

10 percent of the cases getting to court with a legitimate cause. The other 90 percent includes those that settled rather than incurring the expense of defending a non-meritorious suit.

What Can Physicians Do?

Our best weapon is truth. We must make our case to our patients. Unless our freedom and economic rights are restored, we will continue to be overwhelmed by more government intrusion. Patients need to hear that the most direct, the most economical, and the best medical care is a result of direct contract between patients and their physicians, with no middleman.

Americans need to be reminded that the Constitution grants only limited and defined powers to the federal government. The government does not have a legitimate authority to deny physicians the right to receive a market price for their services: a right enjoyed by mechanics, plumbers, carpenters, architects, engineers, athletes, film stars, government employees, and lawyers.

Shortly after his inauguration, President Ronald Reagan, speaking before a crowd of 5,000 at the Jefferson Memorial, presented his Economic Bill of Rights, based on fundamental constitutional principles: 1. Freedom to work; 2. Freedom to enjoy the fruits of that work; 3. Freedom to own and control property (that includes intellectual property); 4. Freedom to participate in a free market.

Physicians today are denied every one of these freedoms. It is time to say "Enough!" Only strong, sustained political activism will regain these rights. To win the battle, we must fight it, and as Winston Churchill told the graduating class of his old prep school, "Never, never, never give up!"

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Fighting to Preserve Private Medicine: the Role of AAPS

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The Formation of AAPS

The first meeting of the Association of American Physicians and Surgeons was held on December 1, 1943, at the Elks Club in East Chicago, Indiana. It appears that the formation of AAPS was initially the idea of Ronnel Waterson, a layman who saw the need for such an organization while serving as executive secretary of the East Chicago, Indiana, Academy of Medicine.

AAPS Directors emphasized the point that AAPS was not a rival of the AMA, but was intended to function more as its conscience. Initially, membership in the AMA was a prerequisite for joining AAPS. And for a time, AAPS had its headquarters on Michigan Avenue in Chicago.

The founders had, in fact, tried to work through the AMA to "preserve the American System of the practice of private medicine." The Lake County Medical Society prepared a resolution asking the AMA to adopt an aggressive attitude in medical economics, public relations, and legislation. The resolution was adopted by the Indiana State Medical Association, and a delegate was instructed to present it at the next AMA House of Delegates meeting. Because no action was taken on this resolution by the AMA House of Delegates, a group of Lake County Physicians decided that a new organization was needed.

By the time of the fourth meeting of AAPS on February 6, 1944, 120 doctors from 35 states had joined in response to a mailing of 108,700 copies of "The News." By that time, \$4,200 had been deposited in the bank. The mailing cost \$711 for copies and \$1,090 for postage.

There was some discussion regarding solicitation of financial support from ancillary organizations such as hospitals, pharmacies,

and drug manufacturers. There was strong insistence that such financial support have no strings attached although AAPS leaders called that "an impossible dream."

By early 1945, Mr. Waterson and several of the directors had addressed 19 different medical societies from Massachusetts to San Diego. A number of medical organizations endorsed AAPS, including the Colorado State Medical Society and six county medical societies in that state; the Alachua County Medical Society in Gainesville, Florida; the Christian County Medical Society in Taylorville, Illinois; three county medical societies in Indiana; two county medical societies in Michigan, including the Wayne County Medical Society in Detroit; the Clark County Medical Society in Las Vegas, Nevada; the Sullivan County Medical Society in Monticello, New York; three societies in Ohio; the Cambria County Medical Society in Johnstown, Pennsylvania; and the Colleton County Medical Society in Wentche, South Carolina.

AAPS Advocates Non-Participation

The first mention of the National Physicians Committee, which advocated government medicine, occurred at the 1945 meeting. In response to this proposal, AAPS decided to promote the idea of non-participation in any federal insurance plan. Though AAPS discussed the promotion of private insurance, this suggestion was not implemented because the AMA had made similar plans (which were later dropped).

