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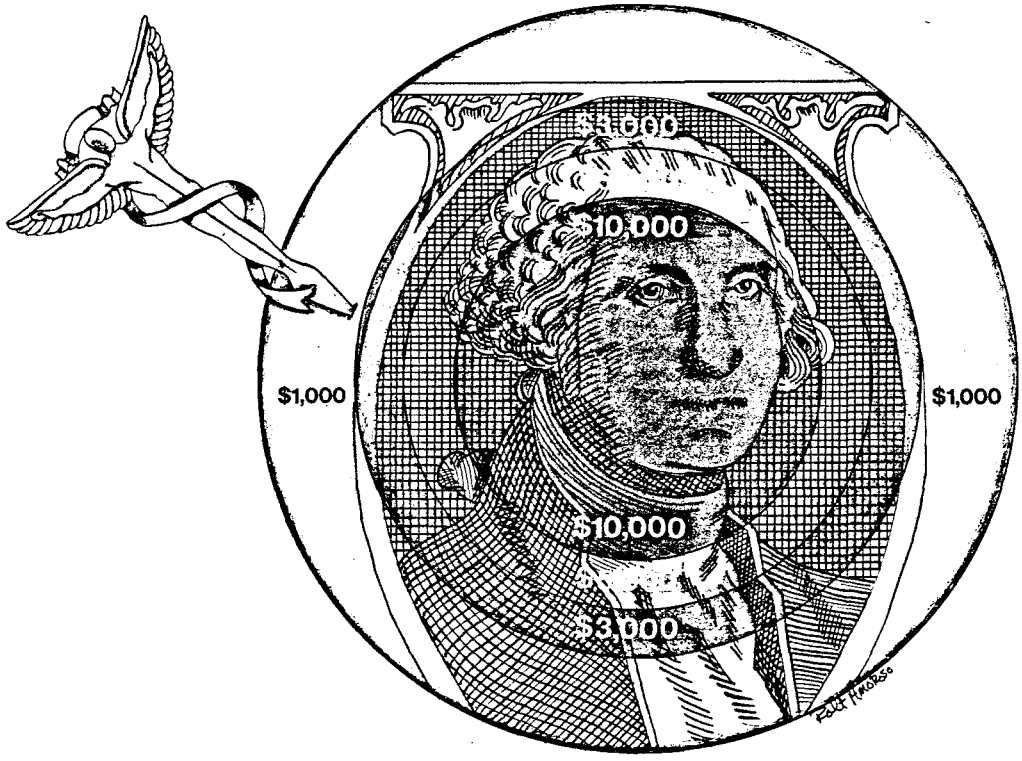
PHYSICIAN-OWNED LABS:



GOOD INVESTMENT OR BAD MEDICINE?

BY SIMSON L. GARFINKEL

It seemed like a splendid idea. The radiologists at the Condell Memorial Hospital in Libertyville, Illinois, wanted a magnetic resonance imaging (MRI) scanner, but the hospital couldn't afford one. So Condell Memorial contracted with four other hospitals that were similarly located 40 miles northwest of Chicago and built NE Illinois MRI, a stand-alone, out-patient imaging center.

Nearly one-third of the cost of the NE Illinois MRI was financed by offering 100 "limited partnerships" to physicians, at the price of $10,000 each. As limited partners, the physicians would share in the profits of the facility, if there were any, but would not be involved in the day-to-day operations.

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SPECIAL REPORT *Continued from cover* **Controversies in Medical Practice**

Physician-Owned Labs: Good Investment or Bad Medicine?

"We just thought that it would be a good way for the physicians to invest," says Larry Swanson, Condell's vice president of finance.

So did the physicians. Within six weeks, all of the limited partnerships were sold—many to physicians who would later refer their patients to the planned facility. In November 1987, NE Illinois MRI began operation, and a year after that the limited partners each received a check in the mail for $900, or 9 percent of their initial investment. This year, says Stanley Driscol, administrative head of the facility, the return on the investment should be 14 percent.

NE Illinois is far from alone. Freestanding diagnostic, therapeutic, and home-care medical facilities with physician-investors are springing up all over the country. Although accurate statistics of the number of physicians investing in such partnerships are unavailable, estimates run from 10 percent to as high as one in three.

On one side, defenders of these "limited partnerships" claim that they are providing needed services in an environment that allows physicians to carefully monitor the quality of the procedures being provided. They say that facilities that have physicians as investors treat their patients and their referring physicians in a more timely and courteous manner than do hospital outpatient clinics. They maintain that such partnerships represent legitimate investment opportunities for physicians, as long as there is no explicit per-patient payment to referring physicians.

"Who better to own interests and undertake investment in medical facilities than physicians?" asks the manager of one such facility.

Professional and Legislative Opposition

But there is a growing contingent of legislators and professionals in the medical community who feel that limited partnerships in health-care facilities that are sold to referring physicians are nothing more than sophisticated kickback schemes. Physician-investors are sought, critics say, in order to guarantee a steady stream of referrals and thus ensure financial success. Moreover, facilities that do not have physician-investors are at an economic disadvantage.

When physicians have a financial interest in a diagnostic facility, the argument goes, they tend to overprescribe the very services and procedures that the particular facility offers. Indeed, critics say, it is the extraordinary profits that some diagnostic facilities promise and, in some cases, have earned, that support these claims.

