

Guidelines [AMA/HCFA Evaluation and Management (E&M) Documentation Guidelines]

Excerpted from *AAPS News*, June 1998

The AMA/HCFA [Health Care Financing Administration, now Centers for Medicare and Medicaid Services, CMS] partnership met with Federation representatives in Chicago, April 27, to permit ventilation of concerns about the 1997 AMA/HCFA Evaluation and Management Documentation Guidelines. Attendees included AAPS Executive Director Jane M. Orient, M.D. (as Vice President of the federated Pima County Medical Society), and AAPS Past Presidents John Dwyer, M.D., and Nino Camardese, M.D. Dr. Camardese flew in from Ohio, despite being repeatedly denied an invitation, and was barred entrance to the main meeting room despite his longstanding loyal support for the AMA.

Presentations were made by AMA President Percy Wootton, M.D.; CPT Editorial Panel Chair T. Reginald Harris, M.D.; Assistant Inspector General Joseph E. Vengrin; CPT Editorial Panel Executive Committee member Douglas E. Henley, M.D.; and HCFA official Robert Berenson, M.D., former member of six Clinton Task Force Working Groups (chairman of two), founder of the National Capital Preferred Provider Organization, and consultant to the Urban Institute, the Alpha Center, and the Robert Wood Johnson Foundation.

Dr. Berenson read the “applause line” for the meeting: a letter from HCFA Director Nancy-Ann Min DeParle¹ stating that implementation of the 1997 guidelines had been postponed “indefinitely.” (AMA translation: for “a short time,” during which a “new framework” is to be developed.)

Attendees were permitted two minutes each to comment and ask questions, until the scheduled hour and a half ran out. Dr. Orient inquired whether the AMA had a contract with the federal government and when they would release the details of this contract to their members. Thomas Reardon, M.D., Chair of the AMA Board of Trustees, stated: “CPT has been in effect since 1966. In 1983, yes the AMA has a contract with HCFA to provide a coding system which will be used in Medicare and Medicaid. We receive no money for that contract. Any moneys that we receive from CPT activities are royalties that we get from selling the CPT book. But we have a contract for a physician-driven CPT organization so that physicians have input into the coding system.”

In preparation for the meeting, the AMA had solicited input and had received 150 comments. At the fly-in, AAPS distributed written summaries from 648 responses [that it had received]. Of AAPS members, 83% thought the E&M documentation guidelines were “unlawful and unconstitutional,” as did 71% of nonmembers. Sample open-ended comments described the guidelines as “a first-year medical student exercise,” “a political tool to destroy private medicine,” “a complete waste of time and effort,” and “an invasion of privacy.”

In afternoon break-out sessions, a participant remarked that

use of the 1997 guidelines had increased transcription time by 20%, with no increase in quality of care or payment and with a probable increase in gaming the system. Another participant raised the question of the “reliability” (precision) of the CPT codes: Do different people, or the same people at different times, code the same visit the same way? One study showed that 30% of the codes assigned by trained personnel were discordant by at least one level of visit.

What is the legal consequence of such disagreement? Mark Segal, Ph.D., Vice President, AMA Strategic Market Programs, quoted the October 1997 issue of *CPT Assistant* in correspondence to AAPS: “These are guidelines, not a rule or law.” Dr. Wootton echoed these words: “Guidelines must be tools to help physicians document the care they provide—not as hard and fast rules that generate fear and threaten physicians.”

Nonetheless, the use of the AMA/HCFA coding system as a basis for civil penalties and criminal prosecutions was obviously of great concern to participants. For example, Stephen Babic, M.D., of Florida reported that, according to a coding seminar, 38% of physicians would undergo an audit, and that resulting penalties would range from \$10,000 to \$500,000, with an average of \$80,000. As part of its “three-pronged strategy,” the AMA promises to “provide advocacy to protect physicians from unwarranted fraud and abuse penalties.” Such penalties, in their view, have not occurred yet, but vigilance is advisable, just in case.

In reading the non-rules, AAPS noted 27 occurrences of the word “require,” 16 of the word “must,” and 0 of words such as “suggest,” “recommend,” or “optional.” And with or without guidelines, it is clear that HCFA intends to base penalties on what is (or is not) in the medical record: “If it isn’t documented, it wasn’t done.”

In other words, reality is judged by the medical record; in HCFA’s view, the medical record *is* reality.