The press response was hostile to AAPS:

"At least one organization of physicians seeks support on the basis of a pledge from doctors to refuse to serve under any system of politically controlled distribution of medical care." On the other hand, "the National Physicians Committee takes the unqualified position that doctors *must serve within the framework of any system that is officially adopted as a national policy*. It holds that the menacing threat of state medicine can be avoided and the independ-

ence of the medical profession can be preserved only through constructive and effective action to meet the crystallized demands of the public” [emphasis added].¹

The founders of AAPS thought that they had a sure solution in non-participation. They may have thought that the idea would sweep the profession, for they could scarcely conceive of a physician who would not immediately see the logic of their proposal. They actually seemed to be taken aback when substantial opposition developed within their own profession.

AAPS Goals Explained by First President

At the assembly meeting in August, 1944, the first President of AAPS, J. Robert Doty, M.D., gave an address that outlined the thinking behind the origin of the organization. The most salient features of the talk are as follows:

Our most miraculous advances in medicine came about through “individual initiative, which has always been possible under the American System of the practice of medicine, where men like the Mayos and Criles may develop great medical centers and become the recognized leaders of the world. These things were possible because the physicians of the past have not been hampered or molested by government regulation or dictatorship, which wiped out their enthusiasm, or took away their feeling of responsibility for the health and well-being of their individual patients.”

Dr. Doty observed that while physicians cared for the sick according to the dictates of their own consciences, and were often underpaid, deriving their compensation largely from the satisfaction of a job well done, the public gradually acquired the notion, through the influence of popular magazines, that the medical profession derived its income from exorbitant fees.

Governmental agencies provided the indigent with clothing, food, housing, and other commodities necessary for life, secured from local merchants and real estate dealers “at prices that equal or are above that paid by the self-supporting individual,” but physicians caring for the indigent were asked to cut their fees.

“In fact, it is often demanded by public opinion and public officials that [the physician] do his work gratis or for one-third to one-half the amounts paid for the same service by a private individual.”

The physician, stated Dr. Doty, “is a servant for anyone who is, or pretends to be, ill.” Although he thought that charity was admirable, and that the medical profession always has and always will do its share of charity, “the time has come when we must look out for ourselves when we must place our practice on a sound economic and financial basis.”

Moreover, he stated that doctors “were virtually told what could and could not be done in the care of a large percent of our population who were then on relief.”

Although an attempt was made to band together to correct the situation, Dr. Doty stated, “The attempt was blocked by several members of the County Medical Society who refused to cooperate with the effort” and then “took over at a very respectable figure for the time and service rendered, the care of all the indigents in one particular township.”

The Lake County Medical Society decided to take action and hired a full-time secretary, Mr. Waterson. It changed from a passive organization acting like a noonday luncheon club to a militant organization that “met and defeated all opponents locally who attempted to dictate the methods or standards under which we were to practice the art of healing.” He gave as an example: “The system of handling of indigent patients was revamped, until the patient could have free choice of physician and more reasonable fees were

secured.”

Additionally, “the Department of Public Welfare, the Octopus, which under state and federal funds is gradually reaching out its tentacles and growing rapidly in strength and power, this group who openly sponsored the Wagner-Murray-Dingell Bill, was corralled, and cooperation, rather than dictation, has been the result. Fee schedules here again have been revised upward, and a standing committee of physicians reviews all questionable accounts and disbursements. To date their recommendations have been accepted as final.”

Dr. Doty stated that the small local success indicated what could be done nationally with proper organization. “At present only our opponents are strongly organized,” he said.

Regarding the AMA, Dr. Doty said that AAPS had no objection to the work that the AMA had done in the scientific field, but criticized “only their sins of omission.” He felt that one problem was that the AMA had come under the guidance to a large extent of specialists, to the exclusion of the general practitioner. Thus, the AMA lost the “comprehensive viewpoint.” Moreover, the leaders, being men of science, “have little knowledge of the actual problems in medical economics and public relations that are part of the daily lives of the vast majority of the members of the American Medical Association.”

Explaining further, Dr. Doty said: “The tide of discontent with the refusal of the AMA to accept and intelligently execute its proper responsibilities in medical economics, legislation, and public relations has been growing constantly during the past few years. Action has been demanded, and these demands have been increasing from all sections of the nation, culminating in the organization of the AAPS.”

