Has the Time for Nonparticipation Come?

Jane M. Orient, M.D.

ABSTRACT

Nonparticipation in federal insurance plans as well as in contractual arrangements with other third parties has been the official policy of the Association of American Physicians and Surgeons (AAPS) since its founding. The initial reluctance of physicians to participate was, however, overcome by the lure of increased cash flow and the fear of being isolated and bankrupted as the majority of physicians signed on.

The American Medical Association encourages and facilitates participation. The AMA itself derives a substantial portion of its revenue from business interests dependent on Medicare regulations, and profits further as other third parties adopt mechanisms developed for Medicare. The AMA cites antitrust law as the reason for its failure to fight against increasing third-party intrusions; however, the actual cases relate to price fixing and attempts to destroy competition. Conflicts of interest are also a possible factor.

Now that the liabilities for government entitlements and prepayment schemes are coming due, physicians are discovering that they are being used to sustain programs that are financially as well as ethically bankrupt. The nonparticipation movement is gaining force.

Historical Background: Organized Medicine and Nonparticipation in Medicare

The Association of American Physicians and Surgeons (AAPS) was founded to oppose socialized medicine, in the belief that the American Medical Association (AMA) could not be relied upon to do this.[1] The precursor to Medicare, the King-Anderson Bill, was defeated, probably owing to the principled opposition of physicians.

In 1962, President John F. Kennedy promoted the bill at the Senior Citizen Rally in Madison Square Garden. The next day, AMA President Edward Annis, M.D., speaking to empty seats and debris from the rally, delivered a televised rebuttal, including this prophetic statement:

> This Bill [the King-Anderson Bill] would put the government smack into your hospitals! Defining services, setting standards, establishing committees, calling for reports, deciding who gets in and who gets out—what they get and what they don't—even getting into the teaching of medicine—and all the time imposing a federally administered financial budget on our houses of mercy and healing. It will create an unpredictable burden on every working taxpayer. It will undercut and destroy the wholesome growth of private voluntary insurance and prepayment health plans for the aged which offer flexible benefits in the full range of individual needs. [Just prior to the passage of Medicare, 7.7 million seniors had private insurance coverage—now there is no private insurance market for seniors at all.—Ed.] It will lower the quality and availability of hospital services throughout our country. It will stand between patients and their doctors. And it will serve as the forerunner of a different system of medicine for all Americans.[2]

Also in May 1962, the *New York Times* reported that 200 New Jersey physicians had signed a resolution stating that they would "refuse to participate in the care of patients under the provision of the King-Anderson Bill or similar legislation," but they would "continue to care for the medically indigent, young and old, as we have in the past." Similar resolutions were signed by small groups of physicians elsewhere in the country.[3]

After Medicare passed in 1965, AAPS reaffirmed its principled objections (see Box 1). Many physicians who opposed Medicare on ethical grounds were able to keep their consciences clear by keeping Medicare payment at arm's length. They received benefits from the program only indirectly, by having patients file their own claims—until September 1990.

When it appeared likely that the Clinton Health Security Act would complete the job of nationalizing American medicine, AAPS once again ratified a statement of support for nonparticipation (see Box 2).

Although the AMA has been credited with, or criticized for, opposition to the enactment of Medicare, which originally was intended to cover only hospital bills, it actually proposed ElderCare, which became Medicare Part B, giving physicians a share of the new government largesse. The AMA urges physicians to seek a "seat at the table," with the AMA as their voice, in order to ameliorate the conditions of their servitude. While Medicare price controls, which the AMA has never opposed on principle, cause physician remuneration to decline in real terms, the AMA derives a substantial portion of its revenue from its monopoly on providing constantly revised Current Procedure Terminology (CPT) codes for administering these restrictions. About two-thirds of its $200 million in annual revenue is from non-dues sources, and the most

prominent share is from publication sales.[4] This conflict of interest makes it virtually impossible for the AMA to advocate nonparticipation. As more and more prescriptive standards are imposed from the top down, the AMA has ever more to gain from collaboration with government to supply the needed directives, with the authoritative professional imprimatur.

Physicians may well ask why the AMA failed to oppose the incremental changes detailed below, which have greatly increased Medicare's impact on medical practice.

Box 1. Non-Participation Program of AAPS

Reaffirming action adopted by the AAPS Board of Directors, July 31, 1965

The Non-Participation Program of the Association of American Physicians and Surgeons follows this brief explanation.

To participate means to be a party to in greater or lesser degree; conversely Non-Participation means to refrain from being a party to in any degree whatsoever.

Although we may be forced to obey any specific legal edict, as moral and ethical individuals we cannot, in good conscience, be a party to any voluntary act that violates our moral and ethical beliefs.

The Social Security Act Amendments of 1965 do not create any mandatory obligation on anyone beyond the payment of certain stipulated taxes. Inasmuch as this law has been duly enacted, we cannot avoid the payment of these taxes. However, the other provisions of the Social Security Amendments of 1965, as they relate to physicians, are all a matter of voluntary decision. The decision of whether or not to participate is a matter of individual choice. Certain coercive factors may influence the decision to participate but no such factors are intended in the advocacy of Non-Participation.