For now, the 1997 guidelines are on the “scrap heap,” said President Elect Nancy Dickey, M.D., in her closing statement,² although physicians may use them if they choose.

The next few months will be critical times as the CPT Editorial Panel and the AMA House of Delegates meet. The perception may be that these entities speak for all physicians, not just the 31% who are AMA members....

Don’t Ask

Speaking at the annual institute on Medicare and Medicaid Payment Issues sponsored by the American Health Lawyers Association, Alice G. Gosfield, a Philadelphia attorney specializing in health care fraud and abuse issues, stated:

If you don’t remember anything else that I tell you today, this is the cardinal rule of survival in the [Medicare] Part B world: Don’t call the carrier to find out anything....

They are instructed that one of the sources to find post-payment audits and fraud audits is correspondence [from providers].... Calling them up and saying, "How do we do this?" is a surefire way to shine a laser beam on yourself for something further down the road.

Although it is probably safe to have outside counsel ask a question on your behalf, don't rely on the answer, Gosfield advised. "If you ask [the carrier a question] three times, you'll get three different answers." Referring to *Crawford County Health Services v. Heckler* (467 US 51(1984)), she noted that by Supreme Court ruling, there is "no estoppel against the federal government or its agents when they give out misinformation" (*BNA's Health Care Fraud Report* 4/8/98).

Knocks on the Door

The FBI is increasingly using sting operations in which undercover investigators pose as Medicare beneficiaries or subcontractors. They try to draw employees into making incriminating statements. Another ploy is to knock on the employee's door at dinner time and ask her not to inform the employer about the interview. The agent may tell employees that they flew into town just to see them, or use some other guilt trip to induce conversation. Former U.S. Attorney David Queen advises doctors that they may tell their staff that they have every right to ask to see the agents' identification and to tell them it is not a convenient time to speak (*Medicare Compliance Alert* 4/20/98).

Denials Reach 60%

When HCFA demands to see documentation in auditing a claim, up to 60% may be denied or downcoded. One problem is that physicians don't know the difference between a consult and a referral. "If any carriers start auditing consults, half the nation will be in deep trouble," stated Jan Rasmussen of MedLearn of St. Paul, MN.

Doctors who fail to send in documentation when asked, possibly because they feel it's not worth the trouble for the amount at stake, raise red flags at HCFA (*Part B News* 4/13/98). Anyone who wants to keep information from the government is assumed to have something to hide.

Medicare Prognosis Desperate

HHS Secretary Donna Shalala recently said that Medicare will have enough money for "years to come." That's seven (7) years, stated David Lack of the Council for Affordable Health Insurance (CAHI) at the May 9 meeting of the American Legislative Exchange Council's Health Care Task Force. Bill Clinton's claim to have extended the life of Medicare for 7 years is already two years less than previously claimed.

"Medicare Part A will be gone by 2008," Lack stated. "Part B will be here as long as the United States is solvent." Budget legerdemain transferred the most rapidly growing portions of the budget from Part A to Part B, which is funded from general revenues. The Part A "Trust Fund," of course, is an accounting fiction. As Baby Boomers retire, Social Security faces a deficit of \$3.5 trillion by 2040....

Judge Rules Against Seniors

On April 14, 1998, Judge Thomas Hogan granted the government's motion for summary judgment in the case of *United Seniors Association v. Shalala*. Plaintiffs had asked the Court to enjoin the enforcement of §4507 of the Balanced Budget Act, so that Medicare Part B beneficiaries could contract privately with the physician of their choice, even if he did not opt out of Medicare for two years.

Plaintiffs argued that before Congress passed §4507, there was no restriction on private contracting. The government argued that "private contracting to circumvent Medicare rules was never permitted; section 4507 merely opened up a narrow escape valve." The Court found the factual dispute to be "irrelevant in light of the fact that Plaintiffs failed to allege the deprivation of a constitutionally protected right."

There is *no right*, in Judge Hogan's view, for individuals to contract privately with their physicians: "**The Supreme Court has declined to extend the right to autonomous decision-making beyond certain limited contexts** involving child rearing and education, family relationships, procreation, marriage, contraception, and abortion.... This Court is not inclined to create new areas of constitutional protection."

Plaintiffs argued that Congress overstepped its Spending Clause authority in requiring Medicare beneficiaries to relinquish contracting rights in order to receive a federal benefit. Not so, said the Judge. Congress has repeatedly employed its power "to further broad policy objectives by conditioning receipt of federal moneys upon compliance by the recipient with federal statutory and administrative directives."