The result, Dr. Doty concluded, was that “since the organization of the AAPS, the long-awaited action on the part of the AMA has begun to appear.”

Dr. Doty believed that “the future of American medicine is in the balance.” He suggested several aggressive objectives:

“First: The decisive defeat of the Wagner-Murray-Dingell Bill or any of its modifications which limit the right of the American Public to choose at all times under any or all conditions its own physician, or which attempts to regulate or stifle by legislation the free action of the American physician in caring for his patients. We are unalterably opposed to any method of assignment of patients or to any contract practice which entails an unlimited amount of service for a specified sum of money.

“Second: The adoption of a workable, voluntary health and medical insurance plan, which is within the financial reach of the general public and available to all.”

The AMA had, Dr. Doty observed, taken some steps to accomplish the objectives outlined by the AAPS at the time of its inception. “But the question is, are they sincere? Why do they not show a willingness to cooperate with this organization and support the program of the AAPS in its legislative and economic program? First, they said they couldn’t do the things the AAPS proposes, and then, after we organized, they included our objectives as a part of their program.”

Could physicians then rely on the AMA’s continued efforts in this direction? Dr. Doty didn’t think so: “An organization that has been goaded into doing something seldom has much enthusiasm for its job and can usually be counted upon to relax its efforts just as quickly as possible or in this case just as soon as the present emergency is over, and it is allowed to lapse again into its former lethargic state.”

Dr. Doty called for physicians to fight valiantly for their right to practice medicine as free men.

After Wagner-Murray-Dingell: a Change in Strategy

The Wagner-Murray-Dingell Bill was an attempt to collectivize the practice of medicine under federal government control all at once. After this bill was soundly defeated, proponents of socialized medicine began to work through the incremental method. Increasingly, it appeared that they had allies within organized medicine.

Although the AMA resisted Medicare—socialized medicine for the elderly regardless of need—it did work for the implementation of Kerr-Mills, which was means tested.² As an alternative to Medicare, which as initially drafted covered hospital care only, the AMA proposed Eldercare, which covered both hospital and doctor bills for the needy. Eldercare evolved into Medicare Part B, part of the “three-layer cake” of Medicare Parts A and B and Medicaid.

Wilbur J. Cohen, Lyndon Johnson's point man on Medicare, crowed: “In effect, [Rep. Wilbur] Mills had taken the AMA's ammunition, put it in the Republicans' guns, and blown both of them off the map.”³

Some AAPS members continued (and still continue) the strategy of working within the AMA. Frank Rogers, M.D., for example, served as the California Delegate to the AMA for 53 sessions, introducing a series of resolutions supporting private medicine. Most members, however, also recognized the complicity of the AMA in the evolving problems of American medicine, including its role in the acceptance, support, and design of the Medicare program.

The initial direction of AAPS to attempt to influence organized medicine continued for at least 25 years following the formation of the organization. However, by the time the Medicare law had been passed, it was becoming more apparent that the AMA was not changing its direction. Indeed, over the past 50 years the AMA has followed a slow, steady progression towards centralized health planning with federal control of the practice of medicine. For that reason, AAPS has over the past 25 years begun to separate itself more from the AMA. Rather than criticizing the AMA as an organization, AAPS has most often elected to focus on specific issues, including utilization review, the influence of the Joint Committee on Accreditation of Healthcare Organizations (JCAHO), changes in medical ethics, health planning, and physicians' fees.

The basic Non-Participation Policy of AAPS has remained unchanged in principle. After the passage of Medicare, AAPS distributed a Non-Participation Kit, including a sign for the office (“I am not a government doctor”) and a number of pamphlets, such as “‘Hobson's Choice’ or Non-Participation?” by Executive Director Harry E. Northam; “The Heartless Hoax Called Medicare” by Frederick B. Exner, M.D.; “Participate in Medicare? Not Me” by Robert England, M.D., and “Why I Never Did, Cannot, and Never Will Accept Government-Dominated Medicine” by Walter W. Sackett, Jr., M.D. Three letters were sent to all 185,000 American physicians by Presidents E.E. Anthony, M.D., and Thomas L. Dwyer, M.D., the last with the headline “It is estimated that already more than 50,000 doctors have made their firm decision not to participate in Medicare, although the socialized medicine program does not start until July 1, 1966.”