The Association of American Physicians and Surgeons recommends a policy of Non-Participation to all physicians as the only legal, moral and ethical means of concretely expressing their complete disapproval of the spirit and philosophy behind these amendments.

The opinion of competent legal authority assures us that Non-Participation is legal.

It is our belief that anything that is morally right is ethical. It is further our belief that any measures that tend to lower the standards of medical care are evil and anything that is evil is unethical and immoral. Experience in every area of the world where it has been tried has demonstrated that governmental assumption of the responsibility for medical care (socialized medicine) for the general population (as opposed to the members of the armed forces and former members with service connected disabilities, to whom there is an extraordinary and recognizable obligation) has resulted in the deterioration of the quality of medical care thus creating an effect opposite to the alleged and stated intent of the amendments. Thus the effect of the law is evil and participation in carrying out its provisions is, in our opinion, immoral.

Therefore, it is our belief that the only proper course for physicians is to:

1. Decline to serve on boards or committees established for the purpose of implementing, interpreting, expanding and administering the Social Security Amendments of 1965.
2. *Decline to sign papers or execute forms necessary to implement the provisions of the Social Security Amendments of 1965.*
3. Emphasize to their patients that there is no intention of preventing any person from receiving needed medical care but that such care must be rendered under conditions that are acceptable to both patient and physician.
4. *Clearly and emphatically explain to their patients that the policy of Non-Participation is in the best, long-range interest of patients, physicians, and good medical care.*

The Medicare Footprint

By the early 1970s, Medicare was already violating its promise never to interfere in medical care, with the establishment of Professional Standards Review Organizations[1] (PSROs, or "Physicians Should Roll Over," according to one AAPS wag). The 1980s brought the Medicare participation program, through the Deficit Reduction Act of 1984 (DEFRA), along with a "temporary" 15-month fee freeze, which was extended several times.

The participation program represented the first effort to move away from physicians control over their own fees—a key element of economic autonomy. Physicians were to be induced to relinquish control voluntarily, through incentives,[5] such as promises of quicker payment, listing in a directory, and messages to patients about the advantages of choosing a participating physician.[6] The most important incentive was probably discrimination against patients of nonparticipating physicians, who were reimbursed on the basis of 95 percent of the fee schedule amount, even though their doctors could charge a bit more, 115 percent of the fee schedule amount.[7]

To enforce price controls, the government needed a system for describing the services rendered, and in 1983 the Health Care Financing Administration (HCFA) agreed to use the AMA's CPT-4 system and none other.[8]

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) provided an increase of 4.15 percent in maximum allowed fees for participating physicians, but extended the freeze for nonparticipating physicians.[6]

The maximum allowable actual charge (MAAC) limits were imposed in the Omnibus Budget Reconciliation Act of 1986, as a transitional measure between usual, customary, and prevailing fee structures and a "new" payment methodology—the Resource-Based Relative Value Scale (RB-RVS),[5] based in principle on the Marxist Labor Theory of Value.[9]

As of September 1990, physicians were required to file all Medicare claims, marking what William A. Seidler, Jr., M.D., of Panora, Iowa, called "the end of a medical era" that began with his grandfather's practice in 1870 and was continued by his father until 1952 and by him from 1946 until 1990. He wrote:

> As of Sept 1, 1990, I will no longer see Medicare patients in my practice.... Congress has decreed that doctors will be required to prepare and submit all Medicare Part B claims for all Medicare patients. The ethics which I have abided by for all these years set out my medical responsibilities to my patients, not the Government, Congress, or insurance companies, and the patients were responsible to me. I have been, by the Government's definition, a nonparticipating

physician—meaning to me that I have a physician's relationship only with my patient. I am not a physician who takes care of a patient and is then subservient to the Government for payment, and is controlled by the Government as to the patient's treatment.

Now I find by our congressmen's directive that even though I have cared for, billed to, and collected from that Medicare patient, I must now fill out and submit this demanded paperwork (for which they forbid any charge for the additional paperwork and time) for each Medicare service, ...and they will reprimand and fine me if I do not carry out this mandate. Congress has also "in its wisdom" set it up so the doctor can take one year to submit this form...; meanwhile, the patient would have to wait for his reimbursement.

It has come to pass that we as doctors are now spending more time responding to Congress's rules...than we are spending with patients....[10]

The momentous nature of this claims-filing requirement passed mostly unobserved, although Congress did anticipate some resistance and provided for fines of $2,000 per violation for physicians who "willfully and repeatedly" failed to submit Part B claims. Medicare carriers encouraged patients to inform on their physicians.[11]

The claims-filing requirement removed one significant advantage enjoyed

Box 2. Statement on Nonparticipation Distributed at 50th Annual Meeting in 1993

Morris Fishbein, former editor of the *Journal of the American Medical Association*, asserted in the 1940s that under socialized medicine, physicians would assume the role of *Gauleiter*. (*Gauleiter* were brutal National Socialist district leaders.)

SHALL PHYSICIANS DECLARE INDEPENDENCE?

Conclusions reached after a study of President Clinton's Health Care Reform Plan as outlined in September, 1993, and of the AAPS Non-Participation Policy, adopted in July, 1965.

[Ratified by the Assembly of Association of American Physicians and Surgeons at the 50th annual meeting, October 6, 1993, San Antonio, Texas.]