It serves the "general welfare," ruled the Court, to limit the amount that Medicare beneficiaries pay for services and to make it easier for them to submit claims. Moreover, reporting requirements in the statute are legitimate to help enforce federal price controls. "The Secretary is required...to keep track of changes in the proportional mix of services being performed on assigned and non-assigned bases."

The Plaintiff's complaint that §4507 discriminates against senior citizens was rejected because "**age is not a suspect class.**" Therefore, **discrimination on that basis is allowable if it is "rationally related to furthering a legitimate government interest."** Under the rational test basis, courts may not "substitute their social and economic beliefs for the judgment of legislative bodies."

"Apparently, the Founders' intentions are being turned upside down, and by a reportedly 'conservative' judge," stated AAPS Executive Director Jane Orient. "The judge has no difficulty with expanding vague terms to encompass almost any nonenumerated power that Congress cares to assume. But with citizens' rights, the opposite is the case."

In Judge Hogan's view, once becoming eligible for Medicare, "a person no longer has the liberty to use his own property to buy a life-saving treatment outside of Medicare—at least, not from a Medicare 'provider,'" Dr. Orient said.

The escape valve opened by §4507 may, however, turn out to be wider than anticipated. As of April 2, HCFA had received 300 affidavits from physicians and practitioners opting out of Medicare, according to Nancy-Ann Min DeParle in a letter to Representative Charles Rangel. Of the 278 physicians, 140 are psychiatrists, 27 are family physicians, 18 are general

practitioners, 13 are internists, 12 are plastic and reconstructive surgeons, 12 are dermatologists, and 11 are otolaryngologists. Medicare carriers are to provide a quarterly report.

Administrative Law Hearings

On May 7, AAPS member George Krizek, M.D., and Executive Director Jane Orient, M.D., testified before the Commercial and Administrative Law Subcommittee of the House Judiciary Committee, chaired by Rep. George Gekas (R-PA), concerning how citizens are affected by administrative agencies other than the IRS [see below].

Dr. Krizek's career was destroyed because of accusations that he had violated the False Claims Act through "reckless disregard" of the coding requirements. His wife, in filing the claims, made no effort to find out how much time he had spent with a particular patient, and he did not review the claims (see *AAPS News*, Aug 1997). In response to questioning, Dr. Krizek explained: "First, they accused me of billing for non-existent patients. When shown that the patients existed, they said OK, but you did not see them. When we proved that I had seen them, they said OK, but you didn't see them for as long as you said. When we prevailed there, they said OK, but the service was not medically necessary."

Members' Page

The Evils of Medicare. The first patient of my day recently spent close to \$1 million on a luxury vacation in Puerto Rico. The government forced me to give him an 82% discount on the duplex carotid scan that I performed for him, despite the fact that at my current income level it will take me close to 20 years of hard work to bring in \$1 million. Federal price controls are but one of many evils of this program. The fundamental evil is this: Medicare confiscates money from working people to pay for the medical care of others. To add insult to injury, the people who receive the benefits of this legalized plunder often don't need the assistance. I wonder what the minimum-wage worker at the local McDonald's would say if he knew he was paying for the medical care of a multimillionaire. Most workers struggle to make ends meet and blame "low pay," not realizing that government is robbing them to redistribute their wealth to others. The left-wing concept of "social justice" is a very warped concept indeed.

As to the beneficiaries, few of them realize that they have surrendered some of their liberties so they can receive all this free stuff. The multimillionaire was shocked to learn that he had to abide by the decisions of nonmedical bureaucrats with regard to what is necessary and what isn't. Most seniors can't believe that and think doctors must have some ulterior motive such as greed for saying such a thing. "Our country would never do such a thing to the older folks," they think.

We need to expose the truth to one mind at a time.

Lawrence R. Huntoon, M.D., Ph.D., Jamestown, NY

Explain It to Congress. From a letter to Senator Dianne Feinstein: I am sending you the material that I received regarding Medicare's new laboratory regulations. I am required to fill out and explain several forms to my patients, the majority of whom will not understand a word of it. Congress must not understand what is going on.