Dr. Dwyer wrote: “A majority is not necessary to remain free. AAPS is numerically a comparatively small organization. But, in its zeal to preserve good medical care, freedom and constitutional government, and its unswerving adherence to principle, it has no peer. Many right causes have been won without large numbers or a majority. Only about one-third of the colonists favored complete independence from Britain. They achieved their noble purpose because they were right. One-third of the nation's ethical physicians

can win this battle over regimentation and tyranny” (Dwyer T, correspondence, Nov. 15, 1965).

Quoting Dr. Anthony's Presidential Address, Dr. Dwyer continued: “At the present time, doctors have a choice. It is between collaboration or refusal to participate. Since it is legal, ethical and moral for doctors to refuse to participate in this program, which will eventually hurt every man, woman and child in this land for longer than any of us can foresee, and since Congressman Mills plotted our course when he stated that the program cannot succeed without the willing, intelligent cooperation of the doctors, this doctor takes his stand alongside of his patients and his Nation. I say for myself only, I will continue to care for my patients on the same basis and in the same conscientious manner that I've cared for them for over 30 years. I will not participate in this unholy, political scheme to increase government control over all of us.”

In a letter to members dated October 4, 1965, Dr. Anthony expressed a fervent hope that the AMA House of Delegates would pass a Non-Participation resolution at the special session called for October 2-3, 1965. “This wise act by the AMA would give virtual assurance of the success of Non-Participation in Medicare.”

This hope was not realized. “After the AMA's leaders quelled a move by its members to boycott Medicare, it made sure doctors would benefit from the new national program.... Medicare became a pipeline of money to doctors and hospitals.”³

Issues Drawing Physicians to AAPS

Physicians have often become involved with AAPS upon recognizing ways in which government and other third parties were intruding into medical affairs in their geographic area and field of practice. Most often, they were aware of AAPS through personal contact with a member. The AMA and its affiliates, as well as the press and the government, tended either to ignore AAPS or actually to vilify its politically incorrect views: adherence to the Oath of Hippocrates; the idea that private medicine involves just two people, a sick patient and the physician that he selected to care for him; respect for constitutionally limited government; and a conviction that voluntary transactions optimize both the availability and quality of medical care.

Controls by Hospitals

As his field of vascular surgery was first developing, W. Daniel Jordan, M.D., became aware of the San Joaquin Foundation for Medical Care, which was spreading the movement to control medical care through utilization review and other methods within the hospital.

During the early 1970s, hospital administrators' control was exerted in somewhat more subtle ways than today. Usually, administrators would recruit some member of the medical staff to assist in coercing physicians to perceive issues in the way that the administration wished.

In the Atlanta area, a number of hospital staffs were essentially closed to doctors who were not of the correct political persuasion or who were not acquainted with the right people. The AMA was not helping practicing physicians in any way. Meanwhile, the Foundation for Medical Care attempted to get county medical societies to set up foundations so that they could control the individual physicians' practices.

The Council of Medical Staffs, headed by an AAPS member, Jose Garcia-Oller, M.D., educated many physicians about the function and malfunction of organized medicine and hospital administrators (Jordan WD, interview with Leithart PW, 2000).

Controls by the Federal Government: AAPS vs PSROs

Also during the 1970s, the Professional Standards Review Organizations (PSROs), the predecessor to the current peer review organizations (PROs), were developed. AAPS became very involved in this issue, as did the Congress of County Medical Societies, which was founded in the 1960s in an effort to counteract the AMA's cooperation with Medicare. Its founder was another AAPS member, Francis Davis, M.D., who was also for many years the editor of the now defunct journal *Private Practice*.

The first AAPS lawsuit against the government, *AAPS v. Weinberger*, challenged the PSRO. In 1975, the U.S. Supreme Court declined to hear the case, thus allowing the District Court's decision to dismiss the case to stand.

