” accumulated via  
21 “performance improvement projects and data collection exercises” as a prerequisite to  
22 the re-examination of physicians.<sup>21</sup> In the years that followed, ABMS and the member

23  
24 <sup>20</sup> Westby G. Fisher & Edward J. Schloss, *Medical specialty certification in the*  
25 *United States – a false idol?*, 47 J. of Interventional Cardiac Electrophysiology 37  
26 (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5045479/> (last visited Sept.  
27 11, 2019). These renewal requirements also have been described as the “watershed  
28 moment [that] forever changed the landscape of specialty certification from one that  
primarily served the needs of practicing physicians to one that threatened ‘uncertain  
consequences’ and mandated additional requirements designed in large part to serve  
the ethical views and ongoing financial needs of the Specialty Boards.” *Id.*

<sup>21</sup> *Id.*

1 boards expanded the number of required MOC points over shorter time periods.  
2 Moreover, failure to comply with defendants' MOC requirements would be publicly  
3 labeled as "not meeting MOC requirements" and would result in IBC revocation if  
4 not ultimately complied with.<sup>22</sup>

5 33. The cost of ABMS MOC requirements to maintain physician certification  
6 has grown exponentially. For example, "[t]he cost of participating in MOC in general  
7 medicine mushroomed 244% (or 16.3% per year) from \$795 in 2000 to \$1940 in  
8 2014. Similarly, the cost for subspecialty re-certification grew 257% (or 17.2% per  
9 year) over the same time period."<sup>23</sup> The top-earning specialties, which includes  
10 orthopaedic surgeons, bear even greater costs. As an example, "[a] recent cost  
11 analysis estimated general internists incur an average cost of \$23,607 (95% CI \$5380  
12 to \$66,383) and cardiac electrophysiologists incur an average cost of \$52,196 (95% CI  
13 \$9773 to \$115,916) in total MOC costs over 10 years."<sup>24</sup> These costs and fees are  
14 unchecked by any meaningful competition due to defendants' anticompetitive  
15 conduct.

16 34. ABOS and all other ABMS board MOC is not the same as state-  
17 mandated CME requirements, under which physicians are required by their licensing  
18 states to accumulate a minimum number of CME credits regularly over a number of  
19 years as part of maintaining their license to practice medicine. CME is a valuable part  
20 of continuing physician knowledge that enhances a physician's practice. MOC is a  
21 separate set of requirements imposed, not by the states, but by defendants on  
22 physicians in order for physicians to maintain their certifications.

23  
24 <sup>22</sup> *Id.* Significantly, "[t]hese new re-certification mandates were conceived or  
25 overseen by ABMS-imposed leadership officers of whom only 9% collectively had  
26 recertified in general medicine and 25% had recertified in any certified subspecialty."  
*Id.*

27 <sup>23</sup> *Id.*

28 <sup>24</sup> *Id.*

1           35. In the context of CME, ABMS MOC has been described as “add[ing]  
2 little more than an additional burden to physicians’ time and finances.”<sup>25</sup> It too, adds  
3 a meaningful burden to a doctor’s support staff, who must help track the ever-  
4 changing requirements and document compliance efforts. Research indicates no  
5 credible evidence that the ABMS program has led to patient outcome improvements  
6 since the MOC requirements’ inception.<sup>26</sup> Indeed, in relation to those physicians with  
7 lifetime certifications who maintain their ABMS specialty certifications without any  
8 participation in MOC, research indicates “no differences in outcomes for patients  
9 cared for by internists with time-limited or time-unlimited certification for any  
10 performance measure.”<sup>27</sup> Similarly, there is no evidence whatsoever of lesser  
11 performance by physicians who are “grandfathered in” and do not have to participate  
12 in MOC.

13           36. MOC does little to demonstrate whether a doctor is capable of practicing  
14 in his or her chosen field and does not evaluate his or her ability to take care of

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16 <sup>25</sup> *Id.* MOC is distinct in this regard from initial certification, which is unchallenged  
by plaintiff and the class.

