CEJA Report C – I-91
Conflicts of Interest: Physician Ownership of Medical Facilities

INTRODUCTION

At the 1990 Annual Meeting, the House of Delegates referred two resolutions to the Board of Trustees regarding physician ownership of medical facilities. Resolution 137, introduced by the American Society for Therapeutic Radiology and Oncology, called for reconsideration of the Association's guidelines on passive investments in radiation therapy facilities by Physicians who refer patients to those facilities. Resolution 188 requested the Council on Ethical and Judicial Affairs to declare it unethical for physicians to refer patients to a medical facility if the physicians or their families hold a financial interest in the facility and the facility is outside of the sphere of the physicians' medical expertise.

The Council presented an Interim report in response to these resolutions at the Annual Meeting in 1991 which called for aggressive enforcement by state and county medical societies of the Council's existing guidelines on conflicts of interest.[1] This report responds to the substantive issues raised by the resolutions. The Council is recommending a change in the Association's approach to the question of self referral.

BACKGROUND

The Council issued a major report on conflicts of interest in the practice of medicine in 1986.[2] The Council's view then was that conflicts are inherent in the practice of medicine and that the problem of referral of patients to outside facilities in which physicians have an investment ("self referral") was not significantly different in principle from other conflicts presented by fee-for-service medicine. In a report in 1990 the Council also identified the patient conflicts presented by certain managed care arrangements, particularly HMOs which reward physicians for providing less care.[3]

With all of these arrangements, the Council's primary guidance was to remind physicians that the profession of medicine is unique and that physicians are expected to put their patients' interests first. Thus, where a physician's financial interest may conflict with the best interests of a patient, it is assumed that the physician will not take advantage of the patient.

The Council did recognize that some arrangements may present too great a conflict to be appropriate, but with regard to self-referral the Council issued a list of safeguards to help ensure that the patient's interests would not be jeopardized. That list was most recently updated in 1989.[4]

Since these reports and opinions were issued, several studies have been performed analyzing self-referral and drawing conclusions with regard to increased utilization and cost of the practice.

At the request of the Council, the AMA's Center for Health Policy Research reviewed this evidence. The review focused on the three studies that provide original data and analyses on the effects of self-referral on utilization and costs: (1) *Financial Arrangements Between Physicians and Health Care Facilities,* a 1989 report by the Office of the Inspector General of the Department of Health and Human Services;[5] *(2)Joint Ventures Among Health Care Providers in Florida,* a recently completed study issued by the Florida Health Care Cost Containment Board;[6] and (3) "Frequency and Costs of Diagnostic Imaging in Office Practice - A Comparison of Self Referring and Radiologist - Referring Physicians, " an article by Bruce J. Hillman and others that appeared in the *New England Journal of Medicine* (December 6,1990).[7]

Although the Center found that all of these studies have flaws, several important points could be made with regard to their findings:

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In the neighborhood of 10% of physicians nationwide have ownership interests in health care entities that have been associated with potential self- referral issues. However, not all of the physicians with such ownership interests engage in self-referral, so other motivations exist for physicians to make such investments. Moreover, there is significant geographic variation in the extent of physician ownership of health entities that is not readily reconciled with differential opportunities to self-refer.

For several important classes of services for which physicians make referrals, patients of physicians who self-refer have higher utilization rates than other patients. None of the studies, however, examined the appropriateness of the utilization levels of physicians who self-refer and those who refer to other sources.

The HHS study found that self-referring physicians referred patients for clinical lab testing at a 45% higher rate than non-investing physicians; the Florida study concluded that physicians' utilization of clinical labs, diagnostic imaging centers, and PT/Rehabilitation Centers was "significantly higher" where physicians are owners; the Hillman study concluded that physicians with a financial interest in diagnostic imaging facilities referred patients at a rate of 4-4.5 times that of non-investing physicians.

There is no evidence in these sources on the extent to which physicians may profit from self-referrals, so the degree of the conflict is not known, except anecdotally.