The District Court found that the PSRO was "rationally related to a legitimate government purpose," did not discriminate against physicians "arbitrarily or invidiously," was not "unconstitutionally vague," and did not infringe on the right to practice medicine or interfere with the patient-physician relationship:

Underlying the constitutionality of the challenged legislation is the basic premise that each individual physician and practitioner *has the ability to choose whether or not to participate in the program*. It is true that there will exist economic incentive or inducement to participate in the program. However, such inducement is not tantamount to coercion or duress [emphasis added].⁴

Robert H. Bork, who was U.S. Solicitor General at the time, wrote in his Motion to Affirm that the statute also had no unconstitutional effect on patients:

Patients whose medical care is provided by public funds *have no constitutional right to whatever care [their physicians] using the "highest standards of medical practice" ... may "judge necessary" ... or to obtain that care "from a physician *** of their choice"* [emphasis added].⁵

Managed Care or Prepayment Schemes

Initial efforts to sell the concept of prepaid per capita or closed-panel group practice to Americans failed, even after someone tagged them with the fraudulent name of Health Maintenance Organizations.... The ill-advised and irresponsible program of the Congress to force HMOs on the people by the use of their tax money for massive HMO subsidies is an acknowledged failure," stated Dr. Donald Quinlan in congressional testimony.⁶

While there was no evidence that prepaid group practice costs less than fee-for-service for the same service, it had another untoward effect recognized by Dr. Sidney R. Garfield, who was considered to be the father of the Kaiser-Permanente program:

Only after years of costly experience did we discover that the elimination of the fee is practically as much a barrier to earlier sick care as the fee itself. The reason is that when we remove the fee we remove the regulator of flow into the system.... The impact of this demand overloads the system and, since the well and worried-well are a considerable proportion [of patients], the usurping of available doctors' time by healthy people actually interferes with the care of the sick.⁷

Inherent in the HMO or prepayment structure is an incentive to deny care, as the patient who actually receives a service is a liability. Therefore, AAPS has consistently advocated the policy of Non-Participation with HMOs as well as government programs and produced a number of pamphlets warning both patients and physicians of their pitfalls (see "brochures" at

www.aapsonline.org). AAPS legal counsel has repeatedly affirmed the legality of this position.

Although many AMA members share the concerns that AAPS expresses with regard to managed care, the AMA pleads impotence, blaming the U.S. Supreme Court and the Federal Trade Commission.⁸ This saga deserves an article of its own, but these are the highlights:

In June, 1975, the U.S. Supreme Court ruled, in the case of *Goldfarb v. Virginia State Bar*, that federal antitrust laws do not distinguish the activities of "learned professions" from other commercial activities. In December, 1975, the FTC began to investigate the AMA for antitrust violations. In the shadow of a 7-year investigation, the 1957 Principles of Medical Ethics were revised, eliminating the restriction on voluntary professional association with non-scientific practitioners, the general injunction to accept the profession's "self-imposed disciplines" (which could be interpreted to mean restrictions on advertising), the prohibition on solicitation of patients, and the statement about fees being "commensurate with the patient's ability to pay" (Latham SR, correspondence, March 26, 1998).

Section 6 of the 1957 code was excised in its entirety. This section read exactly the same as section 4 in the current AAPS Principles of Medical Ethics: "The physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

The actual consent decree that the AMA signed in 1982, after the revisions to the ethical code, prohibited the AMA from "declaring unethical, interfering with, or advising against" the publishing of information about prices or conditions. The AMA was also restrained from involvement in determining "consideration" or in advising about the propriety of "medical service arrangements that limit the patient's choice of physician." There was, however, no specific mention of Section 6 or its wording. Moreover, the decree explicitly did *not* prohibit the enforcement of reasonable ethical guidelines about "unsubstantiated representations" or "uninvited, in-person solicitation of actual or potential patients, who, because of their particular circumstances, are vulnerable to undue influence."⁹

Whether antitrust fears are the reason or merely a pretext, the AMA has left principled opposition to prepayment schemes entirely to AAPS. In fact, the AMA formed a clearinghouse on medical-society-sponsored managed care organizations. Plans formed by AMA Federation members were described with no mention of the ethical landmines.¹⁰

True Insurance and Medical Savings Accounts

Fifty years ago, most insurance did not cover physicians' fees. Without the intervention of the AMA, Medicare coverage might also have been restricted to hospital care.