17 <sup>26</sup> *Id.*; see also P.N. Fiorilli, *et al.*, *Association of Interventional Cardiology Board*  
18 *Certification and In-Hospital Outcomes of Patients Undergoing Percutaneous*  
19 *Coronary Interventions*, 63 *J. Am. Coll. Cardiology* 2904-05 (Apr. 1, 2014) (a study  
20 that examined the effect of physician certification status, including lapsed  
21 certification, on patient outcomes revealed no effect after coronary intervention); T.H.  
Lee, *Certifying the Good Physician, A Work in Progress*, 312 *J. Am. Med. Ass’n*  
2340-42 (Dec. 9, 2014) (according to two studies, re-certification and performance or  
quality measures are not associated).

22 <sup>27</sup> John H. Hayes, *et al.*, *Association Between Physician Time-Unlimited vs Time-*  
23 *Limited Internal Medicine Board Certification and Ambulatory Patient Care Quality*,  
24 312 *J. Am. Med. Ass’n* 2358 (Dec. 10, 2014). Importantly, there is no reconciling the  
25 purported justification by ABMS for mandatory MOC requirements in maintaining  
26 ABMS certification – “ensur[ing] better patient care through a physician’s  
27 participation in an ABMS MOC process which continually assesses and helps enhance  
28 professional medical knowledge, judgment, professionalism, clinical techniques, and  
communication skills” – with the fact that a significant number of physicians with  
initial board certifications – those with lifetime certifications that pre-date the MOC  
requirements – are exempt from the costs of MOC compliance, including fees,  
educational curriculum, testing and time costs. *ABMS Overview and FAQs*, ABMS  
(Jan. 2016), [https://www.abms.org/media/93956/abms-moc\\_overview\\_6-15.pdf](https://www.abms.org/media/93956/abms-moc_overview_6-15.pdf) (last  
visited Sept. 11, 2019).

1 patients. Rather it serves as a measure of who can afford to take the test, who is a  
2 good test-taker, and who has enough time to take away from their family and practice  
3 to prepare for the re-certifications.

4 37. ABOS's conduct in changing its requirements, in particular, demonstrates  
5 the miniscule value MOC has to practicing physicians. In the past years, ABOS has  
6 begun to provide alternate ways in which to complete certification where a physician  
7 is required to read materials given by the board and take a test on those materials.  
8 This alternative – which like the original testing does not squarely address whether  
9 adequate patient care is being given – clearly demonstrates that the original testing is  
10 of little value, otherwise why could it be replaced by a reading comprehension exam.

11 38. Physicians, as well, express dissatisfaction with defendants' MOC. For  
12 example, the following are attributed to “physicians representing various specialties  
13 across the U.S.”:

- 14 • “Board recertification has almost nothing to do with my daily  
15 work as a primary care physician. It is an angst-generating  
16 exercise in arcane minutiae that robs me of work and family time  
17 for little gain or benefit. In my opinion, it is academic extortion  
18 and a blatant money grab. Unless absolutely forced to because of  
19 business reasons, I hope not to recertify a third time as it is a  
20 painful experience that does not really help me or my patients.”
- 21 • “After starting the MOC process for family medicine, I realized  
22 there was no relevance to my current practice of medicine and that  
23 it was pure busy work and a waste of my time. Having recertified  
24 six times before taking the same test that residents fresh out of  
25 training were taking, I could not find any reason for the change.  
26 The certification board was assuming duties left to state licensure  
27 boards with a huge overreach grab for power. As I investigated  
28 further, the board could not supply me with a satisfactory  
explanation or real science to back up their claims. They were  
making a voluntary program mandatory with financial gain and  
power on their part as the real reason.”
- “Board certification used to be a mark of excellence, not a form  
of extortion, revenue generation and busywork. Maintenance of  
certification, with its practice improvement, patient voice, patient  
safety, and secured high-stakes examination, has no bearing on  
what happens in the examination room; there is zero impact on the  
actual care of patients. I have to recertify, otherwise I cannot  
maintain my insurance, hospital, or employment relationships; this  
is what makes it extortion”