Moral reasons why a physician bound by the Oath of Hippocrates may not participate in the Nationalization of American Medicine (as proposed in President Clinton's Health Care Reform Plan, September, 1993, or in a "nonpartisan" variant or compromise that accepts the same principles):

1. ***A physician's first duty is to his patient.***

Nationalized medicine requires a "balance" between the interests of a patient and that of "`Society," as determined by the government or quasi-governmental agency.

2. ***Physicians are obligated to prescribe for the benefit of their patients, according to the best of their own knowledge and judgment.***

Nationalized medicine will establish "practice guidelines" imbued with the "force of law."

3. ***Physicians are obligated to keep confidences.*** ("All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and never reveal.")

The Clinton Health Plan will require that data from all encounters be recorded in electronic format and will authorize audits in physicians' offices to assure compliance with the rules.

4. ***Physicians are forbidden to do harm to their patients.***

Physicians who serve the Clinton Health Plan, particularly as "primary care providers," must unavoidably restrict access to care that patients might otherwise obtain, in collusion with governmental regulators.

5. ***Physicians may not give a deadly potion to anyone.***

The Clinton Health Plan, by *requiring* that all persons who enroll in a Health Plan be offered information concerning advance directives or living wills, sets the stage for pressuring patients to "choose" premature withdrawal of treatment or euthanasia. Community forums that ask citizens to reach consensus on "prioritizing" care, in effect denying it to some persons, help to lend legitimacy to the neglect of the disabled, the chronically ill, and other persons of low political standing.

6. ***Physicians may not give a woman a means to procure an abortion.***

Although the Clinton Plan does not require physicians to perform abortions, it may force all Americans to fund this procedure, even in instances abhorrent to most (for example, third trimester abortions for reasons such as sex selection), as a condition of being able to receive medical care.

As a compromise, the Clinton Plan may allow Americans to choose a Plan that does not provide abortions, although they may have to sacrifice other choices to do so.

An entity that has the authority to give a special dispensation also has the authority to withhold it. An agency such as a National Health Board that has the authority to set accepted standards of morality is the functional equivalent of an Established Church, which is specifically forbidden by the First Amendment.

By participating in Nationalized Medicine, physicians serve as enablers, assisting the state to violate the consciences of some citizens and their Constitutional right to practice their religion without government interference.

Forcing Americans into complicity with elective abortions could set a precedent for conscripting physicians to perform state-sanctioned killings such as executions or involuntary abortions or euthanasia. Physicians are bound to respect the sanctity of human life. The roles of Healer and of Killer must not be commingled.

7. ***According to the AAPS Code of Medical Ethics, physicians may not dispose of their services under conditions that tend to reduce the quality of care.***

Physicians must learn their own strengths and limitations. Under Nationalized Medicine, the central planning agencies may prevent physicians from practicing in their field of greatest competence and instead direct them to perform activities for which they are less well suited by interest, aptitude, or training.

Physicians must not place themselves in a situation of conflict of interest with their patients. Under Nationalized Medicine, physicians are rewarded by the State (or by quasi-private entities controlled by the State) for compliance with State directives, not by patients who receive a beneficial service. Physicians cannot serve two masters; they will be inclined to serve the one who controls their livelihood.

In addition, Nationalized Medicine would extend the current system of Administrative Law that subjects physicians to the threat of Draconian penalties and deprives them of their civil rights, should they incur the displeasure of the authorities. Most fearsome are asset forfeiture provisions derived from the "war on drugs." Property may be seized upon mere accusation of "fraud,"' which may be defined as provision of an "unnecessary service" *or* failure to provide a "necessary service." The government has been known to use agents posing as patients in order to entrap physicians. In the resulting atmosphere of terror and distrust, physicians (being human beings) cannot freely put their best judgment at the disposal of their patients. Rather, they must always be mindful of the desires of the authorities who have the power to destroy their livelihood.

Participating physicians may strive to do the best they can for their patients as circumstances permit, even as Nationalized Medicine proceeds to undermine and eventually destroy the foundations of the patient-physician relationship. Nevertheless, the system depends upon the complicity of physicians. Therefore, participation makes a physician an accessory to the evil that will result.

Ethical physicians should shun the role of enablers, codependents, and collaborators and refuse to participate in Nationalized Medicine.

Table 1. Denied Medicare Claims for Patients of a Non-participating Dermatologist

Year	Number of patient examinations per year	Number of Medicare individuals treated per year	Individuals with at least one illegally denied claim in one year	Ratio of Medicare individuals with an illegally denied claim	Average number of Illegally Denied Medicare Claims per individual with a denied claim
2000	3,242	466	63	1 in 7.4	2.05
2001	2,932	447	91	1 in 4.9	3.26
2002	2,646	411	96	1 in 4.28	1.85
2003	2,176	370	80	1 in 4.6	1.40
2004	1,852	332	53	1 in 6.26	1.19
2005	1,871	329	64	1 in 5.14	1.45
2006	1,561	269	99	1 in 2.72	1.71

Source: Richard B. Swint, M.D., printed with permission.

by nonparticipating physicians: freedom from onerous and expensive paperwork. Very quickly, the forms became far more complicated. To see how much simpler the filing process was not so long ago, download the form[12] that congressmen have provided to some patients, a few of whom have received reimbursement (R.B. Swint, personal communication, 2007). Note that the description of an itemized statement, which must be attached to the form, does not mention any requirement for a CPT code or an ICD-9 diagnostic code.