Medicare has suddenly decided not to pay for certain lab tests. Fine, but have Medicare write to its members and tell them the truth, instead of putting the burden on doctors. The patient is supposed to sign an agreement stating that he will pay for services that Medicare doesn't cover for his diagnosis. All labs are mandatory assignment, and if Medicare doesn't pay, I can assure you the patient never will. The lab is not even planning to waste money billing patients who sign the agreement; they want all the paperwork solely to avoid the incredible penalties allowed under Kassebaum-Kennedy [HIPAA].

I scanned the big blue book which Medicare probably spent a fortune creating. Is a CA-125 covered for primary adenocarcinoma of the lung? No. I guess Medicare is not aware that this is the best tumor marker for this type of lung cancer. What about for carcinoma of the appendix? No, only the CEA is covered. My patient is out of luck, since only the CA-125 is elevated, unless I want to spend 30 minutes explaining this every time I restage the patient. I did notice that there are 3 pages of diagnoses to choose from if I want to test for syphilis. That might help me more if I were practicing medicine in the 1900s....

Linda W. Wilson, M.D., Culver City, CA

And War Is Peace, and Love is Hate.... Today I got a brochure for a conference sponsored by the American Medical Informatics Association (AMIA) and all five of the other "major players" in general computer technology in medicine. As usual, these organizations are open to academics who have nothing practical to do and have been steeping in ivory tower juices too long, so they function in a very liberal manner. But somehow it still surprised me how unabashedly they tried to market their conference to me under the title: "Step Toward Compliance: Understanding the Complexities of Administrative Simplification"!

William M. Chop, Jr., M.D., Waco, TX

The Goal. The unparalleled assault upon medicine in the United States has been impelled by the desire to transfer control, power, and money from the medical care structure to the government and managed care organizations. It also has the purpose of creating a sense of dependency among our citizens, patients, and doctors. [Providing medical care, while] break[ing] the bonds between patients and doctors,...is only an instrument to accomplish these goals.

Paul S. Friedman, M.D., Philadelphia, PA

Why Self-Reliance. We need to teach the people to become more self-reliant and not dependent on the government. The government is running out of money and will let us down. They are punishing hospice programs if the people live too long! That is being considered Medicare fraud!

Alieta Eck, M.D., Piscataway, NJ

Why Take the Risk? I am sending a check for \$275 to join AAPS in its battle for private medicine. I retired as Professor of Surgery at UTHSCSA at age 55, after 20 years. Among the reasons was my reticence to risk an arbitrary and capricious fine of \$10,045 for a \$15.00 Medicare bill. Why would anyone want to be a teaching doctor under the present rules?

Carey P. Page, M.D., Helotes, TX

Testimony on Administrative Law: Excerpts

Subcommittee on Commercial and Administrative Law
House Judiciary Committee, May 7, 1998
on behalf of AAPS by Jane M. Orient, M.D.

The Internal Revenue Service has been under recent scrutiny, and Americans are well aware of the power and lack of accountability of this agency. They are less aware of the other government agencies that have comparable power. We are glad that this committee is taking a broader view and appreciate the opportunity to focus attention on the Health Care Financing Administration, which administers regulations that are even more complex than the Internal Revenue Code....

Under administrative law, the physician is, in effect, presumed guilty and must prove his innocence. There is an affirmative duty for "compliance," and compliance must be demonstrated....

Spokesmen for law enforcement agencies can easily find examples of scams involving millions of dollars in claims emanating from post office boxes for fictitious services provided to nonexistent patients. The fact that such scams exist is a grave indictment of the Medicare program as well as law enforcement. However, there is no evidence that private physicians are responsible for any significant amount of Medicare fraud, much less that such fraud is responsible for the imminent insolvency of the Medicare program....

Even if there were evidence of actual fraud by some physicians, this would not be a rationale for armed invasions of doctors' offices by federal agencies, or for treating all physicians like convicted drug dealers....

[An] official testament to good intentions appeared in the *Wall Street Journal* on May 1, 1998, p. A15: "As we do in other enforcement areas, we are continuing to refine our approach in fraud cases to ensure that we are using the tools that Congress has provided us fairly and responsibly.... Honest hospitals and other health-care providers have nothing to fear." This letter was written by Deputy Attorney General Eric Holder.... [Such] statements do nothing to limit the unbounded discretion of prosecutors. The laws under which they are acting are a virtual invitation to prosecutorial abuse. Neither the Department of Justice nor the Office of Inspector General have taken any action to investigate abuses that have already occurred....