- 1           •       “Board certification under ABMS is not essential to my practice  
2           of family medicine.”<sup>28</sup>

3           39.       Physicians are not averse to “lifelong learning.”<sup>29</sup> As an industry-leading  
4       cardiologist has stated in reference to the American Board of Internal Medicine’s  
5       MOC:

6                       We all support lifelong learning, but an excellent alternative to  
7                       MOC already exists: continuing medical education (CME). Currently,  
8                       medical licensure for physicians requires an annual minimum of  
9                       approximately 25 hours of CME, depending on the state. Physicians  
10                      accept this requirement because they perceive it as having value.  
11                      Organizations providing recognized CME programs are regulated by the  
12                      Accreditation Council for Continuing Medical Education, which requires  
13                      each CME offering to provide an “educational gap analysis,” a needs  
14                      assessment, information about speakers’ potential conflicts of interest,  
15                      and course evaluations, as well as meeting other performance standards.  
16                      ***CME offerings must compete with one another, and they therefore  
17                      provide choice.*** If physicians do not perceive value in a particular CME  
18                      offering, they will go elsewhere – a situation in stark contrast with the  
19                      ABIM monopoly on MOC.<sup>30</sup>

20           40.       The American Medical Association (“AMA”), likewise, has not remained  
21       silent on the subject. While the AMA “supports physician accountability, life-long  
22       learning and self-assessment,” in 2014 it adopted a “policy [that] outlines principles  
23       that emphasize the need for an evidence-based process that is evaluated regularly to  
24       ensure physician needs are being met and activities are relevant to clinical practice”:

- 25           •       MOC should be based on evidence and designed to identify  
26           performance gaps and unmet needs, providing direction and  
27           guidance for improvement in physician performance and delivery  
28           of care.
- 29           •       The MOC process should be evaluated periodically to measure  
30           physician satisfaction, knowledge uptake, and intent to maintain  
31           or change practice.
- 32           •       MOC should be used as a tool for continuous improvement.

33           <sup>28</sup> *Physicians fed up, feel trapped by MOC*, Medical Economics (April 10, 2016),  
34       <http://www.medicaleconomics.com/medical-economics-blog/physicians-fed-feel-trapped-moc>  
35       (last visited Sept. 11, 2019).

36           <sup>29</sup> Paul S. Teirstein, *Boarded to Death – Why Maintenance of Certification is Bad for  
37       Doctors and Patients*, 372 *New Eng. J. Med.* 106, 108 (2015).

38           <sup>30</sup> *Id.* (emphasis added).

- 1 • The MOC program should not be a mandated requirement for  
2 licensure, credentialing, payment, network participation or  
employment.
- 3 • Actively practicing physicians should be well-represented on  
4 specialty boards developing MOC.
- 5 • MOC activities and measurement should be relevant to clinical  
6 practice.
- 7 • The MOC process should not be cost-prohibitive or present  
8 barriers to patient care.<sup>31</sup>

9 None of these standards is met by the ABMS MOC.

10 41. Defendants' conduct constitutes an unreasonable restraint of interstate  
11 trade and commerce in violation of the Sherman Act and the laws of various states.

12 42. As a result of defendants' unlawful conduct, plaintiff and the other  
13 members of the Class (as defined herein) have been injured in their business and  
14 property in that they have paid more for MOC than they would have paid in a  
15 competitive market.

### 16 THE RELEVANT MARKET

17 43. For purposes of this action, the relevant geographic market is the United  
18 States.

19 44. Interstate commerce is substantially affected by the conduct challenged  
20 herein.