As AAPS has repeatedly pointed out, coverage of routine, predictable expenses violates the principles of insurance. In fact, the only sickness expenditures that meet the criteria for insurable risks are catastrophic ones.¹¹ Because of the federal tax code, most private "health plans" are, like Medicare and Medicaid, not true insurance. Medical Savings Accounts, formerly called "health IRAs"¹² have been advocated by AAPS for decades as a method of promoting tax equity and the restoration of an insurance market.

The AMA is officially in favor of MSAs (Policy H-165.869), though promotion of MSAs or criticism of low deductibles has to date been conspicuous by its absence or rarity in member alerts or *AMNews*.

National Health Insurance, Again

In the 1970s, Senator Edward Kennedy was again urging the adoption of a universal healthcare system similar to the one in Britain. Having graduated from the University College Goldway of the National University of Ireland in 1947, and having worked under the British National Health Service for more than four years, AAPS President Donald Quinlan, M.D., was especially well qualified to testify. Dr. Quinlan was also President of the North Shore branch of the Chicago Medical Society and served on the Judicial Council of the Chicago Medical Society and of the Illinois State Medical Society.

The arguments that he presented to the Health Subcommittee of the Ways and Means Committee in 1975 included the inevitability of rationing, the impact of bureaucratic interference in the practice of medicine, and the prospect of bankrupting the federal government. The inaccuracy of past cost projections was highlighted:

[T]he bureaucrats solemnly assured the Congress ... that hospitalization under Medicare the first year would cost \$900 million. Actually, the first year cost was \$2.7 billion. They said that after the 10th year it would cost \$1.7 billion and it is actually costing \$10.9 billion. The first year cost was three times as much as the bureaucrats said it would be and the 10th year cost has soared to over six times as much as they promised.⁶

One method of financing these expenditures, AAPS pointed out, was through eroding the value of the currency:

A dollar that a person saved in 1940 is now worth only 24 cents. A dollar that a person saved in 1967 is now worth only 64 cents.... This means that since 1940, over three fourths of the value of the dollar has been deceptively taken by government.... Certainly, [this inflation] is gouging the elderly, the widows who are living on fixed incomes and the poor who cannot vote themselves, as Congressmen have done, income which is protected from the escalation in inflation.⁶

If the estimates of the costs of the Kennedy-Corman bill were as inaccurate as those for Medicare, its tenth year cost would have been \$829 billion.⁶

In 1977, an informal coalition of groups was organized to counteract President Carter's ambition to pass national health insurance legislation. A national tour group, organized by Francis Davis, M.D., made about 36 appearances in 36 major cities in 1977. Physicians from England, Australia, and Canada joined some American physicians in this tour. Most of the American participants were members of AAPS (Jordan WD, interview with Leithart PW, 2000).

In contrast, the AMA, rather than opposing nationalized insurance outright, supported a compromise bill in the late 1970s that included employer mandates and a government-mandated benefits package.³

The idea of national health insurance, while periodically defeated, keeps coming back.

In 1993, the Clinton Administration planned to push through a far-reaching plan to federalize American medicine, through a scheme resembling "managed competition," during the first 100 days of the Administration. While the AMA all but endorsed the Clinton Health Security Act, the AAPS led the effort to expose the illegal secret activities of the Clinton Health Care Task Force and the Interdepartmental Working Group headed by Ira Magaziner. Mailing information about the Task Force and the Plan to all office-based physicians in the U.S. resulted in tripling the membership of the organization.