In the 1991 edition of the AMA's CPT code book, only four pages were required to describe evaluation and management (E&M) services. In the 1992 code book, the new confusing and complex E&M guidelines, introduced by HCFA in collaboration with the AMA, required 44 pages of explanation—with every page bearing an AMA copyright notice.[13]

In addition to the statutory and regulatory changes imposing more burdens and removing any advantages to nonparticipation, Medicare carriers had their own methods, such as sending letters to patients accusing their nonparticipating physician of over-charging—as well as simple nonpayment.

In his small solo neurology practice, Lawrence R. Huntoon, M.D., Ph.D., accumulated more than 20,000 pages of correspondence with Medicare bureaucrats. He estimated that he spent about half his time fighting the bureaucracy.[14]

In his small dermatology practice that treats mostly low-income patients in Abilene, Texas, Richard B. Swint, M.D., has determined that one-third of his patients have been denied Medicare reimbursement for correctly filed paper claims between Jan 1, 2004, and Oct 30, 2006. The number has been steadily increasing, and the effect on his practice has been devastating, as patients seek treatment elsewhere, presumably from a participating physician (see Table 1). (It appears that some patients have all of their claims denied, while other patients with similar conditions are generally paid.)

As a result—intended or unintended—of government policy, most physicians have abandoned attempts to collect payment directly from Medicare beneficiaries. The proportion of physicians signing Medicare participation agreements increased steadily[15] (see Table 2). At present, only 1.0 percent of Medicare payments go to patients of nonparticipating physicians who do not accept assignment, and 2.7 percent to nonparticipating physicians accepting assignment.[16] Thus, Medicare beneficiaries have come to expect that all of their medical bills, except for nominal copayments, will be paid by the federal government.

While small practices report being driven into destitution by Medicare, many physicians who participate in multiple managed-care plans report that Medicare is their best payer.

The complexity of dealing with Medicare and also managed care is one reason physicians choose to join large groups. In the 1960s, solo practice was the norm for general practice, as it evolved into family practice. In 1984, 54 percent of members of the American Academy of Family Physicians were in solo practice, and 14 percent in a two-person practice. By 1997, these proportions had dwindled to 25 percent and 8 percent, respectively. Fewer than 5 percent of graduating family-practice residents were choosing solo practice.[17]

Large organizations can more easily manage administrative requirements—and government and payers can more easily manage groups than individuals. As Douglas Iliff, M.D., a solo family physician, pointed out, "groups have a bias for argument, posturing, ego gratification, blame shifting—anything except action."[17]

The Managed Care Takeover: Trust and Antitrust

Rather than discussing the forces pushing physicians into managed care, let us focus on the lack of a strong pushback. Physicians do tend to place considerable trust in their colleagues—a factor deliberately exploited by government, hospitals, and insurers. This may contribute to their willingness to sign contracts without reading them.

AAPS has consistently advised physicians not to enter arrangements that put them in a conflict of interest with their patients. But why hasn't the AMA spoken out on managed-care practices that can be construed as fee splitting or the corporate

Table 2. Medicare Participation Rates[15]

Participation period	% physicians signing agreements	% of covered charges attributed to par physicians
Oct 1984—Sept 1985	30.4	36.0
Oct 1985—Apr 1986	28.4	36.3
Apr 1986—Dec 1986	28.3	38.7
Jan 1987—Mar 1988	30.6	48.1
Apr 1988—Dec 1988	37.3	57.9
Jan 1989—Mar 1990	40.2	62.0
Apr 1990—Dec 1990	45.5	67.2
Jan 1991—Dec 1991	47.6	72.3
Jan 1992—Dec 1992	52.2	78.8
Jan 1993—Dec 1993	59.8	85.5
Jan 1994—Dec 1994	64.8	89.4
Jan 1995—Dec 1995	72.3	92.6
Jan 1996—Dec 1996	77.5	N.A.
Apr 2005[16]	N.A.	96.3

practice of medicine, widely recognized to be unethical if not actually illegal?

When asked at a meeting of the Pima County (Ariz.) Medical Society why the AMA will not encourage physicians to avoid even the most disadvantageous contracts, an AMA attorney remarked that she envied the ability of AAPS to give such advice. The AMA was constrained, she said, by Supreme Court decisions pertaining to antitrust law and to an order imposed by the Federal Trade Commission.

