CHAPTER 1

On the Business of Medicine

LEARNING OBJECTIVES

Students will be able to:

- UNDERSTAND THE DISTINCTIVE ELEMENTS OF HEALTH AS A BUSINESS ENTERPRISE
- BECOME FAMILIAR WITH PROFESSIONAL NORMS IN HEALTHCARE
- EXPLORE THE RISE OF FOR-PROFIT MEDICINE THROUGH THE LENS OF SPECIALTY HOSPITALS AND HOSPICE PROVIDERS

INTRODUCTION

The business of medicine, a broad concept incorporating everything from physicians who treat patients in the clinic to marketers who promote pharmaceuticals on television to the scientists and engineers who create medical devices, includes several aspects that create dynamics unlike many other businesses. The healthcare industry is different from other market transactions in some very fundamental ways that are important to consider before we get too far into the legal, ethical, and policy issues that we'll be exploring in this textbook.

I. THE MISSION OF MEDICINE, "CUSTOMER OR PATIENT," AND ISSUES OF PROFESSIONALISM

One way in which healthcare organizations differ from other business entities is in their mission. Business ethics professor Patricia Werhane[1] states it like this:

> "Few corporations define their mission solely in terms of profitability. However, whatever the mission, a goal of any for-profit business firm is the economic well-being of its shareholders. In a healthcare organization, there is no such tight relationship between the rationale of the organization's existence and the condition for its economic survival. The difference between garden-variety corporations and any healthcare organization (whether a for-profit organization or not) is that the **primary mission of healthcare organizations is always the provision of health services to individuals and populations**. This constitutive goal stands in an uneasy relationship with an organization's economic ends. What is strange is not that a healthcare organization is concerned with efficiency, profitability, or—at least—economic survival. The trouble begins when a healthcare organization realigns its mission or creates an organizational culture in which efficiency, productivity, or profitability become the first priorities." [emphasis added]

Professor Werhane's point about priorities is important to consider, and perhaps it has emerged in other courses. It is not limited to a course exploring the world of healthcare, but it is especially important in this context.

---

[1] DEVELOPING ORGANIZATION ETHICS IN HEALTHCARE: A CASE-BASED APPROACH TO POLICY, PRACTICE, AND COMPLIANCE. Editors: Mills, Spencer, & Werhane, University Publishing Group (2001) "Introduction to Organization Issues in Business Ethics," by Patricia H. Werhane (pp. 13–18).

A. In a Business, What Is the Top Priority? What Is the Top Priority in the Healthcare Setting? Can These Priorities Be Reconciled?

The question of top priority in a business has triggered many debates in business school classrooms. Answers range from profit-maximization to enhanced social welfare, including meaningful employment, safe products, quality services, and customer satisfaction. As Harvard Professor Michael E. Porter and Mark R. Kramer have observed, another important business priority is building "shared value" for a variety of stakeholders. What additional priorities or goals might be important?

Obviously, making money is critical! No entity, whether organized as a for-profit or a non-profit entity, can stay in business very long if it can't keep the lights on and make payroll. However, financial solvency cannot be the only priority for a healthcare organization. Concern for the well-being of patients must be an additional concern. For most types of businesses, customers (i.e. the consumers of those businesses) may be important stakeholders, but they are not always the primary stakeholders. On the other hand, for healthcare organizations, patients (i.e., the consumers of the healthcare services provided by the healthcare organization) have a privileged status for a variety of reasons.

In the clinical context—i.e., at the bedside or in the examination room, these "consumers," i.e. patients, create a particularly unique and challenging set of concerns. Kenneth Arrow, the Nobel laureate economist, famously noted that the relational dynamics between a physician and her patient make it impossible for patients to be the same rational and savvy consumers they might otherwise be in most other marketplace settings.[2] Arrow observed that unlike many commodities, the need for healthcare is often unpredictable and needed urgently. Waiting, like one might for the newest mobile phone to be released, is

[2] Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AMERICAN ECONOMIC REVIEW 941, 948–54 (1963).

not always possible when one is seeking health care. Moreover, Arrow noted the asymmetry of information, where a patient—even with access to WebMD and Google—may never have complete information about her medical condition or the costs associated with her recommended treatment.

Additionally, unlike shopping for a new car—where a test drive is always an option prior to the purchase—with healthcare services such as a surgical procedure, no test drive is available. Rather, a patient/consumer must trust that the healthcare procedure being performed or prescription being recommended is appropriate. In short, the engagement between physician and patient is frequently infused—for both parties—with trust, intimacy and vulnerability, as well as fear and uncertainty regarding the potential life and death consequences of decisions made and actions taken. The complex relationship between a patient-consumer and a physician-provider creates a unique transaction experience with few analogues. Indeed, a question worth pondering is what analogues do exist in other industries and markets.

The healthcare delivery business is, in essence, a business where the primary commodities are treatment and advice, i.e. service. Literally, care for another individual's health is what is being bought and sold. The dynamics of this transaction between doctor and patient have at least three distinctive and inter-related qualities: the centrality of a relationship predicated upon trust between a professional healthcare provider and a patient; the unique potential for vulnerability and compromised judgment on the part of both the patient and the provider; and the myriad systematic issues of cost and access that inevitably impact upon one's encounter—or even access to an encounter—with his healthcare provider.

The vast array of treatment facilities (inpatient and outpatient), clinicians, insurance companies, marketing and advertising firms, information technology consultants, billing and collection agencies, the global pharmaceutical industry, and other producers of life science products and devices constitute a complex "healthcare business" that

Arnold S. Relman famously described as a "new medical-industrial complex."

Dr. Relman, the Harvard Medical School professor and former editor of *The New England Journal* was among the earliest observers and critics of the healthcare business that mushroomed throughout the latter third of the 20th century in the wake of Medicare/Medicaid passage in 1965. Dr. Relman distinguishes between the "old" medical-industrial complex, primarily pharmaceutical and medical device corporations, and the "new" emerging "network of private corporations engaged in the business of supplying healthcare services to patients for a profit." Relman's article provides a valuable historical perspective—as well as an implicit critique of medicine's increasing for-profit environment—as he comments on trends near the end of the 20th century that gave rise to the challenges those in the business of medicine continue to face over thirty years later in an American context even more dominated by for-profit, market-driven, MBA-orchestrated healthcare business models.

THE NEW MEDICAL-INDUSTRIAL COMPLEX[3]

Arnold S. Relman
303 New Eng. J. Med. 963 (1980)

IN his farewell address as President on January 17, 1961, Eisenhower warned his countrymen of what he called "the military-industrial complex," a huge and permanent armaments industry that, together with an immense military establishment, had acquired great political and economic power. He was concerned about the possible conflict between public and private interests in the crucial area of national defense.

The past decade has seen the rise of another kind of private "industrial complex" with an equally great potential for influence on public

[3] New England Journal of Medicine, Arnold S. Relman, The New Medicial-Industrial Complex, Volume 303, Page No. 963. Copyright © 1980 Massachusetts Medical Society. Reprinted with permission from Massachusetts Medical Society conveyed through Copyright Clearance Center, Inc.

policy—this time in health care. What I will call the "new medical-industrial complex" is a large and growing network of private corporations engaged in the business of supplying health-care services to patients for a profit—services heretofore provided by nonprofit institutions or individual practitioners.

I am not referring to the companies that manufacture pharmaceuticals or medical equipment and supplies. Such businesses have sometimes been described as part of a "medical-industrial complex," but I see nothing particularly worrisome about them. They have been around for a long time, and no one has seriously challenged their social usefulness. Furthermore, in a capitalistic society there are no practical alternatives to the private manufacture of drugs and medical equipment.

The new medical-industrial complex, on the other hand, is an unprecedented phenomenon with broad and potentially troubling implications for the future of our medical-care system. It has attracted remarkably little attention so far (except on Wall Street), but in my opinion it is the most important recent development in American health care and it is in urgent need of study.

In the discussion that follows I intend to describe this phenomenon briefly and give an idea of its size, scope, and growth. I will then examine some of the problems that it raises and attempt to show how the new medical-industrial complex may be affecting our health-care system. A final section will suggest some policies for dealing with this situation.

In searching for information on this subject, I have found no standard literature and have had to draw on a variety of unconventional sources: corporation reports; bulletins and newsletters; advertisements and newspaper articles; and conversations with government officials, corporation executives, trade-association officers, investment counselors, and physicians knowledgeable in this area. I take full responsibility for any errors in this description and would be grateful for whatever corrections readers might supply.

The New Medical-Industrial Complex

Proprietary Hospitals

Of course proprietary hospitals are not new in this country. Since the past century, many small hospitals and clinics have been owned by physicians, primarily for the purpose of providing a workshop for their practices. In fact, the majority of hospitals in the United States were proprietary until shortly after the turn of the [twentieth] century, when the small doctor-owned hospitals began to be replaced by larger and more sophisticated community or church-owned nonprofit institutions. The total number of proprietary hospitals in the country decreased steadily during the first half of [the twentieth] century. In 1928 there were 2435 proprietary hospitals, constituting about 36 per cent of hospitals of all types; by 1968 there were only 769 proprietary hospitals, 11 per cent of the total.

However, there has been a steady trend away from individual ownership and toward corporate control. During the [1970s] the total number of proprietary hospitals has been increasing again, mainly because of the rapid growth of the corporate-owned multi-institutional hospital chains.

There are now about 1000 proprietary hospitals in this country; most of them provide short-term general care, but some are psychiatric institutions. These hospitals constitute more than 15 per cent of nongovernmental acute general-care hospitals in the country and more than half the nongovernmental psychiatric hospitals. About half the proprietary hospitals are owned by large corporations that specialize in hospital ownership or management; the others are owned by groups of private investors or small companies. In addition to the 1000 proprietary hospitals, about 300 voluntary nonprofit hospitals are managed on a contractual basis by one or another of these profit-making hospital corporations.