The Plan as a whole was ultimately defeated in Congress, though the Republican Congress later enacted a substantial chunk of it in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The AMA endorsed most of the Act, then called Kassebaum-Kennedy:

After years of disappointment about health system reform, the Senate's unanimous approval of the Kassebaum-Kennedy bill is a welcome sign that progress is possible.... The AMA has championed these fundamental reforms for a long time. Recall that the AMA's landmark 1990 reform proposal was called Health *Access America* [emphasis in original].¹³

Passage of HIPAA was one of the reasons for merrymaking at the AMA's sesquicentennial celebration.¹⁴ Apparently, only AAPS noticed that two-thirds of the bill was lifted word for word from the criminalization of medicine and privacy destruction sections of the Clinton Health Security Act.¹⁵

Price Controls

In 1984, AAPS challenged the federal freeze on Medicare fees in the case of *Whitney v Heckler* (780 F.2d 963 (11th Cir. 1986)), brought by Atlanta surgeons Douglass Whitney, M.D., and W. Daniel Jordan, M.D. The Court did not find the fee freeze unconstitutional; however, in a footnote that is often cited to establish standing, the court did rule that physicians are not required to choose between complying with what they claim to be an illegal policy and risking sanctions by violating the policy in order to obtain judicial review.

The argument that the Medicare fee freeze was an unconstitutional bill of attainder was rejected on the grounds that the Medicare Act did not fall within the historical meaning of a legislative punishment. Nor did the freeze violate the Fifth Amendment to the U.S. Constitution: "Governmental regulation that affects a group's property interests does not constitute a taking of property where the regulated group is not required to participate in the regulated industry."¹⁶ Moreover, the fee freeze was said to be "temporary."¹⁷

The Physicians Payment Review Commission was apparently set up by Congress as a result of this case, to counter an argument that price controls on physicians were unprecedented in that there was no mechanism by which the regulated industry could provide input.

The temporary freeze, of course, was succeeded by a permanent price-control scheme based on the concept of a relative value scale (RVS).

An RVS was initiated in the early 1970s in an effort to help physicians grade services in a more uniform fashion. The federal government took issue with anesthesiologists who started the whole concept and stated that to publish a relative values system is a violation of antitrust law. Therefore, anesthesiologists were forced to stop using the system as a mechanism for determining fees (Jordan WD, interview with Leithart PW, 2000).

AAPS has consistently taken a stand against this concept on principle. As early as 1961, Robert Moorhead, M.D., explained its pitfalls with great prescience.¹⁸ It was called the "comparable worth of medicine" and a derivative of the Marxist Labor Theory of Value.¹⁹

The AMA, on the other hand, embraced the concept and linked it with a system of procedural codes, the Current Procedural Terminology or CPT. In 1983, unbeknownst to most physicians, the AMA signed a contract with the Health Care Financing Administration under which HCFA agreed to require the use of the CPT terminology on all government claim forms.²⁰ In effect, the

federal government required physicians to use AMA-copyrighted material. This may explain why the AMA did nothing to oppose the imposition of price controls on physicians' fees for Medicare patients.

The lucrative AMA coding monopoly has been the issue leading to the most direct confrontation that AAPS has had with the AMA, with AAPS²¹ and the AMA²² filing amicus briefs on opposite sides in the case of *Southern Building Code Congress International (SBCCI) v. Veeck*, which could greatly diminish an important source of AMA revenue if Veeck ultimately prevails.

Private Contracting with Medicare Beneficiaries

While *AAPS v. Weinberger* established that patient acceptance of a Medicare subsidy meant government control over that treatment, the issue of whether Medicare beneficiaries could escape the controls by forgoing Medicare coverage on a case-by-case basis was left open. Medicare carriers, however, produced a number of directives stating or implying that acceptance of private fees from a patient enrolled in Medicare Part B was illegal. In an attempt to establish the right to privately contract, AAPS President Lois Copeland, M.D., together with a number of her Medicare patients, filed suit in federal court in New Jersey, *Stewart v. Sullivan*.^{23,24}

While the case was dismissed for lack of ripeness, AAPS considered case-by-case private contracting to be perfectly legal. After all, Judge Politan's 1992 opinion²⁵ stated that he had not found a clear policy against private contracting articulated by the Secretary of the Department of Health and Human Services.