[With new resources provided under Kassebaum-Kennedy] and the high priority assigned to health-care fraud by the Department of Justice, it is not surprising that the number of audits is expected to double. **In 1996, the federal government collected more than \$1 billion in fines and settlements, a seven-fold increase over the previous year. More than 4,000 civil health care matters were opened (an increase of 61%), and 282 criminal indictments were filed.**

Informed physicians believe that total compliance with the law is impossible. Most physicians would prefer an IRS audit to an audit by the Health Care Financing Administration (HCFA), despite the notorious cases of abuse by the former agency.

The acknowledged complexity of the tax code pales by comparison with the regulations applicable to medicine. **Medicare regulations run to 42,000 pages, compared with a mere 17,000 pages of IRS regulations.** Moreover, coding updates are published monthly by the AMA. There are literally thousands of forbidden coding combinations, and thousands of errors in the lists.

The interpretations of the codes may actually be a secret; physicians have had to file Freedom of Information Act requests to find out the precise interpretation of a requirement, as they attempt to defend themselves against a \$50,000 sanction for noncompliance....

It is possible that certain important rules are not actually written down anywhere, but are simply conjured up whenever desired at the whim of law enforcers. When one physician, who is now in federal prison, demanded that the prosecutor submit in writing the rule that he was accused of violating, the prosecutors replied that they were under no obligation to do that.

[We must ask]: **What constitutes a law, and who writes it?**

An official of the AMA has stated that the [1997 E&M Documentation "Guidelines," under which physicians fear being fined \$10,000 for not writing enough "bullets" in the chart] are simply that, rather than a "rule" or a "law".... Yet, publications of the AMA stated that the "guidelines" were to become mandatory in July 1998. By what process? No such rules for coding have ever been promulgated according to the requirements of the Administrative Procedure Act. The proposed rules have not been published in the Federal Register. The public...has had no opportunity to comment. Nor have the rules met the requirements of the Paperwork Reduction Act. This Act protects small businesses and others, including physicians (most of whom are small businessmen), from onerous, irrational regulatory requirements. Why should HCFA ignore this requirement with regard to physicians?

In addition to the legal question, there is a scientific issue. The present set of procedure (CPT) and diagnostic (ICD-9) codes, which are supposed to "match," and which must be carried out to the highest possible level of specificity (say four or five significant digits), have never been scientifically validated....

[T]here are no written standards that give a permissible range of "error" or variance for purposes of assessing multiple \$10,000 fines. **Nor are there standards for what constitutes a "pattern" of upcoding or provision of "medically unnecessary" services (itself an undefined and undefinable term). One physician in federal prison was declared to have a practice "permeated with fraud" on the basis of less than 0.1% of his practice.** (All charts were reviewed, and the very worst brought to trial. His entire earnings from all insurance payments for an extended period were seized.)

What constitutes the gold standard for accurate codes in the case of a dispute? The prosecutor's witnesses at trial may have the final word. One Michigan office manager spent one year in the Ingham County Jail because the jury believed expert testimony that a certain code required a physical examination. Actual reading of the coding manuals in effect at the time lead to the conclusion that the office manager's coding was quite correct. And in administrative proceedings, it is not even necessary for the prosecutor to convince a jury, but simply a judge who is hired by the agency.

How, then, do these unvalidated codes, developed in defiance of government-in-the-sunshine requirements and never even subjected to the rigors of the Administrative Procedure Act or Paperwork Reduction Act, acquire the functional equivalent of the force of law?...

Apparently, the codes acquire their force through a process of **government by behind-the-scenes deal-making.** The codes, along with the "guidelines," are apparently authored by

AMA-appointed committees based on an exclusive contract with HCFA. They acquire their credibility from the AMA imprimatur, even though the AMA probably now represents less than one-third of practicing physicians. They require their legal force from the power of the executive to simply impose them.

This procedure goes far beyond the delegation of power from the legislative to the executive branch (which in itself needs to be examined to see whether constitutional limits have been exceeded). Here, an executive agency is apparently delegating its power to private entities: the Medicare carriers...and the AMA. The private organization stands to profit enormously from the “public-private partnership.” For example, the AMA sells monthly coding updates (CPT Assistant) for a subscription price of \$139 per year. The code books need to be purchased yearly; the regular price for a set suitable for a small office is \$210.