The proprietary hospitals are mostly medium-sized (100 to 250 beds) institutions offering a broad range of general inpatient services but few outpatient facilities other than an emergency room. Some are smaller

than 100 beds and a few are larger than 250 beds, but none would qualify as major medical centers, none have residency programs, and few do any postgraduate teaching. Most are located in the Sunbelt states in the South, in the Southwest, and along the Pacific Coast, in relatively prosperous and growing small and medium-sized cities and in the suburbs of the booming big cities of those areas. Virtually none are to be found in the big old cities of the North or in the states with strong rate-setting commissions or effective certificate-of-need policies.

Although there are no good, detailed studies comparing the characteristics and performance of proprietary and voluntary hospitals, there is a generally held view that proprietary hospitals have more efficient management and use fewer employees per bed. It is also said that fewer of the patients in proprietary hospitals are in the lower income brackets and that fewer are funded through Medicaid. One prominent hospital official told me that proprietary hospitals generally have per diem rates that are comparable to those in the voluntary hospitals, but that their ancillary charges are usually higher. However, this official stressed the lack of good data on these questions.

Last year the proprietary-hospital business generated between $12 billion and $13 billion of gross income—an amount that is estimated to be growing about 15 to 20 per cent per year (corrected for inflation). A major area of growth is overseas—in industrialized Western countries as well as underdeveloped countries—where much of the new proprietary-hospital development is now taking place. Of the two or three dozen sizable United States corporations now in the hospital business the largest are Humana and Hospital Corporation of America, each of which had a gross revenue of over $1 billion last year. Others are American Medical International (AMI) and Hospital Affiliates International (a unit of the huge INA Corporation), with gross revenues last year of approximately $0.5 billion each.

Proprietary Nursing Homes

Proprietary nursing homes are even bigger business. In 1977 there were nearly 19,000 nursing-home facilities of all types, and about 77 per cent

were proprietary. Some, like the proprietary hospitals, are owned by big corporations, but most (I could not find out exactly how many) are owned by small investors, many of them physicians. The Health Care Financing Administration estimates that about $19 billion was expended last year for nursing-home care in the United States. Assuming that average revenues of proprietary and nonprofit facilities are about equal, this means that about $15 billion was paid to proprietary institutions. This huge sum is growing rapidly, as private and public third-party coverage is progressively extended to pay for this kind of care.

Home Care

Another large and rapidly expanding sector of the health-care industry, but one that is even less well defined than the nursing-home business, is home care. A wide variety of home services are now being provided by profit-making health-care businesses. These services include care by trained nurses and nurses' aides, homemaking assistance, occupational and physiotherapy, respiratory therapy, pacemaker monitoring, and other types of care required by chronically ill house-bound patients. The total expenditures for these services are unknown, but I have been told that the market last year was at least $3 billion. Most of these services are provided by a large array of small private businesses, but there are about 10 fairly large companies in this field at present, and their combined sales are probably in excess of $0.5 billion. The largest corporate provider of home care is said to be the Upjohn Company. About half the total cost of home health care in this country is currently paid by Medicare. As Medicare and private third-party coverage broadens, this health-care business can be expected to grow apace.

Laboratory and Other Services

Last year, about $15 billion was spent on diagnostic laboratory services of all kinds. The number of laboratory tests performed each year in this country is huge and growing at a compound rate of about 15 per cent per year. About a third of the diagnostic laboratories are owned by profit-making companies. Most of these are relatively small local firms,

but there are a dozen or more large corporations currently in the laboratory business, some with over $100 million in sales per year. Some of these corporations operate laboratories in the voluntary nonprofit hospitals, but most of the proprietary laboratories are outside hospitals and use an efficient mail or messenger service. Including all proprietary laboratories, large and small, in and out of hospitals, probably some $5 billion or $6 billion worth of services were sold last year.

A large variety of services are being sold by newly established companies in the medical-industrial complex. Included are mobile CAT scanning, cardiopulmonary testing, industrial health screening, rehabilitation counseling, dental care, weight-control clinics, alcohol and drug-abuse programs, comprehensive prepaid HMO programs, and physicians' house calls. Two markets that deserve special mention are hospital emergency-room services and long-term hemodialysis programs for end-stage renal disease.

With the decline in general practice and the virtual disappearance of physicians able and willing to make house calls, the local hospital emergency room has become an increasingly important source of walk-in medical and psychiatric services in urban and suburban areas. The use of emergency rooms has increased rapidly in the past two decades and has stimulated the development of emergency medicine as a specialty. Most third-party payers reimburse for services rendered in hospital emergency rooms at a higher rate than for the same services provided by physicians in their private offices.

The result has been a vigorous new industry specializing in emergency services. Many large businesses have been established by entrepreneurial physicians to supply the necessary professional staffing for emergency rooms all over the country, and this has proved to be a highly profitable venture. In some cases, large corporations have taken over this function and now provide hospitals with a total emergency-care package. Once an appropriate financial arrangement is made, they will organize and administer the emergency room, see to its

accreditation, recruit and remunerate the necessary medical and paramedical personnel, and even arrange for their continuing education. At least one large corporation that I learned about has such arrangements with scores of hospitals all over the country and employs hundreds of emergency physicians. I do not know exactly how much money is involved or how many physicians and hospitals participate in such schemes around the country, but I am under the impression that this a very large business.

Hemodialysis

Long-term hemodialysis is a particularly interesting example of stimulation of private enterprise by public financing of health care. In 1972 the Social Security Act was amended to bring the treatment of end-stage renal disease under Medicare funding. When the new law was enacted, only about 40 patients per million population were receiving long-term hemodialysis treatment in this country, almost entirely under the auspices of nonprofit organizations. Forty per cent of these dialyses were home based, and renal transplantation was rapidly becoming an alternative form of treatment. The legislation provided for reimbursement for center-based or hospital-based dialysis without limit in numbers. The result was an immediate, rapid increase in the total number of patients on long-term dialysis treatment and a relative decline in home dialysis and transplantations. The number of patients on dialysis treatment in the United States is now over 200 per million population (the highest in the world), and only about 13 per cent are being dialyzed at home.

Proprietary dialysis facilities began to appear even before public funding of end-stage renal disease but the number increased rapidly thereafter. These facilities were usually located outside hospitals and had lower expenses than the hospital units. Many were purely local units, owned by nephrologists practicing in the area, but one corporation, National Medical Care, soon became preeminent in the field. This company was founded by nephrologists and employs many local nephrologists as physicians and medical directors in its numerous

centers around the country. It currently has sales of over $200 million annually and performs about 17 per cent of the long-term dialysis treatments in the country. It has recently expanded into the sale of dialysis equipment and supplies and the provision of psychiatric hospital care, respiratory care, and centers for obesity treatment, but its main business is still to provide dialysis for patients with end-stage renal disease in out-of-hospital facilities that it builds and operates. According to data obtained from the Health Care Financing Administration, nearly 40 per cent of the hemodialysis in this country is now provided by profit-making units. This figure suggests that total sales are nearly $0.5 billion a year for this sector of the health-care industry.

Income and Profitability

This, in barest outline, is the present shape and scope of the "new medical-industrial complex," a vast array of investor-owned businesses supplying health services for profit. No one knows precisely the full extent of its operations or its gross income, but I estimate that the latter was approximately $35 billion to $40 billion last year—about a quarter of the total amount expended on personal health care in 1979. Remember that this estimate does not include the "old" medical-industrial complex, i.e., the businesses concerned with the manufacture and sale of drugs, medical supplies, and equipment.

The new health-care industry is not only very large, but it is also expanding rapidly and is highly profitable. New businesses seem to be springing up all the time, and those already in the field are diversifying as quickly as new opportunities for profit can be identified. Given the expansive nature of the health-care market and the increasing role of new technology, such opportunities are not hard to find.

The shares of corporations in the health-care business have done exceedingly well in the stock market, and many Wall Street analysts and brokers now enthusiastically recommend such investments to their clients. According to an article in the Wall Street Journal of December 27, 1979, the net earnings of health-care corporations with public stock

shares rose by 30 to 35 per cent in 1979 and are expected to increase another 20 to 25 per cent in 1980. A vice-president of Merrill Lynch appeared [recently] on "Wall Street Week," the public television program, to describe the attractions of health-care stocks. According to this authority, health care is now the basis of a huge private industry, which is growing rapidly, has a bright future, and is relatively invulnerable to recession. He predicted that the health business would soon capture a large share of the health-care market and said that the only major risk to investors was the threat of greater government control through the enactment of comprehensive national health insurance or through other forms of federal regulation.

Why Have Private Businesses in Health Care?

Let us grant that we have a vast, new, rapidly growing and profitable industry engaged in the direct provision of health care. What's wrong with that? In our country we are used to the notion that private enterprise should supply most of the goods and services that our society requires. With the growing demand for all kinds of health care over the past two decades and the increasing complexity and cost of the services and facilities required, wasn't it inevitable that businesses were attracted to this new market? Modern health-care technology needs massive investment of capital—a problem that has become more and more difficult for the voluntary nonprofit institutions. How appropriate, then, for private entrepreneurs to come forward with the capital needed to build and equip new hospitals, nursing homes, and laboratories, and to start new health-care businesses. The market was there and a good profit ensured; the challenge was simply to provide the necessary services efficiently and at an acceptable level of quality. In theory, the free market should operate to improve the efficiency and quality of health care. Given the spur of competition and the discipline exerted by consumer choice, private enterprise should be expected to respond to demand by offering better and more varied services and products, at lower unit costs, than could be provided by nonprofit voluntary or governmental institutions. Large corporations ought to be better managed than public or voluntary institutions; they have a

greater incentive to control costs, and they are in a better position to benefit from economies of scale. We Americans believe in private enterprise and the profit motive. How logical, then, to extend these concepts to the health-care sector at a time when costs seem to be getting out of control, voluntary institutions are faltering, and the only other alternative appears to be more government regulation.

That, at least, is the theory. Whether the new medical-industrial complex is in fact improving quality and lowering unit cost in comparison with the public or private voluntary sectors remains to be determined. There are no adequate studies of this important question, and we will have to suspend judgment until there are some good data. But even without such information, I think that there are reasons to be concerned about this new direction in health care.