21 45. The relevant product markets include (i) the IBC market, and (ii) the  
22 MOC market. These markets are distinct and not interchangeable, as demonstrated by  
23 the fact that ABMS sold IBC long before it started selling MOC and excludes a  
24 material number of pre-MOC IBC purchasers from being forced to purchase MOC in  
25 order maintain their certification.

26 46. By ABMS's and ABOS's unlawful conduct challenged herein and the  
27 fact that ABMS has and continues to monopolize and maintain the MOC market,

28 <sup>31</sup> *AMA adopts principles for maintenance of certification*, AMA (Nov. 10, 2014),  
[https://www.ama-assn.org/education/cme/ama-adopts-principles-maintenance-  
certification](https://www.ama-assn.org/education/cme/ama-adopts-principles-maintenance-certification) (last visited Sept. 11, 2019).

1 including illegal tying of IBC with its MOC, ABMS injures competition in the MOC  
2 market and collects mandatory supracompetitive MOC fees from certificated  
3 physicians. ABMS sells MOC directly to plaintiff and Class members across the  
4 United States. There is no legitimate pro-competitive justification defendants might  
5 offer for their illegal course of conduct that is not outweighed by the anticompetitive  
6 effects alleged herein.

7       47. By its monopoly of the IBC and MOC markets, ABMS has, and exerts,  
8 the power to exclude competition from the MOC market. Because, as discussed  
9 herein, the vast majority of insurers and hospitals in the United States require  
10 physicians to have ABMS board certification in order to treat and admit patients,  
11 respectively, IBC is necessary for plaintiff and the Class members to meaningfully  
12 maintain their commercial medical practices. With the exception of those doctors that  
13 ABMS excluded from the required MOC, the failure of a physician to submit to  
14 defendants' imposition of forced and excessive MOC results in the inability of that  
15 physician to maintain their IBC and, therefore, to meaningfully maintain their  
16 commercial practice.

17       48. The IBC market is and has been controlled by defendants from the mid-  
18 twentieth century to the present. Since the inception of MOC, ABMS has similarly  
19 controlled the MOC market. Both markets present high entry barriers, not limited to  
20 economic and organizational barriers. ABMS stands alone in selling IBC to  
21 physicians; no other source of IBC has meaningfully competed with ABMS in this  
22 regard. And, as discussed herein, because ABMS leverages its IBC market power to  
23 illegally tie its MOC to its IBC, meaningful competition in the MOC market is  
24 foreclosed. Indeed, because ABMS will not recognize any competing MOC other  
25 than ABMS's MOC in the maintenance of IBC, and because physicians are effectively  
26 unable to maintain their commercial practices if they do not purchase MOC from  
27 ABMS, ABMS blocks the emergence of any meaningful competition in the MOC  
28 market.

1           49. The anticompetitive effects of ABMS’s conduct is illustrated by the  
2 inability of its primary MOC market competitor, the National Board of Physicians and  
3 Surgeons (“NBPAS”), to gain market share.<sup>32</sup> NBPAS requires that a physician  
4 possess an ABMS IBC, be properly licensed, and complete a set amount of CME in  
5 order to obtain MOC from it. Making NBPAS MOC desirable to physicians, NBPAS  
6 offers MOC at significantly lower fees than ABMS and requires less physician time  
7 for compliance. However, despite its national presence and comparable MOC  
8 product, because of ABMS’s market power, as of September 2018, according to the  
9 NBPAS website, no commercial health insurance provider and less than one percent  
10 of hospitals accept NBPAS MOC.<sup>33</sup> ABMS also refuses to accept competitor MOC,  
11 revoking physician’s IBC where physicians do not obtain ABMS MOC. Because of  
12 the *de facto* requirement that physicians maintain their IBC with ABMS or lose their  
13 certification, competitor MOC providers are effectively excluded from competition.