In 1938 a federal grand jury indicted the AMA for conspiring with several county medical societies, individuals, hospitals, and others to hinder and obstruct the operations of Group Health Associates, Inc., through the enforcement of ethical opinions (*United States v. AMA, et al.*). Group Health was a cooperative association of federal employees to provide medical and hospital services on a prepaid, risk-sharing basis. At the time, it was considered unethical for a physician to be a salaried employee of a group prepaid plan, or for another physician to provide consultation to such a salaried employee.[18]

The indictment stated that the AMA "condemns as 'unethical' group medical practice on a risk-sharing prepayment basis principally because such practice is in business competition with…doctors engaged in [private] practice." The AMA gave a different interpretation of its action. AMA editor Morris Fishbein quoted the House of Delegates: "[We will exhaust]…the last recourse of distinguished legal talent to establish the ultimate right of organized medicine to…oppose types of contract practice damaging to the health of the public."[19]

This behavior was grounds for expulsion from the county medical society, and a hospital that granted medical staff privileges to a physician who was not a member of the county medical society could not have its internship approved by the AMA Council on Medical Education and Hospitals. The final result of a ruling by the U.S. Supreme Court was that the AMA and others were prohibited from conditioning medical staff privileges on membership in a county medical society.[18]

Precedence for analyzing antitrust allegations against professional associations on the basis of a rule of reason—rather than the *per se* rule that applies to actions having "no redeeming social value, such as price fixing and boycotts"—was established in a case not directly related to medicine, *Goldfarb v. Virginia State Bar Association*, 421 U.S. 773, in the oft-cited Footnote 17.[18]

As a result of a 1975 Federal Trade Commission (FTC) complaint against the AMA, an order was handed down in 1979, after lengthy discovery, 9 months of hearings, 200 pages of findings, and an appeal (*AMA v. FTC*):

> [The order] continued the prohibitions against restricting, impeding, or advising on the ethical propriety of the consideration offered or provided to a physician in any contract with any entity offering the physician's professional services; the ethical propriety of participation by nonphysicians in the ownership or management of organizations offering physician services to the public; and the ethical propriety of medical service arrangements that limit the patient's choice of physician.[18]

The order also prohibited the AMA from inducing or encouraging others to take the prohibited actions. While the order prevented the AMA from prohibiting physician advertising, the modified order did permit the enforcement of ethical guidelines concerning advertising believed to be deceptive. The final order also permitted "professional peer review of fee practices of physicians."[18]

After the 5 years of adversarial relationship ended, "the AMA and the FTC established a productive working relationship founded on a mutual interest in encouraging the profession's self-regulatory activities."[18]

In *State of Arizona v. Maricopa County Medical Society, et al.*, the U.S. Supreme Court held that the *per se* rule against price fixing applied to a maximum fee schedule.[18]

As of his 1998 review, AMA Chair Randolph D. Smoak, Jr., M.D., did not note any distortion or expansion of the Supreme Court decisions by the FTC.

The question of whether the AMA altered its Principles of Medical Ethics because of government pressure has been raised. Stephen R. Latham, J.D., Ph.D., Director of the AMA Ethics Divisions, writes that the answer is "complicated." Revised Principles were adopted at the 1980 meeting, in the shadow of the FTC proceedings, but were complete before the final order was handed down.

"The major antitrust-inspired change in the Code [that interprets the Principles] was the elimination of a large number of provisions related to advertising" (S.R. Latham, personal communication, Mar 26, 1998).

Latham did not comment on the disappearance of Section 6 of the 1957 code, which remains in the AAPS Principles of Medical Ethics as Principle No. 4:

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

Although it seems blatantly unfair that multi-billion dollar managed care organizations are exempt from antitrust law under the McCarran-Ferguson Act, while physicians are subject to it, the FTC's power does have limits, and the court decisions cited by the AMA are narrower in scope than many seem to believe. It is important to remember also that the AMA was using highly coercive actions against physicians to enforce its views. Additionally, it was attempting to eliminate competitors, especially chiropractors.[20]

AAPS is not aware of any effort by government to limit physicians' right to freedom of speech as by requiring censorship of Principle No. 4 above, or limiting advocacy for the Nonparticipation Policy.

Failure of the AMA to oppose the managed-care revolution is not solely attributable to governmental constraints. In addition to its "productive working relationship with the FTC," the AMA appears to enjoy a cordial relationship with the "major payers," and there appears to be a considerable overlap in persons holding influential positions in organized medicine and managed-care organizations.

Examples[21] include Speaker of the AMA House of Delegates, Nancy H. Nielsen, who was named chief medical officer of Independent Health. The 2005/2006 president of the Erie County (N.Y.) Medical Society was Richard P. Vienne, Jr., the medical director of Univera Health Care. The president of a state chapter of a specialty society regularly appeared in advertisements promoting a managed-care plan that physicians considered very doctor-unfriendly—until a physician complained about the apparent blatant conflict of interest.

Calling attention to the complicity of organized medicine in managed-care practices that harm independent physicians can jeopardize one's entire medical career. The physician who complained about the ad—and who also advocated for independent practitioners in other ways—was recently served with a licensure board demand to agree to expensive and intrusive monitoring, on the basis of a patient complaint about refusal to supply a laboratory result without the office visit that is consistently required by the physician, and a $20 fee dispute. The medical board member charged with reviewing the complaint also, the physicians reports, happens to serve on the medical advisory committee of the insurer.

It appears that small independent practices and vocal physicians are a barrier to the establishment of monolithic control over medicine—and a substantial and growing fraction of the American economy.