Some Issues

Can we really leave health care to the market-place? Even if we believe in the free market as an efficient and equitable mechanism for the distribution of most goods and services, there are many reasons to be worried about the industrialization of health care. In the first place, health care is different from most of the commodities bought and sold in the marketplace. Most people consider it, to some degree at least, a basic right of all citizens. It is a public rather than a private good, and in recognition of this fact, a large fraction of the cost of medical research and medical care in this country is being subsidized by public funds. Public funds pay for most of the research needed to develop new treatments and new medical-care technology. They also reimburse the charges for health-care services. Through Medicare and Medicaid and other types of public programs, more and more of our citizens are receiving tax-supported medical care.

The great majority of people not covered by public medical-care programs have third-party coverage through private insurance plans, most of which is provided as a fringe benefit by their employers. At present, almost 90 per cent of Americans have some kind of health insurance, which ensures that a third party will pay at least part of their

medical expenses. Federal programs now fund about 40 per cent of the direct costs of personal health care, and a large additional government subsidy is provided in the form of tax exemptions for employee health benefits. Thus, a second unique feature of the medical-care market is that most consumers (i.e., patients) are not "consumers" in the Adam Smith sense at all. As Kingman Brewster recently observed, health insurance converts patients from consumers to claimants, who want medical care virtually without concern for price. Even when they have to pay out of their own pockets, patients who are sick or worried that they may be sick are not inclined to shop around for bargains. They want the best care they can get, and price is secondary. Hence, the classic laws of supply and demand do not operate because health-care consumers do not have the usual incentives to be prudent, discriminating purchasers.

There are other unique features of the medical marketplace, not the least of which is the heavy, often total, dependence of the consumer (patient) on the advice and judgment of the physician. Kenneth Arrow, in explaining why some of the economist's usual assumptions about the competitive free market do not apply to medical care, referred to this phenomenon as the "informational inequality" between patient and physician. Unlike consumers shopping for most ordinary commodities, patients do not often decide what medical services they need—doctors usually do that for them. Probably more than 70 per cent of all expenditures for personal health care are the result of decisions of doctors.

All these special characteristics of the medical market conspire to produce an anomalous situation when private business enters the scene. A private corporation in the health-care business uses technology often developed at public expense, and it sells services that most Americans regard as their basic right—services that are heavily subsidized by public funds, largely allocated through the decisions of physicians rather than consumers, and almost entirely paid for through third-party insurance. The possibilities for abuse and for distortion of social purposes in such a market are obvious.

Health care has experienced an extraordinary inflation during the past few decades, not just in prices but in the use of services. A major challenge—in fact, the major challenge—facing the health-care establishment today is to moderate use of our medical resources and yet protect equity, access, and quality. The resources that can be allocated to medical care are limited. With health-care expenditures now approaching 10 per cent of the gross national product, it is clear that costs cannot continue to rise at anything near their present rate unless other important social goals are sacrificed. We need to use our health-care dollars more effectively, by curbing procedures that are unnecessary or inefficient and developing and identifying those that are the best. Overuse, where it exists, can be eliminated only by taking a more critical view of what we do and of how we use our health-care resources.

How will the private health-care industry affect our ability to achieve these objectives? In an ideal free competitive market, private enterprise may be good at controlling unit costs, and even at improving the quality of its products, but private businesses certainly do not allocate their own services or restrict the use of them. On the contrary, they "market" their services; they sell as many units as the market will bear. They may have to trim their prices to sell more, but the fact remains that they are in business to increase their total sales.

If private enterprise is going to take an increasing share of the health-care market, it will therefore have to be appropriately regulated. We will have to find some way of preserving the advantages of a private health-care industry without giving it free rein and inviting gross commercial exploitation. Otherwise, we can expect the use of health services to continue to increase until government is forced to intervene.

The Role of the Medical Profession

It seems to me that the key to the problem of over-use is in the hands of the medical profession. With the consent of their patients, physicians act in their behalf, deciding which services are needed and which are not, in effect serving as trustees. The best kind of regulation of the

health-care marketplace should therefore come from the informed judgments of physicians working in the interests of their patients. In other words, physicians should supply the discipline that is provided in commercial markets by the informed choices of prudent consumers, who shop for the goods and services that they want, at the prices that they are willing to pay.

But if physicians are to represent their patients' interests in the new medical marketplace, they should have no economic conflict of interest and therefore no pecuniary association with the medical-industrial complex. I do not know the extent to which practicing physicians have invested in health-care businesses, but I suspect that it is substantial. Physicians have direct financial interests in proprietary hospitals and nursing homes, diagnostic laboratories, dialysis units, and many small companies that provide health-care services of various kinds. Physicians are on the boards of many major health-care corporations, and I think it is safe to assume that they are also well represented among the stockholders of these corporations. However, the actual degree of physician involvement is less important than the fact that it exists at all. As the visibility and importance of the private health-care industry grow, public confidence in the medical profession will depend on the public's perception of the doctor as an honest, disinterested trustee. That confidence is bound to be shaken by any financial association between practicing physicians and the new medical-industrial complex. Pecuniary associations with pharmaceutical and medical supply and equipment firms will also be suspect and should therefore be curtailed.

What I am suggesting is that the medical profession would be in a stronger position, and its voice would carry more moral authority with the public and the government, if it adopted the principle that practicing physicians should derive no financial benefit from the health-care market except from their own professional services. I believe that some statement to this effect should become part of the ethical code of the AMA. As such, it would have no legal force but would be accepted as a standard for the behavior of practicing physicians all over the country.

The AMA's former Principles of Ethics, which has just been superseded by the new set of principles adopted by the House of Delegates at its last meeting, did include a declaration on physicians' financial interests, but it was directed primarily at fee-splitting and rebates. The old Section 7 of the Principles said: "In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients [italics mine]." Although at first glance this statement might appear to have proscribed any involvement of physicians in health-care businesses, it actually did not. The italicized words in effect restricted the application of Section 7 to income derived directly from the care of a physician's own patients. In the Opinions and Reports of the Judicial Council, a more detailed commentary that supplements and interprets the Principles of Ethics, this restriction is made quite clear. The council says that "It is not in itself unethical for a physician to own a for-profit hospital or interest therein," provided that the physician does not make unethical use of that ownership. With respect to ownership of nursing homes and laboratories or interest in them, the council's position is much the same. Similarly, there is no proscription of ownership of a pharmacy or of financial interest in pharmaceutical corporations—only of improper professional behavior on behalf of such economic interests. In the revised new Principles of Medical Ethics just adopted, there is no statement about economic conflicts of interest, but the council's previous Opinions and Reports on this matter will presumably stand.

The position of the Judicial Council seems to be that although physicians must always place the welfare of their patients above their own financial interests, there is nothing inherently improper in physicians' owning or investing in health-care businesses. If they act on their financial interests by overusing services or through kickbacks and rebates, that would be considered improper; but only actual abuses are of concern, not hypothetical or potential conflicts of interest.

The trouble with that policy is that it ignores the public responsibilities of the medical profession. Physicians evaluate drugs, devices,

diagnostic tests, and therapeutic procedures in the public interest. Their opinions—expressed publicly in articles, speeches, and committee reports—not only influence the practices of their colleagues but carry weight in the councils of government and directly affect the fortunes of health-care businesses. That is why the Wall Street Journal and the financial sections of the major newspapers carry so many news items about medical developments. The medical-industrial complex depends heavily on the favorable public judgments of physicians, individually and collectively. Doctors may not be able to affect the profits of large companies by what they do in their own practices, but they can easily do so through published articles, public statements, or committee reports. The Judicial Council, in commenting on the potential abuse of laboratory services, rightly declared that a physician "is not engaged in a commercial enterprise . . . " (Opinions and Reports, Section 4.40(2)). That statement should apply to all of a physician's professional activities in the health-care field, not just to personal practice.

If the AMA took a strong stand against any financial interest of physicians in health-care businesses, it might risk an antitrust suit. Its action might also be misconstrued as hostile to free enterprise. Yet, I believe that the risk to the reputation and self-esteem of the profession will be much greater if organized medicine fails to act decisively in separating physicians from the commercial exploitation of health care. The professional standing of the physician rests no less on ethical commitment than on technical competence. A refusal to confront this issue undermines the moral position of the profession and weakens the authority with which it can claim to speak for the public interest.

A brochure published by Brookwood Health Services, Inc., one of the many new corporations that owns and operates a chain of proprietary hospitals, says that it "views each physician as a business partner." (In evidence of this commercial partnership, the company recruits young physicians and subsidizes their start in private practice.) That sentiment may make for good working relations between hospital administration and medical staff, but it sounds precisely the wrong note for a private

market in which the hospital is the seller, the physician is the purchasing agent for the patient, and the public pays the major share of the bill.

Critics of the position argued here will probably point out that even without any investment in healthcare businesses, physicians in private fee-for-service practice already have a conflict of interest in the sense that they benefit from providing services that they themselves prescribe. That may be true, but the conflict is visible to all and therefore open to control. Patients understand fee-for-service and most are willing to assume that their doctor's professional training protects them from exploitation. Furthermore, those who distrust their physicians or dislike the fee-for-service system have other alternatives: another physician, a prepayment plan, or a salaried group. What distinguishes the conflict of interest that I have been discussing are its invisibility and a far greater potential for mischief.

Other Problems

The increasing commercialization of health care generates still other serious problems that need to be mentioned. One is the so-called "cream-skimming" phenomenon. Steinwald and Neuhauser discussed this problem with reference to proprietary hospitals 10 years ago, when the new health-care industry was just appearing on the scene. "The essence of the cream-skimming argument," they said, "is that proprietary hospitals can and do profit by concentrating on providing the most profitable services to the best-paying patients, thereby skimming the cream off the market for acute hospital care and leaving the remainder to nonprofit hospitals." According to these authors, there are two types of "cream-skimming": elimination of low-frequency and unprofitable (though necessary) services, and exclusion of unprofitable patients (e.g., uninsured patients, welfare patients, and those with complex and chronic illnesses). The nonprofit hospitals could not employ such practices, even if they wished to do so, because they have community obligations and are often located in areas where there are many welfare patients. Another form of "skimming" by proprietary hospitals, whether intentional or not, is their virtual lack of

residency and other educational programs. Teaching programs are expensive and often oblige hospitals to maintain services that are not economically viable, simply to provide an adequate range of training experience.