14           50. Plaintiff’s and Class members’ injuries directly derive from defendants’  
15 unlawful conduct. Defendants’ charge increasingly artificially inflated prices for  
16 MOC, forcing plaintiff and the Class to incur and continue to incur at least hundreds  
17 of millions of dollars in ABMS MOC fees. Absent defendants’ malfeasance, and in a  
18 competitive market, Class members would pay significantly lower, competitive prices  
19 for MOC from a source other than or in addition to ABMS.

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23 <sup>32</sup> NBPAS does not sell IBC. It only offers MOC. This fact also illustrates the  
24 distinct nature of the IBC and MOC markets.

25 <sup>33</sup> ABMS has not been a passive observer of hospital and commercial payer  
26 requirements related to IBC. To the contrary, ABMS has lobbied directly for and  
27 induced these entities and others to require ABMS certification – which includes  
28 ABMS MOC, due to defendants’ illegal tying conduct – in order to obtain necessary  
hospital admitting privileges, reimbursement for services from commercial insurance  
providers, and coverage for malpractice, among other necessary aspects of Class  
members’ medical practices.

**CLASS ACTION ALLEGATIONS**

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51. Plaintiff brings this action as a class action under Rule 23(a), (b)(2) and (b)(3) of the Federal Rules of Civil Procedure. Plaintiff seeks to certify the following Class:

All persons or entities in the United States and its territories who purchased MOC from ABOS or another ABMS member board to maintain their IBC. The Class excludes: (a) defendants, their officers, directors, management, employees, subsidiaries and affiliates; and (b) any judges or justices involved in this action and any members of their immediate families.

52. Class members are sufficiently numerous and geographically dispersed throughout the United States so that joinder of all Class members is impracticable.

53. Plaintiff is a member of the Class, plaintiff’s claims are typical of the claims of Class members, and plaintiff will fairly and adequately protect the interests of the Class. Plaintiff and Class members have been injured by defendants’ actions in connection with the unlawful conduct alleged herein. Plaintiff’s interests are coincident with and not antagonistic to those of the other members of the Class.

54. Plaintiff is represented by counsel who are competent and experienced in the prosecution of complex class action litigation.

55. The prosecution of separate actions by individual members of the Class would create a risk of inconsistent or varying adjudications, establishing incompatible standards of conduct for defendants.

56. The questions of law and fact common to the members of the Class predominate over any questions affecting only individual members, including legal and factual issues relating to liability and damages. Among the questions of law and fact common to the Class are:

- (a) Whether defendants violated §1 of the Sherman Act;
- (b) Whether defendants violated §2 of the Sherman Act;
- (c) Whether defendants violated the Cartwright Act and UCL;
- (d) Whether defendants engaged in illegal tying;

1 (e) Whether ABMS’s monopoly in MOC was illegally created and is  
2 being illegally maintained;

3 (f) The duration of the illegal conduct alleged in this complaint;

4 (g) The nature and character of the acts performed by defendants in  
5 violation of the law;

6 (h) Whether, and to what extent, defendants’ conduct caused injury to  
7 plaintiff and members of the Class and the appropriate measure of damages; and

8 (i) Whether plaintiff and members of the Class are entitled to  
9 injunctive relief to prevent the continuation or furtherance of the violation of the  
10 Sherman Act, the Cartwright Act, and the UCL.

11 57. A class action is superior to other methods for the fair and efficient  
12 adjudication of this controversy. Treatment as a class action will permit a large  
13 number of similarly situated persons to adjudicate their common claims in a single  
14 forum simultaneously, efficiently and without the duplication of effort and expense  
15 that numerous individual actions would engender. Class treatment will also permit the  
16 adjudication of claims by many Class members who could not individually afford to  
17 litigate antitrust claims such as those asserted in this complaint. This class action  
18 likely presents no difficulties in management that would preclude its maintenance as a  
19 class action. Finally, the Class is readily ascertainable.

20 **COUNT I**

21 **For Violation of §§1 and 2 of the Sherman Act**  
22 **on Behalf of Plaintiff and the Class**

23 58. Plaintiff repeats the allegations set forth above as if fully set forth herein.