An Economic Rationale for Nonparticipation

Physicians are beginning to notice that participation in managed care, once thought essential to financial survival, may actually be the road to bankruptcy. The late Robert DeGroote, M.D., an attending surgeon at Hackensack (N.J.) University Medical Center, published the numbers from his practice.[22]

Although financial considerations may dictate that physicians withdraw from managed-care contracts, it's not just about the money. DeGroote writes:

> As a practicing general and vascular surgeon for the last 20 years, I watched the development of a sad scenario that I never thought possible: A once proud, respected, trustworthy, and noble profession brought to its knees by those not trained in the honorable art and science of medicine and whose only motivation is profit.

DeGroote notes that lack of knowledge of costs, or of what one will be paid, is a recipe for financial suicide. "Do you know of any business that would sell a product without knowing what it costs?"

DeGroote determined how much his practice was paid by each insurer per Relative Value Unit (RVU) of service provided, how much it cost his practice to provide one RVU, and the profit (revenue − expense). The profit per RVU was $6.59 for Medicare, $4.89 for Aetna, $4.76 for Oxford, and $5.63 for United. Table 3 shows the range of profits earned per procedure for a number of common procedures. He was shocked to learn that a surgeon made a net profit of only $485 for performing a Whipple procedure for a Medicare patient, and $351 for an Oxford patient. The maximum amount earned for performing a three-vessel coronary artery bypass graft (from Medicare) was $344. To pay a $10,000 increase in malpractice insurance, Dr. DeGroote would have to do 100 extra laparoscopic cholecystectomies.

Compiling average hourly wages earned by physicians of various specialties (Table 4), DeGroote was astonished to discover that a family physician earned less than a nurse working a weekend shift at his hospital ($47.29 v. $50), and a managed-care chief executive officer earned nearly 15 times as much as cardiologists, the highest paid physician specialists ($1,423 v. $96.31).

Table 3. Profits from Performing Various Surgical Procedures

Procedure	Range of profits*
Breast biopsy	$53.40–$73.93
Amputation	$123.99–$171.66
Coronary artery bypass graft	$248.23–$343.66
Abdominal aortic aneurysm	$317.30–$439.28
Femoral-tibial bypass	$198.53–274.86
Lysis adhesions	$119.09–$164.88
Small bowel resection	$124.37–$172.19
Colon resection	$154.03–$220.04
Appendectomy	$77.06–$106.69
Laparoscopic cholestectomy	$82.68–$114.46
Whipple procedure	$350.90–$485.81
Inguinal hernia repair	$58.92–$81.58
Level 3 office visit	$6.61–$9.16
Level 4 office visit	$17.99–$24.91

*Range of profits from Oxford (generally lowest), Aetna, United, and Medicare (generally highest) Source: adapted from DeGroote[22]

Table 4. Estimate of Hourly Wages for Selected Specialties and Nonphysicians[22]

Specialty or occupation	Approximate average hourly wage
Family physician	$ 47.28
Internist	51.38
Neurologist	63.00
Obstetrician/gynecologist	79.58
General surgeon	83.74
Otolaryngologist	84.99
Cardiologist	93.61
Managed care CEO	1,423.00
Weekend nurse	50.00

Table 5. Insurance Reimbursement for Procedures in Humans or Animals[22]

Procedure	Medicare reimbursement	Veterinary insurance reimbursement
Gastric torsion (gastrectomy)	$1,241	$1,993
Intestinal foreign body	725	1,363
Neoplasia pancreas	1,297	2,265
Neoplasia thorax	1,403	2,558

Box 3.The AAPS **H**assle **C**oefficient **F**actor **A**nalysis, revised 2007*

To do the HCFA, and assess your practice liabilities, follow thes e steps. You may want to do a separate analysis for Medicare and managed care.

Preliminary investigations:
For several days, have each staff member and physician use a stopwatch to time every activity related to third-party payment, including telephone calls, correspondence, and study of carrier manuals.

Accounting assessments:
Consult your balance sheet, bank statements, tax forms, payroll records, etc., to make the estimates required to fill in the table.

Overhead Costs for Claims Submissions

1. Salaries, taxes, benefits for employees: Full-time third-party-related work:	$
Part-time insurance-related work (multiply by percentage of time spent on such work)	$
2. Excess computer equipment for claims processing, EHRs, other mandates:	$
Leasing, maintenance, required software upgrades	$
Personnel costs (training, consultation, need for more highly skilled workers)	$
3. Additional telephone lines	$
4. Forms, manuals, and other supplies	$
5. Training and compliance costs (seminar fees, time off for personnel to attend, consultants, voluntary audits)	$
6. Additional credentialing expense	$
7. Excess liability coverage	$
8. (Physician time spent in non-patient care, third-party required work) x (mean hourly earning potential)	$
9. Rental of space needed solely for employees or supplies related to third-party relations	$
10. Other (psychotherapy or medical treatment for stress-related disorders, etc.)	$

Total the amounts to arrive at a monthly or annual estimate of office overhead for claims submissions: $_____

Liabilities

If you have managed-care contracts, estimate the expected income loss due to withholds or possible penalties for overutilization: $_____

Liability due to "anti-fraud" laws:
Method 1 (shortcut): Multiply the functional equivalent of infinity by any nonzero probability.
Method 2: Fill in the table on page 2.

* Title plagiarized from the American Society of Dermatology, and the Health Care Financing Administration, now called the Centers for Medicare and Medicaid Services, or CMS.