Although these arguments seem reasonable, there are no critical studies on which to base firm conclusions about the extent and implications of the skimming phenomenon in the proprietary sector. One has the sense that the larger teaching institutions, particularly those that serve the urban poor, will be feeling increasing competitive economic pressure not only from the proprietary hospitals but also from the medium-sized community hospitals in relatively well-to-do demographic areas. Their charges are generally lower than those of the teaching centers, they take patients away from the centers, and they put the centers in a difficult position in negotiating with rate-setting agencies.

Another danger arises from the tendency of the profit-making sector to emphasize procedures and technology to the exclusion of personal care. Personal care, whether provided by physicians, nurses, or other health-care practitioners, is expensive and less likely to produce large profits than the item-by-item application of technology. Reimbursement schedules are, of course, a prime consideration in determining what services will be emphasized by the health-care industry, but in general the heavily automated, highly technical procedures will be favored, particularly when they can be applied on a mass scale. Just as pharmaceutical firms have tended to ignore "orphan" drugs, i.e., drugs that are difficult or expensive to produce and have no prospect of a mass market, the private health-care industry can be expected to ignore relatively inefficient and unprofitable services, regardless of medical or social need. The result is likely to exacerbate present problems with excessive fragmentation of care, overspecialism, and overemphasis on expensive technology.

A final concern is the one first emphasized by President Eisenhower in his warning about the "military-industrial complex": "We must guard

against the acquisition of unwarranted influence." A private health-care industry of huge proportions could be a powerful political force in the country and could exert considerable influence on national health policy. A broad national health-insurance program, with the inevitable federal regulation of costs, would be anathema to the medical-industrial complex, just as a national disarmament policy is to the military-industrial complex. I do not wish to imply that only vested interests oppose the expansion of federal health-insurance programs (or treaties to limit armaments), but I do suggest that the political involvement of the medical-industrial complex will probably hinder rather than facilitate rational debate on national health-care policy. Special-interest lobbies of all kinds are of course a familiar part of the American health-care scene. The appearance of still one more vested interest would not be a cause for concern if the newcomer were not potentially the largest, richest, and most influential of them all. One health-care company, National Medical Care, has already made its political influence felt, when Congress was considering a revision of the legislation supporting the end-stage renal disease program in 1978.

Some Proposals

The new medical-industrial complex is now a fact of American life. It is still growing and is likely to be with us for a long time. Any conclusions about its ultimate impact on our health-care system would be premature, but it is safe to say that the effect will be profound. Clearly, we need more information.

My initial recommendation, therefore, is that we should pay more attention to the new health-care industry. It needs to be studied carefully, and its performance should be measured and compared with that of the nonprofit sector. We need to know much more about the quality and cost of the services provided by the profit-making companies and especially the effects of these companies on use, distribution, and access. We also must find out the extent to which "cream-skimming" is occurring and whether competition from profit-

making providers is really threatening the survival of our teaching centers and major urban hospitals.

I suspect that greater public accountability and increased regulation of the private health-care industry will ultimately be required to protect the public interest. However, before any rational and constructive public policies can be developed, we will need a much greater understanding of what is happening. A vast amount of study is still to be done.

The private health-care industry is primarily interested in selling services that are profitable, but patients are interested only in services that they need, i.e., services that are likely to be helpful and are relatively safe. Furthermore, everything else being equal, society is interested in controlling total expenditures for health care, whereas the private healthcare industry is interested in increasing its total sales. In the health-care marketplace the interests of patients and of society must be represented by the physician, who alone has the expertise and the authority to decide which services and procedures should be used in any given circumstance. That is why I have urged that physicians should totally separate themselves from any financial involvement in the medical-industrial complex. Beyond that, however, physicians must take a more active interest in assessing medical procedures. Elsewhere I have argued for a greatly expanded national program of evaluation of clinical tests and procedures. Such a program would provide an excellent means by which to judge the social usefulness of the private health-care industry, which depends heavily on new technology and special tests and procedures.

If we are to live comfortably with the new medical-industrial complex we must put our priorities in order: the needs of patients and of society come first. If necessary services of acceptable quality can be provided at lower cost through the profit-making sector, then there may be reason to encourage that sector. But we should not allow the medical-industrial complex to distort our health-care system to its own entrepreneurial ends. It should not market useless, marginal, or unduly

expensive services, nor should it encourage unnecessary use of services. How best to ensure that the medical-industrial complex serves the interests of patients first and of its stockholders second will have to be the responsibility of the medical profession and an informed public.

After reading and reflecting on Dr. Relman's seminal article, what do you think about the role of the market—and especially for-profit providers—in the delivery of medicine?

B. Additional Differences Between Health Care Organizations and Many Other Businesses

An additional dynamic of the healthcare business which reverberates throughout society is the ripple effect this industry has upon all other sectors of the economy. In short, the general health of a population is a requisite condition for sustained economic wellbeing. Thus, in addition to ethical concerns involving individual patients and broader concerns regarding conceptions of a good or just society, it is in everyone's best interest, financial and otherwise, for there to be broad and comprehensive access to healthcare providers.

As suggested above, these variables, particularly the relational dynamics, are infused with ethical concerns and serve to differentiate the business of delivering clinical healthcare services from other market transactions in fundamental ways. First, physicians and nurses are professionals that have historically enjoyed a measure of public respect and deference concomitant with an expectation that their medical judgments would be guided first and foremost by what is in their particular patient's best interest. Regardless of her socioeconomic status or level of education, and notwithstanding the past forty years of bioethicists' emphasizing the necessity for patient autonomy and choice, a patient must ultimately rely upon the advice and direction of her healthcare professionals for her wellbeing. Even as the more savvy healthcare consumer seeks multiple opinions and consults virtual

libraries of data on the Internet, the motivation to self-educate and question one's physician is not born of *caveat emptor*.[4]

Rather, one seeks a second opinion because it is understood that medicine is as much art as science. Healing is an interpretive exercise, and a patient's decision to seek alternative interpretations should be animated by a rational and prudent awareness of medicine's subjectivity, not fear or mistrust regarding a physician's potential ulterior motivations or incentives.[5] Patients, particularly those who for whatever reason are especially vulnerable, should not have to beware of what self-interested profit motivations might be lurking in the shadows and influencing their doctor's medical judgment.

Of course, even the most altruistic caregiver rightly expects to receive some measure of compensation. However, if a patient's confidence in her healthcare provider to put the patient's best interests ahead of the physician's own pecuniary interest is too badly shaken, how soon will it be before patients no longer submit to invasive and painful procedures, or even routine and regular preventive examinations? What are the public health consequences if what Arrow terms the patient's perception of her physician's "moral authority" is replaced with the perception that her physician is only, or primarily, motivated by profits?

The delivery of healthcare is, "at its roots, a helping enterprise,"—a business permeated with the concept of care—that has historically been characterized by individual and corporate commitments to serving the best interests of others, not a reductionist pursuit of profit maximization driven by advertising campaigns, efforts to increase sales, and strategies for capturing market share. It was this more expansive view of the healthcare business as a helping profession with its clinical boundaries governed by a robust ethical tradition that led healthcare executive Troyen Brennan, nearly twenty-five years ago, to argue that

---

4 Latin for, "Let the buyer beware."

5 *See* Heather Elms et al., *Ethics and Incentives: An Evaluation and Development of Stakeholder Theory in the Health Care Industry*, 12 BUS. ETHICS Q. 413, 425 (2002) (concluding that economic incentives can encourage physicians to behave in ways inconsistent with the ethical norms of the profession).

the goal of health policy should be "moral consistency between the realm of clinical interventions and access to the institutions that provide them."[6]

Attempting to influence the healthcare reform debates that raged during the first half of the 1990s, Brennan argued in favor of an ethical approach to health policy reform that extrapolates from the virtues of traditional bedside medical ethics, such as the relational dynamics of physician-patient relationships governed by principles of nonmaleficence and beneficence, to form "a foundation for an ethics of health care reform."

In Brennan's formulation, such a move requires an expansion "in focus from the relationship between doctors and patients to [include] the relationship between the class of patients and the health care system." To prioritize the commitments for this approach to ethical healthcare reform, Brennan borrows from Rawls's original-position thought experiment to consider how physicians might think about and care for patients if they were completely blind with regard to both their and their patient's socioeconomic status.

In short, Brennan asks, "What would a healthcare system look like if physicians were guided by the altruistic, patient-centered values of medical ethics and professionalism?" He concludes that three principles would emerge as guideposts: (1) An expansion of the traditional altruistic commitment between physician and patient to a broader concern for the welfare of all potential patients; (2) An institutional commitment that respects and supports the essential therapeutic relationships between individual patients and providers, while also balancing the reality of systematic resource limitations in the allocation of services; and (3) A renewed sense of membership in a "healing community" populated by health care providers that recognize the interconnected and collective impact of their individual actions and

[6] Troyen A. Brennan, *An Ethical Perspective on Health Care Insurance Reform*, 19 AMERICAN JOURNAL OF LAW AND MEDICINE 37, 48 (1993).

the necessity of practicing medicine in a spirit of solidarity and harmony with one another.

Brennan anticipates an objection to his ethical approach to health policy by advocates of market-based approaches "who would prefer to draw health care directly into the liberal state rather than use ethical impulses to reform the present system." Indeed, for over a decade, arguments for a free and largely unregulated market for healthcare have proliferated, perhaps promoted most effectively by Regina Herzlinger, the Harvard Business School professor and, according to *Money Magazine*, the "Godmother" of the movement towards consumer-driven healthcare.