24 59. Defendants’ conduct alleged herein constitutes illegal tying of the  
25 purchase of MOC to defendants’ initial medical specialty certifications, as well as the  
26 creation and maintenance of a monopoly in the MOC market. During the relevant  
27 period, defendants and co-conspirators engaged in a continuing combination or  
28 conspiracy to unreasonably restrain trade and commerce in violation of the Sherman

1 Act by the conduct alleged herein, artificially reducing or eliminating competition in  
2 the MOC market, and artificially fixing, raising, and/or maintaining the costs of MOC  
3 in the United States. Such conduct constitutes a *per se* violation of the Sherman Act.

4 60. Defendants' conduct has anticompetitive effects in the MOC market, and  
5 has had and continues to have the effect of artificially inflating the price of purchasing  
6 MOC in the United States.

7 61. As a direct and proximate result of defendants' unlawful conduct,  
8 plaintiff and the other members of the Class paid more for MOC than they otherwise  
9 would have paid in the absence of defendants' unlawful conduct.

10 62. By reason of defendants' unlawful conduct, plaintiff and members of the  
11 Class have been deprived of free and open competition in the purchase of MOC.

12 63. As a direct and proximate result of defendants' conduct, plaintiff and  
13 members of the Class have been injured and damaged in their business and property in  
14 an amount to be determined.

15 64. While defendants' conduct as described herein is a *per se* violation of the  
16 Sherman Act, it is also unlawful under the rule-of-reason standard, as it an unlawful  
17 restraint of trade. There are no legitimate or pro-competitive justifications for  
18 defendants' conduct. Plaintiff respectfully submits that the Court should apply well-  
19 recognized *per se* rules in order to condemn these challenged trade restraints, but in an  
20 abundance of caution pleads this claim in the alternative so that it is raised not only  
21 under the *per se* rules, but also under the rule-of-reason standard.

22 65. Plaintiff and members of the Class are entitled to damages from and an  
23 injunction against defendants, preventing and restraining the violations alleged herein.  
24 Specifically, plaintiff and members of the Class seek to have current certification  
25 become permanent without need for MOC or further recertification.

26 66. Plaintiff and members of the Class further seek certification reinstatement  
27 for those members of the Class whose time-limited certification expired.

28

COUNT II

**For Violation of the Cartwright Act,  
Cal. Bus. & Prof. Code §16700, *et seq.*,  
on Behalf of Plaintiff and Class**

67. Plaintiff repeats the allegations set forth above as if fully set forth herein.

68. Defendants’ conduct alleged herein violates the Cartwright Act, Cal. Bus. Prof. Code §16700, *et seq.*

69. Plaintiff brings this claim on behalf of a nationwide class. Alternatively, plaintiff brings this claim on behalf of California residents meeting the class definition.

70. Defendants’ conduct alleged herein constitutes an illegal conspiracy and combination, including tying the purchase of MOC to defendants’ initial medical specialty certifications, as well as the creation and maintenance of a monopoly in the MOC market. Such conduct constitutes a *per se* violation of the Cartwright Act.

71. It is appropriate to bring this action under the Cartwright Act because a large number of members of the Class resides in California, members of the Class conduct their medical practices in California, purchased their MOC in California, many of the illegal tying arrangements were made and executed in California, and because overt acts in furtherance of the conspiracy and wrongful charges flowing from those acts occurred in California.

72. Defendants’ conduct has anticompetitive effects in the MOC market and has had and continues to have the effect of artificially inflating the price of purchasing MOC in California.

73. As a direct and proximate result of defendants’ unlawful conduct, plaintiff and the other members of the Class paid more for MOC than they otherwise would have paid in the absence of defendants’ unlawful conduct.

74. By reason of defendants’ unlawful conduct, plaintiff and members of the Class have been deprived of free and open competition in the purchase of MOC.