THE ADVISORY PANEL

The Council also appointed an expert advisory panel to assist it. The panel members consisted of Russel Patterson, MD, Chief of Neurosurgery at Cornell University, New York and a former Chairman of the Council, Newton M. Minow, senior partner in the law firm of Sidley & Austin, former FCC Chairman, Trustee Emeritus of the Mayo Clinic, Director of the Rand Corporation and Director of the Annenberg Washington Program of Northwestern University, and Robert Veatch, PhD, Director of the Kennedy Institute of Ethics. The panel studied the data and other evidence with regard to physician self-referral and reviewed the Council's prior reports and opinions.

The panel members met with the Council and provided an important perspective on the issue. The panel made no formal recommendations to the Council but assisted the Council in establishing a framework for analysis of the issue. The panel identified several considerations of particular significance:

- The medical profession's ability to preserve autonomy and the nature of the physician-patient relationship during periods of transformation have succeeded in large part due to the profession's lack of tolerance for "commercialism" in medicine.
- Government policies toward the profession have been contradictory and have contributed significantly to the rise of commercialism in medicine. The Federal Trade Commission has made unfettered competition a priority in medical practice and has seen physicians primarily as businesspeople. The Commission has acted against certain professional regulatory efforts, in particular, self-imposed restraints on advertising and fees. In contrast, Congress and the Health Care Financing Administration have established an extensive system of oversight and controls that place restrictions on physician practices which are often at odds with the Commission's free market approach. The only consistent theme of government policies is their treatment of physicians as entrepreneurs rather than professionals, with little value being given to physicians' fiduciary obligations.
- The treatment of the self-referral question has important symbolic significance for the public and policymakers with regard to which of two alternative conceptualizations of the physician's role - that of professional or that of entrepreneur - the medical profession will move toward in the era of health care reform. Although physicians will unquestionably continue to be forced into business oriented behavior, and market forces will have an important function in controlling health care costs, the

Association should make clear what balance will be maintained with the profession's unique ethical traditions.

A NEW APPROACH RECOMMENDED BY THE COUNCIL

The Council believes that it is necessary to strengthen its opinion on self referral. It believes that physicians in general can be trusted to deal appropriately with the conflicts presented by self-referral. Indeed, the Council believes that physician investment and self-referral have on balance been positive for patients and the nation's health care system. But anecdotes of excessive profit and utilization have been widespread, and the formal studies which have been done strongly suggest, although they do not actually prove, inherent problems with the practice.

In addition, the Council takes notice of the change in our nation's health care priorities, and in particular, of our patients' expectations about physicians. In the 1990s and beyond, the growth in the costs of health care is likely to be the dominant concern of our patients. The nation has today, and is likely to continue to have, unparalleled availability of health care facilities and technology of all varieties.

In this environment, the Council believes that the issue of self-referral is a part of the larger issue of physicians' commitment to professionalism. As professionals, physicians are expected to devote their energy, attention and loyalty fully to the service of their patients. This does not mean they cannot have outside investments and activities or that they should not invest in health care facilities. It does mean that, to the extent possible, physicians should not be in the business of profiting purely from their ability to refer patients to outside facilities. Such a practice is fundamentally different from deriving financial reward from treating patients in their offices or in outside health care facilities they have invested in at which they care for or provide services to their patients.

At the heart of the Council's view of this issue is its conviction that, how- ever others may see the profession, physicians are not simply businesspeople with high standards. Physicians are engaged in the special calling of healing, and, in that calling, they are the fiduciaries of their patients. They have different and higher duties than even the most ethical businessperson. This is the teaching of the Hippocratic oath and of the great modern teaches of ethical behavior. There are some activities involving their patients which physicians should avoid whether there is evidence of abuse or not.