Professor Herzlinger argues that the best prescription for healthcare reform is to remove the "regulatory straightjackets" from entrepreneurially-minded physicians, whose specialized health care facilities, in which they have an ownership interest, "represent the best hope for a higher-quality and higher productivity healthcare system."[7] Herzlinger argues that cardiology and orthopedic services, for example, are only highly profitable because "insurance and government bureaucrats" have unilaterally set reimbursement rates at wrongly generous levels that are insulated from the market forces that should govern. If healthcare consumers, i.e., patients, were made more sensitive to the cost of services, and then empowered to make informed health care decisions within the context of a consumer-driven insurance system, the nation's "healthcare woes" would be cured "the good, old-fashioned American way, with a market of competitive suppliers," able to match the simplicity and repetition of "focused factories," such as Federal Express and McDonald's.

While there is much to be admired about "good, old-fashioned American" approaches, it could be argued that an unregulated market

---

[7] Regina E. Herzlinger, *Specialization and Its Discontents: The Pernicious Impact of Regulations against Specialization and Physician Ownership on the US Healthcare System*, 109 CIRCULATION 2376, 2376–2378 (2004) (arguing also that these physician-owned specialty hospitals are exemplary models of efficiency and specialization that, if left unregulated, might serve as models for more wide-spread, market-based health care system reforms).

in medicine, such as the one Herzlinger finds so effective for the delivery of overnight packages and fast-food hamburgers, fails to address the issues of relational trust, vulnerability, and social justice that are unique to healthcare delivery.

C. Is an Interaction with One's Physician Categorically Different than One's Interaction with the Teenager Selling Hamburgers or the Driver Handling Overnight Package Delivery?

Law professors Mark Hall and Carl Schneider argue that being a patient/consumer of healthcare is particularly difficult because illness disables, pains, exhausts, erodes control, enforces dependence, disorients, baffles, terrifies, and isolates.[8] Consider, for example, the dynamics arising in the context of a medical emergency involving one of the author's young children. Imagine a three-year-old, walking up a set of wooden deck stairs with his hands in his pockets. Tripping, as exuberant toddlers are apt to do, and with his hands buried deep inside his pockets, he lands face first on the edge of the wooden deck. Although difficult to recognize at first due to the blood and screaming, his parents soon discover that he has bitten-through approximately two-thirds of his tongue. Only large, fleshy parts are left dangling.

In an instant the boy's parents are in the car with their son, racing to the nearest emergency room. Upon arrival this boy needs a trained health professional who can stitch-together a three-year-old's tongue, relieve his pain, and calm down his mom and dad. After all, the minds of mom and dad are racing with stress and anxiety. They may or may

---

[8] Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 650–51 (2008).

> Someone who is ill and seeking help—unlike someone who is purchasing a pair of socks or a pound of sausages—is often vulnerable, certainly worried, sometimes uncomfortable, and frequently frightened. [The term c]ustomer, like the other obvious choices—clients, consumers, and users—erases something that lies at the heart of medicine: compassion and a relationship of trust.

Id. at 651 (quoting Raymond Tillis, *Commentary: Leave Well Alone*, 318 BRIT. MED. J. 1756, 1757 (1999)).

not be native English speakers or well-educated, but regardless, in this moment they do not have the ability to read carefully or understand all the fine print on the admittance and consent forms that the intake nurse will put in front of them. These parents could agree to surrender the deed to their house as payment. They could grant the facility permission to videotape the entire experience for a network reality television show. They are unlikely to know precisely what they are signing. In the midst of this healthcare encounter, the hospital is holding all the cards. These parents will not be comparison-shopping for the next nearest emergency department with a better deal on pediatric tongue sutures. Questions about cost, although perhaps in the back of their minds, will not be articulated until—at the earliest—their son's emergent condition is stabilized. In this moment, all these parents know is that they want their son to be treated as quickly and competently as possible.

Beyond the dramas of young children and parenthood, thousands of adult children every day must confront a different set of gut-wrenching dynamics as elderly parents waver between life and death. As one's mom or dad, beloved friend, or life partner is in the process of dying, those who sit vigil at the bedside are in no mental or emotional condition to haggle over the price of palliative medications or second-guess the necessity of additional MRIs and CT scans. Or consider a less bloody or macabre setting, yet no less traumatic: a young woman or man, with a history of being sexually abused by trusted figures wielding authority, is sitting naked in an examination room, being asked intimate questions about his or her body, diet, and lifestyle. It takes an enormous amount of courage and trust for someone to be that vulnerable. Yet, these dynamics—infused with ethical issues—are the hallmarks of the doctor-patient relationship, and they inform a patient's relationship with her healthcare providers.

These scenarios reveal some of the constitutive elements that combine to make encounters with the healthcare system unique from one's daily engagement with other actors and institutions in the marketplace. Often, the healthcare transaction is characterized by a relatively fragile

and unequal relationship that best results in the patient's long-term well-being when the relationship with his physician is characterized by mutual trust and confidence. Even in the context of an elective procedure or formulation of a long-term treatment strategy—moments when "shopping-around" for second and third opinions may be a viable option—the asymmetries in knowledge and power make it virtually impossible to negotiate or otherwise bargain for the best deal. Ultimately, a patient must trust that her physician or surgeon is making recommendations for treatments or procedures with as few unnecessary conflicting distractions as possible.

Beyond these individual patient-provider concerns, an unregulated market approach in healthcare fails to resolve social inequalities and injustice that arise when unfettered healthcare markets fail to provide access to uninsured or under-insured patients.

Moreover, in a broader social context, vast sums of government money subsidize medical training, research and treatment, and so taxpayer money subsidizes much healthcare delivery. Yet, if the healthcare market were left to operate solely pursuant to principles of profit maximization, many of these same physicians—trained at government expense and subsidized by government Medicare or Medicaid programs—would have little incentive—beyond a commitment to professional or moral duty—to treat those who are often the sickest and without private payment sources. As Brennan observes, "the pure procedural justice of the market is admirable," but "the consequence of an unregulated market, especially the unequal access to health care for those unable to pay, undermine ethical health care . . . [and] outweigh the market's other attributes." Thus, some measure of government regulation becomes essential—and such governmental interference in the business of medicine should be informed by ethical principles.

Another way of thinking about the deep ethical connections between medicine as a business and medicine as a policy or regulatory concern is to consider the concept of autonomy. The notion that the patient

ought to be deeply engaged in making decisions about her healthcare is foundational to contemporary medical practice, as well as health law and policy developments. Yet, if a patient does not even have access to healthcare services, ethical concerns over informed and shared decision making with one's physician become moot.

II. UNIQUE PAYMENT & MARKET DYNAMICS

An additional dynamic in a healthcare business is the role of insurance. Again, as noted by Professor Patricia Werhane,

> "in healthcare organizations, recipients of healthcare services are usually not the payers. In healthcare organizations, the correlation between consumer and payer is very different than that which is found in other businesses, and the stakeholder role of "customer" is ambiguous. Various forms of insurance, employer-sponsored health plans, or government agencies purchase health coverage for the individuals and patient groups who are the actual and potential patients for a given HCO. This three-way relationship complicates accountability between the parties affected in healthcare delivery."

The healthcare market is also complicated by several additional dynamics—some of which may have already come to mind. Information asymmetry is clearly a problem, as organizational managers (think executives in the C-suite) and healthcare professionals (think physicians and nurses at the bedside) have very different spheres of knowledge. And, of course, the information gaps between these professionals and the customer-patient can also be great. When considered along with the issues of patient vulnerability discussed above, it is difficult to consider a healthcare organization's customer is ever ~~as~~ fully informed.

Competition in the healthcare space is made difficult by the information asymmetry that exists among healthcare organizations.

Indeed, as Professor Werhane notes, competitive health care organizations "do not have access to customer (patient) information in ways in which other business enterprises have access to market information." This makes the types of competitive relationships we see in other markets very difficult in the healthcare space. Moreover, supply and demand can differ, depending on whether or not the patient-customer is insured or uninsured.

These factors, infused with many ethical and legal dynamics, illustrate why healthcare is so unique and why it deserves to be studied apart from other business organizations.

A. For-Profit vs. Not-for-Profit Healthcare Organizations

As discussed in the article by Professor Relman, another important distinction that permeates the healthcare industry is organizational status as either for-profit or not-for-profit. What are the differences?

For-profit healthcare organizations, e.g. hospitals, are owned by investors or shareholders. These owners can be either private or public. Out of the 5,627 hospitals surveyed by the American Hospital Association in 2014, only 1,053 were organized as for-profit entities. The same study found that 2,870 hospitals were organized as not-for-profit providers, with an additional 1,003 managed by either a state or local government entity.

What does this designation mean? Why might it matter? Primarily, a for-profit designation means that these hospitals can distribute profits to investors, raise capital through investors, and must pay income and property taxes. Some argue that they are also about to invest in more innovative technology and provide better overall care.

Not-for-profit providers have a legal obligation to invest all profits back into the organization and contribute a benefit to the community (such as uncompensated care to uninsured patients or the provision of services that are not profitable), while enjoying a reprieve from paying state and federal taxes on income and property. This exemption, in

total, has been estimated to be as high as $12 billion in year in lost tax revenue.

Can you think of any potential criticisms of for-profit health providers?

Some patient advocates, labor unions, and bioethicists argue that a for-profit healthcare provider as interest that lie more with shareholders or investors than with patients. Critics have been known to accuse for-profit providers of denying care to Medicaid patients or those without health insurance.

Studies have found some differences between for-profit and not-for-profit providers, although it is not always clear how organizational structure is related to these differences. For instance, research by the Congressional Budget Office conducted in 2006 found that the share of operating expenses that went to uncompensated care was 4.7% at not-for-profit hospitals and 4.2% at for-profit hospitals. By comparison, it was 13% at government hospitals. However, the following analysis of physician-owned specialty hospitals did find some differences.

B. Case Study #1: Physician-Owned Specialty Hospitals

Physician-owned specialty hospitals are healthcare delivery businesses that are either partially or fully owned by physician-investors who limit the services provided to three primary specialties: cardiac, orthopedic, or other surgical procedures. Limiting their practice to these high profit-margin services has resulted in healthcare delivery centers that constitute many successful businesses providing tens of thousands of jobs, millions of dollars in state and federal tax revenues (which, as noted above, not-for-profit general hospitals do not pay), and hundreds of millions of dollars in cumulative payroll.