1 75. As a direct and proximate result of defendants’ conduct, plaintiff and  
2 members of the Class have been injured and damaged in their business and property in  
3 an amount to be determined.

4 76. While defendants’ conduct as described herein is a *per se* violation of the  
5 Cartwright Act, it is also unlawful under the rule-of-reason standard, as it an unlawful  
6 restraint of trade. There is no legitimate or pro-competitive justification for  
7 defendants’ conduct. Plaintiff respectfully submits that the Court should apply well-  
8 recognized *per se* rules in order to condemn these challenged trade restraints, but in an  
9 abundance of caution pleads this claim in the alternative so that it is raised not only  
10 under the *per se* rules, but also under the rule-of-reason standard.

11 77. Plaintiff and the Class are entitled to treble damages, attorneys’ fees,  
12 reasonable expenses, and cost of suit for the violations of the Cartwright Act.

13 **COUNT III**

14 **For Violation of the Unfair Competition Law Under**  
15 **Cal. Bus. & Prof. Code §17200, *et seq.*,**  
**on Behalf of Plaintiff and Class**

16 78. Plaintiff repeats the allegations set forth above as if fully set forth herein.

17 79. Plaintiff brings this claim under Cal. Bus. & Prof. Code §§17203 and  
18 17204 to enjoin and obtain restitution and disgorgement of all monetary gains that  
19 resulted from acts that violated Cal. Bus. & Prof. Code §17200, *et seq.*, commonly  
20 known as the UCL.

21 80. Plaintiff and the members of the Class have standing to bring this action  
22 under the UCL because they have been harmed and suffered injury in California  
23 during the relevant period as a result of the violations of the Sherman Act and the  
24 Cartwright Act as alleged herein.

25 81. In formulating and carrying out the alleged agreements and conspiracy,  
26 defendants did those things that they combined and conspired to do, including but not  
27 limited to, the acts, practices and course of conduct set forth herein, and these acts  
28 constitute unfair competition in violation of the UCL.



1 constructive trust consisting of all ill-gotten gains from which plaintiff and the  
2 members of the Class may make claims on a *pro rata* basis.

3 **PRAYER FOR RELIEF**

4 WHEREFORE, plaintiff requests that the Court enter judgment on plaintiff's  
5 behalf and on behalf of the Class herein, adjudging and decreeing that:

6 A. This action may proceed as a class action, with plaintiff as the designated  
7 Class representative and his counsel as Class counsel;

8 B. Defendants violated §§1 and 2 of the Sherman Act (15 U.S.C. §§1 and 2),  
9 the Cartwright Act (Cal. Bus. & Prof. Code §16700, *et seq.*), and the UCL (Cal. Bus.  
10 & Prof. Code §17200, *et seq.*), and plaintiff and the members of the Class have been  
11 injured in their business and property as a result of defendants' violations;

12 C. Plaintiff and the members of the Class are entitled to recover damages  
13 sustained by them, injunctive relief, and entry of a joint-and-several judgment in favor  
14 of plaintiff and the Class against defendants in an amount to be trebled;

15 D. Defendants, their subsidiaries, affiliates, successors, transferees,  
16 assignees and the respective officers, directors, partners, agents and employees thereof  
17 and all other persons acting or claiming to act on their behalf be permanently enjoined  
18 and restrained from continuing and maintaining the unlawful conduct alleged herein;

19 E. Plaintiff and members of the Class be awarded pre-judgment and post-  
20 judgment interest, and that such interest be awarded at the highest legal rate from and  
21 after the date of service of the initial complaint in this action;

22 F. Plaintiff and members of the Class recover their costs of this suit,  
23 including reasonable attorneys' fees as provided by law; and

24 G. Plaintiff and members of the Class receive such other or further relief as  
25 may be just and proper.

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**JURY DEMAND**

Plaintiff demands a trial by jury of all issues triable by jury.