On July 31, 1995, the 30th anniversary of Medicare, AAPS declared "Medicare Patient Freedom Day," and more than 300 members refused to file Medicare claims for services performed on that day. Patients paid \$1 for each service.²⁶ One patient even had brain surgery performed by Michael Schlitt, M.D., of Seattle, for \$1.²⁷ A dire warning was issued by the Florida Medical Association,²⁸ and then by many county medical associations in Florida, that participation might lead to prosecution for violating anti-trust or Medicare law. No physicians, however, even those whose acceptance of the dollar was shown on television, were harassed.

AAPS worked to have Congress pass a bill sponsored by Senator Jon Kyl (R-AZ) to clarify the right to private contract. Ultimately, a version of the bill was incorporated into the Balanced Budget Act (BBA) of 1997, but with a proviso that some thought defeated the whole purpose: the safe harbor for private contracting was an all-or-nothing proposition for 2 years. If a physician undertook the onerous bureaucratic procedure to "opt out," none of his services, except for emergencies, were reimbursable under Medicare for two years. An attempt to repeal the two-year exclusion was introduced by Senator Kyl in the Medicare Beneficiaries Freedom to Contract Act²⁹. The bill faced heavy opposition,³⁰ and was defeated.

United Seniors Association sued, arguing that the BBA deprived its members of the right to contract privately for services not covered under Medicare, for example, because they were found to be "unnecessary." While the Circuit Court of Appeals for the District of Columbia found that seniors could still buy noncovered services, it did not speak to the issue of necessary, otherwise covered services.³¹ Some think that the situation on case-by-case private contracting is basically unchanged, except in perception.³² Most physicians, however, fear to offer private services without opting out.

The AMA is officially in favor of the right to private contract,³³ and filed an amicus brief in *Stewart v. Sullivan*. However, little leadership on this issue has emanated from AMA headquarters in Chicago or Washington, D.C. At least one state medical association (Washington) now offers instructions on how to opt out,³⁴ as AAPS has done since the BBA was passed.

Codes of Ethics and the Patient-Physician Relationship

In 1957, the ethical codes of the AAPS and that of the AMA were nearly identical. The difference is that AAPS has not changed its code of ethics, while the AMA has capitulated to pressures from various other sources, particularly lawyers, and has changed its code several times. Only the AAPS code still maintains unambiguously that the physician's first responsibility is to his patient, rather than to society or national priorities.

Only AAPS has continually pointed out that the single essential element in medicine is a sick patient. Without a sick patient, no doctor, no hospital, no ambulance, no heliport, no pharmaceutical drug houses, no medical device suppliers are needed. In all the publications promoting, and in the schemes for implementing the collectivization of medicine, the least recognized, the least involved, and the least cared for element is the sick patient. The primary role of patients in such schemes appears to be in promotion of the proposed program, which is all about controlling those who provide the care and drugs and devices, and thereby also controlling the patients (Caine CW, interview with Leithart PW, 2000).

AAPS: Past, Present, and Future

While AAPS has certainly not won the battle, its efforts have so far prevented a catastrophic loss. The very existence of AAPS helps to confound the view that "organized medicine" speaks for every physician, even though fewer than 27 percent of practicing physicians belong to the AMA, and the decision not to belong is often based on a belief that the AMA does not represent the physician's views.

Older members recall former AAPS Executive Director Frank Woolley as saying: "The American Medical Association, through its socialist legal staff, is working toward the best way of merging together the government and the American doctor" (Caine CW, interview with Leithart PW, 2000).

After each setback, the most recent one being the defeat of the Clinton plan for federalizing American medicine, the forces intent on central control and planning simply regroup. The latest movement is under the aegis of Physicians for National Health Program. Socialized medicine has been renamed "single payer." Nevertheless, the ideal has not perished, despite the fall of the Soviet Empire and the revelation of the more than 100,000,000 deaths that have been caused by attempts to impose collectivism.³⁵

The movement to socialize medicine can withstand repeated defeats. It needs only one victory. Although the triumph of this idea may not be permanent, experience has shown that it can take more than 70 years to overthrow it, and even then the elements that could reconstitute a truly free and prosperous society may lie in ruins beyond salvage.

The principles and mission of AAPS remain the same: the preservation of private medicine in the United States. Only the players and battleground have changed.

All authors are past presidents of AAPS.

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