However, these specialty hospitals treat a lower percentage of severely ill patients than do their general hospital competitors, suggesting that these physician-owned specialty hospitals either intentionally skim the cream off the top of the patient population or intentionally limit their

technological and personnel capacity so that they are only equipped to treat the healthiest and least costly sector of cardiac, orthopedic, or surgical patients. Moreover, due to differences in staffing levels, employee compensation, and the use of single occupancy rooms, physician-owned facilities have higher costs than do general hospitals, and result in higher utilization rates and greater requests for Medicare reimbursement.

Nonetheless, for their physician-owners who have seen personal incomes decline over the last decade, these investments offer a practice environment where M.D.s—not M.B.A.s—control administrative decisions that impact patient care and produce increased earning opportunities.

Wall Street Journal reporter Ron Winslow's investigation of the Heart Hospital of New Mexico, which opened in 1999, offers an illustration of conflicts created by physician-owned specialty hospitals. At its inception, local cardiologists owned forty-one percent of Heart Hospital, a stand-alone cardiac center, in partnership with MedCath Inc., a publicly-traded nationwide operator of cardiovascular clinics.

The doctors who invested in and planned to practice at Heart Hospital were enthusiastic about "restor[ing] their eroding control over medical decisions and ensur[ing] that, amid relentless cost-containment pressure, the best patient care [would be] delivered."

However, physicians and administrators at the 91-year-old Presbyterian Hospital located across the highway from the Heart Hospital were not as excited about what they viewed as "a wasteful duplication that threaten[ed] to dilute quality of care . . . [while serving as] a vehicle for doctors and their investing partners to cherry-pick the most profitable heart patients to enhance their returns."

The cardiac physician-investors were reportedly prompted to invest in the upstart hospital for two primary reasons. First, during the preceding decade they had seen their income erode dramatically. From 1989 to 1999, the Medicare reimbursement fee for a common cardiac

diagnostic procedure had been reduced by sixty-two percent, while the fee for triple-bypass surgery had been cut by thirty-nine percent.

Meanwhile, hospitals during this same decade had begun retaining a greater percentage of what Medicare paid. For example, in 1989 hospitals kept approximately sixty percent of the Medicare reimbursement for bypass surgery, with the remainder passing through to the heart surgeon. In 1999, however, general hospitals were keeping as much as eighty-five percent, with the remainder being paid to the surgeon.

The second motivating factor for those physicians who would invest in and practice at Heart Hospital was purported to be control. The emergence of managed care in the 1970s had, by the mid-1990s, left physicians and surgeons weary of having their judgment challenged by "cost-obsessed hospital and managed-care bureaucrats." It is reasonable to infer that when MedCath invited cardiologists to invest in and practice at Heart Hospital, the entrepreneurial opportunity presented a solution both to the problem of declining incomes, as well as a remedy to their administrative frustration over bureaucratic second-guessing and other real or perceived practice inefficiencies.

One could conclude that the emergence of physician-owned specialty hospitals is directly linked to disagreements among health care providers, administrators and government bureaucrats, all of whom have failed to recognize the necessity of an interconnected healthcare community. As noted above, in addition to the profit motivations fueled by decreasing physician salaries, expansion of the physician-owned specialty hospital movement was propelled to some extent by community hospital administrators and corporate hospital conglomerates that frustrated physicians' efforts to exercise reasonable and legitimate controls over their clinical practices. The reaction from these disgruntled cardiac and orthopedic surgeons, however, could be seen as disproportionate, as many promptly created their own treatment facility across town and then actively pursued the most lucrative patient population in a grab for high profit-margin market

share. Deeper analysis of the physician-owned specialty hospital industry reveals costs to both the system of healthcare delivery and the individual patient.

1. Systematic Cost Considerations

As noted in the earlier investigation, the opportunity for the physician-investors who would maintain privileges at both Heart Hospital and Presbyterian Hospital was viewed as a destabilizing threat by those administrators and physicians who remained affiliated solely with Presbyterian. After all, the physician-investors at Heart Hospital would have a financial incentive to refer their least costly and most healthy cardiac patients to the facility in which they have an ownership interest, while choosing to operate on their sicker and more complex cases in the general hospital, where the costs of lengthy recuperation could be passed on and an emergency room would stand ready in the event of an emergency. The concerns about the potential impact of shifting patient referral patterns voiced by administrators at Presbyterian Hospital were clearly not unfounded, as they simply forecast rational decision making on the part of the physician-investors at Albuquerque's Heart Hospital.

Additional examples illustrate the concern. In 2001, the Galichia Heart Hospital opened in Wichita, Kansas. Within two years, the full-service Wesley Medical Center in Wichita saw the net revenues from its cardiovascular program drop from approximately $18 million to roughly $2 million. When the Kansas Spine Hospital opened in 2003, it took only a year for Wesley's neurosurgery revenues to decline from $8.8 million to approximately $1 million. To the south, in Oklahoma, the Oklahoma Heart Hospital opened in 2002 in Oklahoma City, and immediately began competing with the Oklahoma University Medical Center (OUMC). Within two years, the number of inpatients admitted for cardiac care at OUMC dropped dramatically, as sixteen surgeons and cardiologists on OUMC's clinical faculty immediately began referring the majority of their patients to the specialty hospital in which they owned an interest. The reduced patient population—directly

attributable to a shift in referrals from OUMC to Oklahoma Heart Hospital—resulted in losses of $11.6 million in the full-service hospital's "cardiology operating income" between 2002 and 2004.

Similarly, in Ruston, Louisiana, the Lincoln General Hospital saw its total number of surgeries cut in half, resulting in an $8 million deficit after forty surgeons opened the Green Clinic Surgical Hospital across the street.

A 2005 report by the Medicare Payment Advisory Commission (MedPAC), an independent Congressional agency, concluded that physician-owned specialty hospitals do obtain most of their patients by taking market share away from community hospitals. Moreover, the report revealed that physician-owned specialty hospitals treat a higher percentage of patients who are less sick, and therefore less costly and more profitable, than patients receiving similar treatments at general hospitals.

Coupled with the finding that most specialty hospitals treat few, if any, Medicaid patients, the MedPAC report speculated that if the specialty hospital industry were to continue to grow without additional regulation, then community hospitals attempting to compete with specialty hospitals could find their profits adversely impacted, which could have a negative ripple effect on their ability to provide charity care and less financially rewarding medical services. MedPAC's data analysis also disputed the specialty hospitals' claim that, through specialization, they were able to have lower overall costs than full-service community hospitals. Likewise, a 2005 report issued by Michael Leavitt, Secretary of the Department of Health and Human Services (HSS), also found that specialty hospitals generally treat a less-sick patient population with "lower severity levels."

In late 2005, Georgetown University Professor of Public Policy Jean Mitchell published additional data again comparing the practice patterns of physician-owners of specialty cardiac hospitals to the practice patterns of physician-nonowners treating cardiac patients at competing full-service community hospitals. A study of Arizona

providers conclusively confirmed that physician-owners were treating nearly twice as many cardiac cases as physician-nonowners. Moreover, the majority of the patients treated at the physician-owner facility were less ill and better insured, either through Medicare or a private insurer.

At the request of Congress, MedPAC released another report in 2006. Analyzing a more robust set of data, the 2006 MedPAC report confirmed several findings from earlier studies. First, MedPAC again found that physician-owned facilities treat fewer Medicaid patients. Second, the 2006 report reconfirmed that patient stays in physician-owned facilities are greater than twenty percent shorter than patient stays in community hospitals, yet the overall costs of patient care are not less.

Furthermore, the 2006 MedPAC report found that when a physician-owned specialty hospital enters a market, the utilization rates and requests for Medicare reimbursements increase. These findings are consistent with what Jean Mitchell found in her analysis of Arizona's healthcare landscape. Professor Mitchell's subsequent comparison of the practice patterns of physician-owners of specialty hospitals in Oklahoma, both before and after they acquired their ownership interest, to the practice patterns of physician-nonowners treating similar cases during the same time frame further highlights the issue.

This research again confirmed that after physicians became owners in their specialty orthopedic hospital, the utilization rates for surgical, diagnostic and ancillary services used to treat back and spine ailments "increased significantly." Mitchell found that during the same time period in the same market, dramatic increases in utilization were not seen in the practices of nonowner physicians. While recognizing the possible limitations of her study, given the fact that it relied only on data from one area of the country, Mitchell concluded that substantial increases in utilization rates can be linked to physician ownership, and that treatment costs are likely to be "significantly higher in comparison to those who obtain care from non-self-referral providers."

2. Patient Cost Considerations

> *[W]hen the doctors own the hospital and operate it to their benefit, when the almighty dollar rather than quality patient care is the bottom line, when physicians can pick and choose who they will treat, and when the hospital has no one holding everyone's feet to the fire, then patients will not be well-served.*
>
> — Michael Wilson, son of Helen Wilson

In the summer of 2005, Helen Wilson, an 88-year-old woman who enjoyed an active, independent life in Vancouver, Washington, began experiencing a nagging pain in her legs and opted for elective lumbar surgery on her lower spine to decompress nerves leading to her legs. On July 27, she was admitted to Physicians' Hospital, a 39-bed physician-owned facility in Portland, Oregon, focusing on the dual specialties of orthopedic surgery and neurosurgery.

Despite the dangers of anesthesia and pain medication in a patient over the age of 85 and Ms. Wilson's specific history of high blood pressure and prior open-heart surgery, her surgeon, Dr. Mark Metzger, elected to operate on her at Physicians' rather than Portland Adventist Hospital, a full-service hospital with an emergency department, at which Dr. Metzger also had operating privileges. Dr. Metzger would not respond to local media inquiries seeking clarification about his motivations, but as one of the thirty-two doctors who co-owned Physicians' Hospital, he would have had an additional financial incentive to treat Ms. Wilson at his hospital.