Even though “private” entities (Medicare carriers, Peer Review Organizations, and other contractors) carry out much of the actual enforcement activity, as well as the rule-making, it is nonetheless done under the protection of sovereign immunity. **The “public-private” partnership thus allows each partner to avoid accountability.** The private partner escapes tort liability by collaborating with the government, and the government apparently escapes due-process requirements and Constitutional restrictions by collaborating with the private partner. The private partner also escapes the pressures of market competition by virtue of its assured monopoly for “compliance” materials. A lucrative industry has arisen to supply the “need” for such materials—a need created by the suppliers themselves....

Carriers and HCFA are supposed to be subject to certain laws. It is, for example, illegal to alter claims. Nonetheless, carriers, such as Upstate Medicare of New York, frequently change the status of claims, as from unassigned to assigned, with impunity. Carriers are required to pay clean claims within a certain period of time, and reimbursement is supposed to be a certain amount. But again there are no enforcement mechanisms. When a carrier paid a physician as much as 40% less than the prescribed amount for an entire year, it eventually acknowledged its error and corrected the rate for subsequent payments, but never repaid the \$15,000 the physician lost due to its “mistake.”

While much attention is focused on “waste” allegedly caused by physicians, carriers themselves are probably responsible for much more waste. Yet rarely do they face an audit or other type of scrutiny for claims that they improperly pay. The Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996 (A-17-95-00096, July, 1997) showed that **HCFA failed to “provide adequate support for its accounts payable estimate [of \$36.1 billion].” Medicare contractors “did not maintain adequate documentation to support reported accounts receivable activity” [accounts receivable reported to be \$2.68 billion].** These material weakness “were reported in previous Chief Financial Officers Act audit reports and remain uncorrected.”

Meanwhile, the government’s search for fraud is focused elsewhere, based on an examination of 5314 claims (a sample of 6.6 per million, or 0.00066% of claims submitted). An analogous response would be for Congress to identify abuse and waste by the IRS, then seek to increase IRS powers in order to solve the problem of occasional taxpayer error. A better solution would be to allow lawsuits to address unscrupulous IRS or Medicare carrier activities.

In the event of administrative proceedings or investigations prompted by malicious informants, prosecutorial career ambitions, “targets” (quotas), or simple error, a physician may spend years and tens of thousands of dollars in legal fees, but even if vindicated can never be made whole. The agency can simply shift its attention to another “target” (the term also refers to physicians), once it has exhausted every possible avenue or level of appeal, and apply the lessons it has learned at the expense of the first physician to increase its likelihood of future “success.” Success is always measured by convictions obtained or penalties collected, never by justice done.

The sense of injustice is heightened by awareness of the high-profile case, *AAPS v. Clinton*, which challenged the illegal secret operations of the Clinton Task Force on Health Care Reform. Eric Holder, who now reassures doctors about the fairness of the Department of Justice, is the attorney who decided that there was insufficient evidence to prosecute Ira Magaziner for perjury. Magaziner had filed an affidavit stating that the working groups of the Clinton Health Care Task Force were made up solely of full-time employees of the federal government and hence could legally reinvent American medicine in secret. A federal court relied on that affidavit in the case of *AAPS v. Clinton*. Recently, Judge Royce Lamberth ordered the federal government to pay plaintiffs more than \$285,000, part of their legal costs. Instead of following the order, the government decided to spend more taxpayer dollars appealing the decision. Interestingly, the amount that the taxpayers may have to pay in sanctions for Magaziner’s conduct is of the same order of magnitude as is demanded of Dr. George Krizek for inadvertently billing under some incorrect codes for long days and nights of serving severely disturbed patients. Magaziner is still a senior government official; Dr. Krizek’s career was ruined long ago, and the federal government is trying to seize his home as well. Magaziner supposedly didn’t know whom he was appointing to serve on Task Force working groups; Dr. Krizek **should have known** how much time he had to spend face to face with a patient, and which room he had to be in to make telephone calls, in order to use certain codes....

Even if the cases known to AAPS are mere “anecdotes,” it doesn’t take very many atrocities to terrorize a population. If one American’s rights can be violated, and the officials never called to account, is any American safe? ... Once the integrity of the judicial process is compromised, the gates are open to widespread abuse....

Most physicians are not aware of the pivotal role that their professional organizations are playing in rule-making and enforcement. Likewise, most legislators are probably unaware of the ways in which the public-private partnership manages to circumvent “government-in-the-sunshine” as well as other procedural requirements. By this means, public-private partnerships are effectively abrogating the rule of law and the system of checks and balances on which the survival of our Republic depends....

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