PATIENT NEED AND NEW GUIDELINES

The Council recognizes that there are circumstances under which patients may be deprived of the best health care if physicians cannot invest and self- refer. Physicians have often been exclusively motivated by the important needs of their patients in becoming involved in such arrangements. Blanket bans on self-referral are inappropriate. Investing and referring when it is a direct extension of a physician's commitment to serve patients' needs is both ethical and desirable. But those needs must not be marginal or rationalized needs, or secondary to a profit motive, and where non-physician or non-referring physician investment is available those sources should be explored and exhausted first.

By recognizing this patient service aspect of physician investment as a basis for ethical self-referral, the Council appreciates that the effectiveness of its general proscription against self referral for profit may be weakened.
Guidelines which do not effect a change in behavior or which are unenforceable because of their vagueness or breadth of exceptions do little to enhance professionalism. Indeed, they reduce the public's confidence in the profession's ability to regulate itself.

The Council does not believe that will occur here. In addition to announcing a shift in its view about self referral - one that finds the practice presumptively inconsistent with the physician's fiduciary duty when adequate alternative facilities exist - the Council is also establishing new and stricter formal guidelines for those physicians who, in order to serve their patients, invest in outside facilities and refer. Only where physicians can demonstrate both the absence of adequate alternative facilities - a plain medical need - and the absence of alternative financing should self-referral take place.

Compliance with these new guidelines, as well as other Council standards, will be enhanced by an increased focus on education and enforcement by the American Medical Association and the constituent state and local societies. The commitment to greater education and enforcement is discussed in a report of the Board of Trustees at this meeting.[8]

RECOMMENDATIONS

Accordingly, the Council on Ethical and Judicial Affairs recommends:

1. Physician investment in health care facilities can provide important benefits for patient care. However, whenphysicians refer patients to facilities in which they have an ownership interest, a potential conflict of interest exists. In general, physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility.

2. Physicians may invest in and refer to an outside facility, whether or not they provide direct care or services at thefacility, if there is a demonstrated need in the community for the facility and alternative financing is not available. There may be situations in which a needed facility would not be built if referring physicians were prohibited from investing in the facility. Need might exist when there is no facility of reasonable quality in the community or when use of existing facilities is onerous for patients. In such cases, the following requirements should also be met:

a. Individuals who are not in a position to refer patients to the facility must be given a bona fide opportunity to invest in the facility, and they must be able to invest on the same terms that are offered to referring physicians. The terms on which investment interests are offered to physicians must not be related to the past or expected volume of referrals or other business from the physicians.

b. There is no requirement that any physician investor make referrals to the entity or otherwise generate business as a condition for remaining an investor.

c. The entity must not market or furnish its items or services to referring physician investors differently than to other investors.

d. The entity must not loan funds or guarantee a loan for physicians in a position to refer to the entity.

e. The return on the physician's investment must be tied to the physician's equity in the facility rather than to the volume of referrals.

f. Investment contracts should not include "non-competition clauses" that prevent physicians from investing in other facilities.

g. Physicians must disclose their investment interest to their patients when making a referral. Patients must be given a list of effective alternative facilities if any such facilities become reasonably available, informed that they have the option to use one of the alternative facilities, and assured that

they will not be treated differently by the physician if they do not choose the physician - owned facility. These disclosure requirements also apply to physician investors who directly provide care or services for their patients in facilities outside their office practice.

h. The physician's ownership interest should be disclosed, when requested, to third party payers.

i. An internal utilization review program must be established to ensure that investing physicians do not exploit their patients in any way, as by inappropriate or unnecessary utilization.

j. When a physician's financial interest conflicts so greatly with the patient's interest as to be incompatible, the physician must make alternative arrangements for the care of the patient.

k. With regard to physicians who invested in facilities under the Council's prior opinion. it is recommended that they reevaluate their activity in accordance with this report and comply with the guidelines in this report to the fullest extent possible. If compliance with the need and alternative investor criteria is not practical, it is essential that the identification of reasonably available alternative facilities be provided.

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