DATED: September 11, 2019

ROBBINS GELLER RUDMAN  
& DOWD LLP  
DAVID W. MITCHELL  
CARMEN A. MEDICI  
ARTHUR L. SHINGLER III

*s/ David W. Mitchell*

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Attorneys for Plaintiff

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

I. (a) PLAINTIFFS

ALEXANDER ROSENSTEIN, M.D., Individually and on Behalf of All Others Similarly Situated,

(b) County of Residence of First Listed Plaintiff Hawaii (EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys (Firm Name, Address, and Telephone Number) David W. Mitchell, Robbins Geller Rudman & Dowd LLP 655 West Broadway, Suite 1900 San Diego, CA 92101 619/231-1058

DEFENDANTS

AMERICAN BOARD OF ORTHOPAEDIC SURGERY and AMERICAN BOARD OF MEDICAL SPECIALTIES,

County of Residence of First Listed Defendant (IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys (If Known)

'19CV1754 GPC WVG

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- 1 U.S. Government Plaintiff, 2 U.S. Government Defendant, 3 Federal Question (U.S. Government Not a Party), 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)

Table with columns for Plaintiff (PTF) and Defendant (DEF) citizenship and business location (Citizen of This State, Citizen of Another State, Citizen or Subject of a Foreign Country, Incorporated or Principal Place of Business In This State, Incorporated and Principal Place of Business In Another State, Foreign Nation).

IV. NATURE OF SUIT (Place an "X" in One Box Only)

Large table with categories: CONTRACT, REAL PROPERTY, CIVIL RIGHTS, TORTS, PRISONER PETITIONS, FORFEITURE/PENALTY, LABOR, IMMIGRATION, BANKRUPTCY, SOCIAL SECURITY, FEDERAL TAX SUITS, OTHER STATUTES.

V. ORIGIN (Place an "X" in One Box Only)

- 1 Original Proceeding, 2 Removed from State Court, 3 Remanded from Appellate Court, 4 Reinstated or Reopened, 5 Transferred from Another District (specify), 6 Multidistrict Litigation - Transfer, 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing (Do not cite jurisdictional statutes unless diversity):

15 U.S.C. §§1 and 2

Brief description of cause:

COMPLAINT FOR VIOLATIONS OF THE SHERMAN ANTITRUST ACT

VII. REQUESTED IN COMPLAINT:

CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P. DEMAND \$

CHECK YES only if demanded in complaint: JURY DEMAND: Yes No

VIII. RELATED CASE(S) IF ANY

(See instructions):

JUDGE M. James Lorenz

DOCKET NUMBER 3:19-cv-00341-L-RBB

DATE

09/11/2019

SIGNATURE OF ATTORNEY OF RECORD

s/ David W. Mitchell

FOR OFFICE USE ONLY

RECEIPT # AMOUNT APPLYING IFP JUDGE MAG. JUDGE

## INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

## Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

- I.(a) Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.
- (b) County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)
- (c) Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".
- II. Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.  
 United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.  
 United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.  
 Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.  
 Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below; **NOTE: federal question actions take precedence over diversity cases.**)
- III. Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.
- IV. Nature of Suit.** Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: [Nature of Suit Code Descriptions](#).
- V. Origin.** Place an "X" in one of the seven boxes.  
 Original Proceedings. (1) Cases which originate in the United States district courts.  
 Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441. When the petition for removal is granted, check this box.  
 Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.  
 Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.  
 Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.  
 Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.  
 Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.  
**PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7.** Origin Code 7 was used for historical records and is no longer relevant due to changes in statute.
- VI. Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service
- VII. Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.  
 Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.  
 Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.
- VIII. Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.
- Date and Attorney Signature.** Date and sign the civil cover sheet.

# ClassAction.org

This complaint is part of ClassAction.org's searchable class action lawsuit database and can be found in this post: [Lawsuit Claims American Board of Medical Specialties Inflates Cost of Physician Certification](#)

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