Following what was believed to be a routine and successful two-hour surgery, Ms. Wilson suddenly began experiencing respiratory distress and cardiac arrest. With Ms. Wilson's husband and son watching in disbelief, several nurses frantically attempted to resuscitate Ms. Wilson. Her physician, Dr. Metzger, was nowhere to be found, and the receptionist for Physicians' Hospital ultimately resorted to dialing 9-1-1 to request for paramedics to be sent to the hospital. With her brain

deprived of oxygen for many minutes, Ms. Wilson never regained consciousness, and she passed away five days later.

While a few tragic and unnecessary deaths suggest a possible proliferation of grave patient safety issues throughout the physician-owned specialty hospital industry, absent additional data, it is unclear to government officials how extensive these threats to patient wellbeing might be. Moreover, with many of these facilities designed to have the "look and feel of a Four Seasons Hotel," *Consumer Reports* magazine had promoted them as the "Number One Hospital" in two-thirds of the markets in which they were operating.

In January 2008, the Department of Health Human Service's Office of Inspector General (OIG) issued a report on physician-owned specialty hospitals and their ability to manage medical emergencies. Out of the 109 specialty hospitals that the OIG reviewed, only fifty-five percent had an emergency department and more than half of these hospitals were equipped with only one emergency bed. Additionally, while ninety-three percent of the physician-owned specialty hospitals were found to have nurses on duty and physicians on call twenty-four hours a day, seven hospitals failed to meet the Conditions of Participation promulgated by the Centers for Medicare & Medicaid Services (CMS). Without the capacity to offer complete, on-site emergency services or the availability of trained personnel, it is not surprising that the OIG report found that sixty-six percent of these facilities instruct their staff to dial the 9-1-1 emergency number as an official component of their medical emergency response protocol.

The use of 9-1-1 "to obtain medical assistance to stabilize a patient" seemingly constitutes a violation of the CMS's Conditions of Participation, which state that a hospital receiving Medicare funds may not rely on 9-1-1 emergency services as a substitute for its own emergency services. Moreover, the OIG's investigation revealed that twenty-two percent of all physician-owned specialty hospitals do not even have a policy or protocol in place that addresses patient emergencies, including appropriate use of response equipment, initial

life-saving treatment, or transfer of patients to full-service hospitals. This too constitutes a violation of the CMS's Conditions of Participation.

The substantive impact of the OIG's report was a series of four recommendations directing CMS to better monitor physician-owned specialty hospitals and to ensure their compliance with existing regulations regarding patient safety and emergency situations. But the real upshot was the additional fuel these data added to the fire of political criticism that the physician-owned specialty hospital industry had been regularly enduring for much of the preceding decade. Given the considerable magnitude and variety of criticism, the industry should not have been caught off guard when it was delivered a mortal wound in March 2010 when Congress and the Obama administration passed the largest legislative healthcare reforms since the creation of Medicare and Medicaid. Commonly known as the Affordable Care Act, or Obamacare, this legislation included a provision that was intended to curb further expansion of these physician-owned specialty hospitals.

C. Case Study #2: For-Profit Hospice[9]

The modern hospice movement traces its origins to the mid-20th century work of physician Dame Cicely Saunders, who founded St. Christopher's Hospice in 1967 in a suburb of London. The hospice concept was imported to America by Florence Wald, the dean of the Yale School of Nursing, who invited Dame Saunders to teach the concepts of holistic treatment of patients' physical, spiritual, and psychological well-being at Yale in the late 1960s. At the same time, the work of Dr. Elizabeth Kubler-Ross was recalibrating social understandings of death and arguing that perhaps death did not have to be seen as the failure of medicine to keep a patient alive. Out of Kubler-Ross's work, the "right" of patients to participate in decisions impacting their death process began to gain traction.

[9] This is adapted from Perry & Stone, *In the Business of Dying: Questioning the Commercialization of Hospice*, JOURNAL OF LAW, MEDICINE & ETHICS 224–234 (2011).

All of this, of course, emerged during a time in which physician paternalism was still the dominant ethos and emerging end-of-life medical technologies were fostering liminal conditions—"twilight zones of suspended animation where death commences while life, in some form, continues"—in which the possibility of postponing death was creating novel bioethical dilemmas.

Nevertheless, the earliest American hospices were "small, volunteer dominated community-based programs which provided spiritual support and palliative care to terminal patients and their families," and they began to spread rapidly during the 1970s. While fewer than 60 hospices existed in 1978, that number had expanded to over 400 by 1981 and the movement soon captured the attention of policymakers in Washington.

Congress created the Medicare hospice benefit in 1982 for patients diagnosed as "terminally ill." To qualify for the benefit, a patient's "attending" physician, as well as the hospice physician, must certify that the patient has "a life expectancy of 6 months or less." For hospice providers caring for a terminally ill patient, the federal benefit pays a fixed per diem. The amount of the daily rate is determined by the appropriate category of care required by the patient: (1) routine home care; (2) continuous home care; (3) inpatient respite care; or, (4) general inpatient care. Importantly, however, the daily rate is paid by Medicare regardless of the services actually provided by the hospice provider on any given day and even if no services are provided. Services covered include nursing care, physician services, pain management, medical social services, counseling (including bereavement services), physical therapy, occupational therapy, speech-language pathology, dietary counseling services, and homemaking services.

According to leaders of the pioneering National Hospice Study, this legislation emerged at the behest of dual constituencies: care givers and entrepreneurs. Care givers, particularly non-M.D. professionals, desired a legal mandate requiring that hospice services be built around

interdisciplinary teams, including volunteers, spiritual counselors, and other "low-technology providers."

Entrepreneurs, on the other hand, envisioned the development of "profit-making hospice chains" and lobbied for the benefit on the basis that it would create a new opportunity to further the competitive, proprietary interests that Dr. Relman had characterized as the emerging "new medical-industrial complex" just two years earlier. As early as 1985, healthcare researchers worried that the "smaller, volunteer-oriented hospices, which have contributed significantly to the image of hospice in our country, may be unable to survive in a commercialized environment."

Throughout the 1990s, the per diem rates paid by Medicare steadily increased, as end-of-life issues, including advanced directives and palliative care, received greater attention from researchers, health care practitioners, and public policy officials. By 2006, approximately 40% of Medicare beneficiaries who died were cared for during their final days or weeks of life under the auspices of a hospice program where specialists working in interdisciplinary teams treated their symptoms, relieved their pain, and provided a range of therapeutic services and other types of support, including, housekeeping duties for those electing to die at home.

As originally conceived, there was "a strong expectation that hospice services would result in lower costs to the Medicare program than conventional medical interventions at the end of life." Yet, as with every other sector of the health care economy, hospice costs have risen at alarming rates in recent years. According to the Government Accountability Office, between 1992 and 2002, "Medicare payments for hospice care increased fivefold, to about $4.5 billion, . . . the number of Medicare patients increased fourfold, to approximately 640,000, . . . [and] the number of Medicare-participating hospices grew by almost 90 percent to 2,275.

Just six years later, hospice expenditures more than doubled to exceed $11 billion, Medicare beneficiaries receiving hospice services (for

increasingly longer periods of time) topped one million, and the number of hospice locations rose to greater than 3,300, with for-profit providers accounting "almost entirely" for this increase. In fact, from 2001 to 2008, the for-profit hospice industry grew 128 percent, while the nonprofit hospice sector only grew by 1 percent and government-owned hospice grew by 25 percent. The result of these trends is that now approximately 52 percent of hospices are for-profit, 35 percent are nonprofit, and 13 percent are owned by the government.

As originally conceived, hospice was marked by a holistic approach to patient care, animated by altruistic motivations that placed ultimate priority on care for the dying individual and her family. The concept has been accepted and embraced by large segments of the American public and policymakers because of its hallmark practices understood to be rational and compassionate components of end-of-life health care. Yet, the increasing dominance of for-profit providers, beholden to the expectations of investors, introduces a profit-making concern that threatens to compete with patient care for ultimate priority. Perhaps the dual goals of profit-taking and care-giving can be aligned theoretically in ways that neither would be compromised. But in the actual business practices of for-profit managers and care decisions of for-profit providers, there is at a minimum some cause for heightened scrutiny.

1. How Do For-Profit Hospice Providers Market Their Services and Recruit Their "Customers"?

In recent years the media have begun to report anecdotally about the manner in which some hospice providers have so successfully grown their business. For instance, VITAS Hospice Services, LLC, the largest provider of hospice services in the United States (operating 46 facilities across 15 states and the District of Columbia), reportedly sends its patient recruiters into nursing homes equipped with pens and coffee cups for staff and then pays a commission to those recruiters who successfully sign-up patients for VITAS's services. A rival hospice

provider was indicted for allegedly paying nursing home operators $10 per day to assist in patient recruitment efforts and paying physicians $89 a month to certify patients as hospice eligible without examining the patient or reviewing medical records. The extent to which some hospice providers may be employing "community education representatives," to market hospice services and recruit hospice patients demands vigilance in the form of either industry self-policing or government oversight.

In fact, the latter option was recommended in 2009 by the Medicare Payment Advisory Commission (MedPAC), which said the Office of Investigator General should investigate "financial relationships between hospices and long-term care facilities [ ] that may represent a conflict of interest and influence admissions to hospice; . . . the appropriateness of enrollment practices . . . ; [and] the appropriateness of hospice marketing materials and other admissions practices."

Hospice-eligible patients, by definition, are facing a relatively imminent death. In this context, many patients and their family member advocates are experiencing myriad emotions potentially compromising their judgment and ability to comprehend the implications of entering into hospice. Given these heightened vulnerabilities, potential hospice candidates are more susceptible to unscrupulous marketing techniques and over-promising with regard to services that will be provided. If a patient recruiter stands to personally benefit in the form of a commission or bonus for reaching and maintaining enrollment goals, such an incentive potentially conflicts with the candor required for a potential hospice patient to make an informed decision about whether to forego continued curative medical treatments, a necessary condition of enrollment in hospice.