Estimating Unfunded Liabilities

1. Legal fees: hourly rate ($_____) times expected duration of investigations, hearings, trials, and appeals	$
2. Civil monetary penalties: $11,000 times number of items potentially subject to adverse determinations for incorrect coding, failure to collect copayments, unnecessary services, etc., i.e. for "fraud" or "abuse"	$
3. Income received from any procedures that could be retrospectively called unnecessary or that could have been coded so as to obtain less reimbursement (i.e. for which claims were "fraudulent" or "abusive"), multiplied by 3	$
4. Value of assets, any portion of which may have been purchased with funds derived from insurance claims determined to be "fraudulent"	$
5. Potential expert witness fees	$
6. Lost income due to loss of reputation, program exclusions, delicensure, and/or imprisonment	$

To arrive at an "expected value," calculate first the maximum plausible value, then multiply by the probability that the maximum liability would occur (the probability is unknown, but you can guess at it): $_____.

Balancing the Account

1. Estimate the amount of income derived directly from third parties (from assigned claims or capitation,: $_____
2. Estimate the amount of income that is dependent upon your office filing an insurance claim (as from Medicare patients or other unassigned claims that you file voluntarily): $_____
3. From the sum of (1) and (2), subtract the overhead calculated above, to give the net: $_____

This would be your immediate net loss if the income could not be replaced. However, there are potential offsets:
a. Medicare patients willing to forego benefits and pay privately if you opt out.
b. Other patients willing to pay privately, out of pocket orut of health savings accounts, or to file their own claims for insurance reimbursement.
c. Other remunerative work that you could do, whether medical or nonmedical, in time freed from third-party hassles.

The desire of patients to contract privately may increase dramatically as patients learn that the filing of an insurance claim implies the risk of total loss of confidentiality. Moreover, the value of a reputation for integrity —of a physician who has not bowed down to the Baal of third-party executives —may someday be recognized.

All of us have the responsibility to support ourselves and our families, so earnings are not irrelevant. But your calculation should not be strictly a cold-blooded financial one. Not every value can be calculated in dollars and cents. Be sure to include the following in your calculus: **honor, integrity, love, joy, sanity, and prudence.**

For various procedures, veterinary insurance reimbursement was nearly twice Medicare reimbursement (Table 5).

DeGroote's answer was to begin dropping managed-care plans. By January 2003, his practice had resigned from all of them. He writes:

> We were frightened but determined that we were no longer going to support a system that denies care to patients, that rewards middlemen with enormous sums of money for essentially no risk, that relies on fear of professional and financial ruin to keep doctors in line, and that reimburses physicians a pittance for the care that they render and the risks that they take.

The result: within 8 months monthly collections had increased significantly. An initial drop in caseload later reversed itself. The offices were "no longer crammed with managed care patients demanding immediate appointments and wanting the latest tests that they have seen on television." Fixed overhead decreased, as staff did not have to deal with the managed-care bureaucracy. Fear of the consequences of resigning was replaced by joy at being able to practice surgery as the doctors were trained to do. And between 2002 and 2006, profits per RVU increased steadily from $6.59 to $24.08, a highly significant (P=.001) 360 percent increase.

Many general surgeons in DeGroote's area decided on their own to take similar steps because of restrictive patient care algorithms and insulting rates of payment. He believes that if doctors do a comparable analysis, "there is only one conclusion [they] can come to in order to survive."[22]

DeGroote's analysis, while highly useful, still omits another factor that is increasing in importance as Medicare's financial situation worsens: the risk of unwarranted investigations, fines, and even prosecutions for alleged "health care fraud." The Health Insurance Portability and Accountability Act of 1996 (HIPAA) poured enormous resources into finding and prosecuting fraud, which is increasingly being defined as deviation from desired practices.[23] HIPAA applies to all insurance plans, not just Medicare and Medicaid.

The AAPS tool for practice analysis (Box 3), initially proposed by AAPS past president Don Printz in 1996, includes consideration of incalculable risks and intangible effects on morale and ethics.

Many AAPS physicians have implemented the nonparticipation policy and presented their experiences at AAPS annual meetings and regional seminars,[24] and in this journal.[25]

Gone With the Wind

Margaret Mitchell's American epic *Gone With the Wind* resonated with people around the world whose lives were being turned upside down by war and revolution. It has been translated into about 40 languages, including Arabic and Farsi. People in Nazi-controlled countries during World War II risked being shot if

caught with the book in their possession. The theme is individual fate in the midst of social upheaval and the destruction of a way of life. Mitchell describes the struggle for survival and freedom in turbulent times. Donald W. Miller, Jr., M.D., writes that America is at risk of experiencing similar times in the not-too-distant future.[26]

Many believe that the noble profession of medicine is already gone with the wind because of physician cooperation in its destruction. No March Through Georgia was necessary to get physicians to capitulate.

Quoting James Cantrell's "Celtic-Southern Thesis," Miller notes that the South chose a pretty illusion of gentility and insisted on defending chattel slavery and the caste system that went with it. "The South, like Scarlett, blinded itself to reality, and thereby lost what was most precious to it."

Conclusions

Physicians are beginning to awaken to the reality that they are being enslaved under a regime dominated by a new gentility. Thinking that participation helps them to preserve their status, they have undermined their integrity, their autonomy, and even their financial solvency.

The AAPS ideal of nonparticipation, while eroded incrementally by government and other third-party blandishments, is gaining increased attention and support by physicians. Those who implement it are discovering new hope for their own practices. AAPS believes that widespread adoption of the nonparticipation policy is needed to save American medicine. We do not know how many physicians are needed to form a critical mass.

Will those who collaborate in and thereby enable the destruction of the profession, even with the rationalization that they were just following guidelines, someday be called *Gauleiter*, as Morris Fishbein suggested in the 1940s (Box 2)?

REFERENCES

1. Pavey C, Leithart PW, Quinlan D, et al. Fighting to preserve private medicine: the role of AAPS. *J Am Phys Surg* 2003;8:19-25.
2. Annis E. Cited in: Huntoon LR. Medicare myths and facts: what the government doesn't want you to know. AAPS Pamphlet 1092, August 2002. Available at: http://www.aapsonline.org/brochures/myths.htm. Accessed Apr 22, 2007.
3. AAPS. A 1965 interview with J. Bruce Henriksen, M.D.: the past is prologue. AAPS Pamphlet 1020, December 1991. Available at: http://www.aapsonline.org/brochures/persuasi.htm. Accessed Apr 22, 2007.
4. Schlafly AL. AMA's secret pact with HCFA. *Med Sentinel* 1998;3:149-150.
5. Culbertson RA, Lee PR. Medicare and physician autonomy. *Health Care Finan Rev* 1996;18:115-130. Available at: http://www.ssaonline.us/history/pdf/MedicarePhysicalAutonomy.pdf. Accessed Apr 23, 2007.
6. Burney I, Paradise J. Data watch: trends in Medicare participation and assignment. *Health Affairs* 1987;6(2):107-120.
7. O'Sullivan J. Medicare: payments to physicians. Congressional Research Service, Mar 3, 2003.
8. Agreement: The Department of Health and Human Services Health Care Financing Administration and American Medical Association, Feb 1, 1983. Available at: http://www.aapsonline.org/medicare/hcfaama.txt. Accessed Apr 22, 2007.
9. Orient JM. The Resource-Based Relative Value Scale: a threat to private medicine. AAPS Pamphlet, 1989.
10. Seidler WA, Jr. Letter. *AAPS News*, October 1990.
11. AAPS. From Capitol Hill. *AAPS News*, October 1990.
12. Centers for Medicare and Medicaid Services. Dept of Health and Human Services. Patient's Request for Medical Payment. Form CMS-1490S (SC) (2-87). Available at: http://www.cms.hhs.gov/cmsforms/downloads/cms1490s-english.pdf. Accessed Apr 23, 2007.
13. Nirschl RP. E&M codes (part I): the demise of value. *Med Sentinel* 2000;5:102-103,110.
14. Huntoon LR. Fraud, abuse, and the Medicare industrial complex. Presented at the Heritage Foundation, Mar 1, 2000. AAPS Pamphlet 1073, May 2000. Available at: https://www.aapsonline.org/brochures/lhherita.htm. Accessed Apr 24, 2007.
15. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Appendix E. Medicare reimbursement to physicians. Available at: http://aspe.hhs.gov/96gb/eappend.txt. Accessed Apr 24, 2007.
16. Steinwald AB. Medicare physician payments: trends in service utilization, spending, and fees prompt consideration of alternative payment arrangements. U.S. Government Accountability Office Testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives, Jul 25, 2006.
17. White B. Readers speak out on solo practice. *Family Practice Management* 1998;5(5). Available at: www.aafp.org/fpm/980500fm/cover.html. Accessed Apr 24, 2007.
18. Smoak RD, Jr. Supreme Court decisions fostering the managed-care revolution. Report of the Board of Trustees. B of T Report 20-1-98.
19. Anon. A.M.A. indicted. *Time*, Jan 2, 1939. Available at: http://www.time.com/time/printout/0,8816,760551,00.html. Accessed Apr 28, 2007.
20. Schlafly A. Antitrust issues. AAPS Legal Supplement, July 2004. Available at: www.aapsonline.org/judicial/antitrust.pdf. Accessed Apr 23, 2007.
21. AAPS. Conflicts of interest. *AAPS News*, October 2006, p 2.
22. DeGroote R. The economics of managed care reimbursement: a rationale for nonparticipation. *Bull ACS* 2007;92(4):28-36. Available at: www.facs.org/fellows_info/bulletin/2007/degroote0407.pdf. Accessed Apr 25, 2007.
23. AAPS. Health care fraud enforcement. *AAPS News*, May 2007, p 3.
24. Panter JA, Eck J, Eck A, Madrigal-Dersch J. Can you eliminate third-party interference from your practice? Presented at AAPS annual meeting 2005. Available at: www.aapsonline.org. Accessed Apr 25, 2007.
25. Stein MJ. Independent personal medical care. *J Am Phys Surg* 2007;12:28-29.
26. Miller DW Jr. *Gone With the Wind*: an American epic. LewRockwell.com, Apr 17, 2007. Available at: www.lewrockwell.com/miller/miller22.html. Accessed Apr 25, 2007.