Moreover, concerns exist over whether hospice providers, regardless of ownership structure, intentionally select patients that are likely to have longer lengths of stay and thus result in the generation of greater revenues. Because of Medicare's current payment policy, which pays the same flat rate per diem (regardless of the patient's specific terminal

illness), a tempting incentive is created to target patients that will require less expensive care over a longer period of time. As a 2009 MedPAC report to Congress noted, "A strong correlation exists between length of hospice stay and profitability . . . . The concern is that some new hospice providers, which are predominantly for-profit, may be pursuing a business model based on maximizing length of stay and thus profitability."

The 2008 MedPAC report found that "hospices with longer lengths of stay are more profitable [because] length of stay in a for-profit hospice is about 45% longer than the length of stay in a not-for-profit facility." While seemingly counterintuitive, it turns out that the longer a patient remains in hospice, the less costly it is for the provider to care for her because over the course of a lengthy hospice arrangement, the patient's baseline of necessary care becomes less rigorous and time intensive.

The current Medicare policy makes sense if one considers that hospice was designed to offer only palliative, not curative, treatment. When the Medicare benefit was created in 1982, the concept of palliative medicine was not disease specific. Therefore, while the revenue from federal reimbursements remains constant, costs associated with patient care do not. Hospice costs during approximately the first four days of patient care are relatively high, due to the additional time required to transition a patient and relevant family members into the hospice program and attend to their emotional and physical needs. Likewise, a patient's final days prior to death are relatively more time and resource intensive, and therefore more costly.

During the intervening time period, however, costs of care are relatively lower and constant. Of course, these intermediary costs escalate in the context of patients requiring more expensive palliative care, such as chemotherapy, radiation, or recreational services, which explains why hospice providers needing to keep investors satisfied, seeking to realize a profit, or simply struggling to maintain a margin that will sustain the organization's mission, are rationally tempted to selectively recruit patients with non-cancer diagnoses, for example. This "U-shaped" cost

function and linear revenue stream creates a "financial incentive for all hospices . . . to maximize the duration" of a patient's stay in order to distribute the higher costs at the beginning and end of treatment and increase overall profits.

Although MedPAC has called for an adjustment to the reimbursement structure that would pay relatively more per day for those higher costs associated with the entrance of a patient into hospice and for those higher costs associated with the patient's death, these payment changes will not be implemented before 2013. Meanwhile, the current per diem paid by Medicare remains constant throughout a patient's stay, regardless of how much time is actually devoted to patient care and the delivery of hospice services. Without changes to the current reimbursement structure, coupled with measures to ensure greater accountability in the use of these benefits, we are concerned about the potential for a more dominant hospice provider to serve selectively a higher percentage of patients with a non-cancer diagnosis. The patient population at such a hospice could thereby average significantly longer and more lucrative periods of time during which the provider would realize a great return on the Medicare per diem payments for those patients, while potentially shifting a disproportionate share of the more costly short-term patients to hospice providers with a broader commitment to a community beyond those with an ownership interest.

While all hospice providers, regardless of ownership status, are incentivized to "game" the system according to the current reimbursement policy, researchers analyzed admission data at 104 for-profit and 534 religious nonprofit hospice providers over a three-year period in an effort to determine whether patterns of patient selection could be identified. Their data demonstrate that for-profit hospices—more so than the religious nonprofit hospices they also studied—respond to the Medicare reimbursement incentive by selectively admitting patients with primary diagnoses, recent curative care, and ages that would suggest probabilities for a longer life trajectory, and correspondingly higher profits.

Additional researchers examined 67 for-profit hospices and 109 nonprofit hospices operating in California to determine whether patterns in patient population could be determined. This study concluded that for-profit hospice providers treat a disproportionate number of patients who were either previously in a long-term care facility and/or suffer with a non-cancer diagnosis. Moreover, these researchers confirmed that a higher percentage of for-profit patients do in fact remain in hospice longer than 90 days.

Longer stays, of course, are not intrinsically problematic. Indeed, getting a patient into hospice for a longer and more managed death process can be more conducive to the holistic and comprehensive care for both patient and family that hospice promises. Recent research also suggests greater systematic cost savings can result from longer stays in hospice. Moreover, a variety of reasons unrelated to fraudulent or nefarious practices may explain differences in enrollment patterns, including a good faith effort on the part of for-profit providers to include terminal, non-cancer patients who have been traditionally under-represented among hospice populations.

2. Do Commercial Concerns Compromise the Quality of Care Delivered by Hospice Providers?

Interdisciplinary, coordinated care has been a hallmark of the hospice philosophy of holistic end-of-life care since the movement's inception. Moreover, government reimbursement via Medicare is conditioned upon the hospice organization's provision of a team that includes at least one physician, one registered nurse, and one social worker. The inclusion of such expertise is necessary to coordinate the medical, psychological, and social components of hospice care "core services" as described in federal law, which pursuant to an individual patient's written plan, must include availability to physician services, skilled nursing care, dietary or nutritional services, psychological counseling (including bereavement therapy), spiritual care, and medical social services. "Noncore" services include physical therapy, speech therapy,

occupational therapy, continuous home care, and household/homemaker services. Hospice providers, however, have discretion with regard to staffing specifics.

At least one study has demonstrated that staffing patterns do differ among hospice providers in ways that correlate to ownership status, although no correlations established patterns of adverse or compromised patient care. The research noted above examining California hospices in the late 1990s also found that for-profit hospices provided a mix of overall less-skilled nursing care, but failed to establish whether quality of patient care in general suffered as a result of these staffing decisions. In fact, this same study found "no significant difference in the actual number of skilled nursing visits per patient day provided by for-profit hospices (0.33) versus not-for-profit hospices (0.35)."

More recent data from researchers at Yale found "substantial variation by hospice ownership type in the patterns of interdisciplinary staff." Again, while correlations to adverse impact on quality of care were not proven, the study did find that for-profit hospice facilities typically employ less expensive labor, including fewer registered nurses, fewer medical social workers, and fewer clinicians.

In addition to staffing differences, other research suggests that patterns of care do differ among hospice providers with different ownership structures, although, again, evidence of wide-spread adverse or compromised patient care does not exist. However, when adjustments are made for differences in patient diagnosis, disability, gender, and other variables; patients of for-profit hospices have been shown to receive significantly fewer types of services than patients of nonprofit hospices, including continuous home care and bereavement services. Due to the difficulties in assessing the relative value of specific services to individual patients, even these limited studies fail to establish an overall diminished quality of care at for-profit providers. However, these findings did prompt one set of researchers to speculate regarding how differences in "origin" influence the hospice endeavor:

> One possible interpretation [for why for-profits provide a narrower range of services when compared with nonprofit hospices] is that the different patterns of care are the result of the differing origins of the for-profit and nonprofit hospice. The traditional, nonprofit hospice emerged as a philosophy of care that emphasized psychosocial support, spiritual care, the use of volunteers and family, and symptom management. The for-profit hospices that have emerged more recently, however, might not be as strongly rooted in this traditional hospice philosophy.[10]

To be clear, Carlson et al. are not suggesting that evidence exists of inferior care at for-profit hospice providers. Rather, these researchers are highlighting the reality that a more commercialized, entrepreneurial approach to hospice may privilege business practices and financial responsibilities to investors in ways that challenge their concomitant commitment to ethical health services and duties to patients. Again, while the financial bottom line driving for-profit hospice providers is the creation of profits, this pressure may not be all that different from that facing the nonprofit hospice provider attempting to bolster enough revenues not only to keep the doors open, but also to expand services and maintain competitive employee compensation.

The quote above by Carlson et al., however, reminds us that business management principles focused on increasing market share, reducing labor costs, and creating economies of scale may become problematic to the extent they threaten to compromise the death experience of the patient, i.e., the "traditional hospice philosophy." To be sure, more data examining potentially negative correlations between business practices and patient care are needed.

Charles F. von Gunten, editor-in-chief of the *Journal of Palliative Medicine*, recently opined that perhaps "there really is no difference in

---

[10] M.D.A. Carlson, W.T. Gallo, and E.H. Bradley, *Ownership Status and Patterns of Care in Hospice: Results from the National Home and Hospice Care Survey*, MEDICAL CARE 42, no. 5 (2004): 432–438.

the care delivered by hospices of differing tax status," and therefore, on the question of profit versus not-for-profit, he concluded: "Who cares?"

von Gunten's position was bolstered by the recognition that current data defining quality and measuring outcomes in the realm of hospice support neither the demonization nor the canonization of either ownership structure. To be sure, our review of the literature confirms the necessity of more sophisticated studies of business practices and patient care throughout the hospice industry, with a keen eye trained on how ethical issues are addressed when they intersect with commercial interests and financial incentives.

The concerns raised in this article, particularly regarding recruitment of patients and patterns of patient care, are intended to highlight ethical conflicts suggested by an increasingly commercialized health services marketplace that is infused with large sums of federal money accompanied by increased regulatory oversight.

Yet, a number of questions suggest the importance of continued inquiry and oversight in this area of hospice:

QUESTIONS

1. Will the patient's experience of hospice services (as envisioned by Dame Saunders, i.e., marked by a fundamentally altruistic system of organization and governance) be compromised by the practices of profit-driven competition and additional costs associated with government regulation?

2. What non-financial costs may be borne by patients, their family, and hospice providers if the hospice industry's traditional emphasis on principles of community welfare maximization cannot be reconciled to more individual notions of profit maximization?

3. How, in ways that are not unnecessarily paternalistic, will the hospice industry guard against the exploitation of an unsuspecting population that is particularly vulnerable?

4. The challenge for medical professionals, health care businesspersons, academic researchers, policymakers, and government regulators going forward will be to address these questions in a manner that will preserve the spirit of hospice as it was originally envisioned and as it has come to be understood, experienced, and relied upon by much of the public.

Additional Questions for Further Discussion

Is medical care just another commercial enterprise in which decisions based on economic efficiency should dominate?

If medicine is viewed as a profession that places the best interest of the patient at the fore, how should administrators and managers approach questions regarding profit?

Have professional values managed to keep the patient at the top of the deck or has money trumped professionalism? How do we guard against the assault on professionalism that such conflicts engender?

How can professionalism be used to counter the excesses of commercialism?

Does it matter whether recipients of healthcare are referred to as "patients," i.e., those suffering or "consumers," i.e., those using services?