REP. FORTNEY "PETE" STARK

Last December's *Christian Science Monitor* reported on six diagnostic facilities whose prospectuses promised annual rates of return between 19 and 229 percent over the first five years. First-year rates of return reportedly were from 9 to 40 percent, with several operations refusing to release earnings figures.

Now, both Congress and the Health Care Financing Administration are looking into the practice. Richard P. Kusserow, the Inspector General of the Department of Health and Human Services, has begun an investigation into the prevalence of limited partnerships and will be making a report to Congress on May 1 with his findings. Even the General Accounting Office has gotten into the act and is examining limited partnerships in two states in an attempt to determine whether physicians involved in such arrangements recommend diagnostic tests more often than physicians who are not involved.

Some minds are already made up:

"In one case, physician-investors can make more than $100,000 over a five-year period based on nothing more than a $10,000 promissory note 'paid' as an 'investment' in a magnetic resonance imaging partnership," Rep. Fortney "Pete" Stark (D-Calif.) told Congress in early February.

Patient Referrals Act of 1989

"Over 10 years ago, Congress enacted a sweeping law that makes the payment of kickbacks for patient referrals under Medicare a felony," said Rep. Stark, who is Chairman of the Health Subcommittee of the House Ways and Means Committee. "Unfortunately, clever deal makers have found a loophole."

Rep. Stark has introduced legislation that he says "would close these loopholes once and for all." His bill, the Patient Referrals Act of 1989, would outlaw referrals of Medicare patients to facilities in which the referring physician has a financial interest. (Rep. Stark's bill contains exceptions for cases in which physician-owned facilities are the sole providers in rural areas, and for cases in which the facilities are owned by publicly traded companies with assets in excess of $100 million in which the physician simply happens to own stock.)

In support of Rep. Stark's bill is a long list of medical and consumer organizations, including the National Association of Public Hospitals, the American Society of Clinical Pathologists, the American Clinical Laboratory Association, the Visiting Nurse Associations of American, the American Physical Therapy Association, and the National Association for Home Care.

The American College of Radiology has endorsed the 1988 version of Rep. Stark's bill, which was introduced too late in the 1988 legislative session for action. "The practice of self-referrals of patients for a diagnostic or therapeutic medical procedure may not be in the best interest of the patient. Accordingly, referring physicians should not have a direct or indirect financial interest in diagnostic or therapeutic facilities to which they refer patients," the college put forth in a written statement of policy last September.

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Dr. Arnold Relman, Editor of the *New England Journal of Medicine*, goes further: "I think that it violates some basic ethical principles. It is a form of kickback. It creates a conflict of interest between the physician's role as an advocate of the patient and his entrepreneurial interests as a businessman."

Susan Lipton Photo

ARNOLD RELMAN, M.D.

The Case for Limited Partnership

Physicians who have actually invested in such facilities say that their investments are providing services that their communities would otherwise lack. They say that their dollars are satisfying a real need—one that is not being met by existing financial markets.

"I thought it was a good thing for my patients," says Dr. Kenneth Lakoff, who invested in such an arrangement in 1985 when he was still a practicing physician in Philadelphia. "I was finding it more difficult to get outpatients seen in a timely manner by traditional hospital institutions, which were geared primarily toward inpatient care. I was constantly having delays for studies."

Today, Dr. Lakoff is vice president of health-care services at Medscan, a Philadelphia venture that operates several free-standing and mobile MRI scanners with both physician- and non-physician-investors. A patient calling Medscan's South Philadelphia MRI facility often can be seen within 24 or 48 hours, or come to the office for a walk-in appointment. By contrast, MRI scanners at Philadelphia's Jefferson and University of Pennsylvania hospitals both have waiting lists of up to three weeks. Nevertheless, MRI scans cost the same at Medscan as at area hospitals, Dr. Lakoff says.

John Kontra, executive vice president of Medscan, says that the majority—68 percent—of the patients visiting his facility are referred there by noninvesting physicians. Furthermore, he says, "in 97 percent of the Medicare cases, we saw something wrong with that person," indicating that the scan was medically warranted.

The big difference that Mr. Kontra sees physician-investors making isn't increased referrals—it's increased surveillance. "The first person to call up when there is a problem is one of the physician-investors. They will not sit still for any kind of inadequacy at the front desk, with technicians, or even with reports from the radiologists. Basically, what I am saying is that they monitor the quality of the service coming out of a particular center, and if they have any suggestions or constructive criticisms, we hear about them immediately."

Echoing Mr. Kontra is the official policy of the American Medical Association. "We think that an across-the-board prohibition of these facilities overlooks some of the benefits," says Dr. Raymond Scalettar, Clinical Professor of Medicine at George Washington University and a member of the AMA's Board of Trustees.

"A facility that is owned and operated [by physicians] may be much more efficient, may be much more courteous, may have more rapid reporting and better turn-around time than a facility at which the physician has no input," says Dr. Scalettar.

A potential conflict of interest does exist, he concedes, but that conflict can be minimized if the referring physician simply tells the patient about his or her financial interest. "The patient should have the option to accept or turn down [the referral], or go to another facility without feeling pressured."

Dr. Relman disagrees, saying that the AMA's endorsement of limited partnerships is in violation of the association's own longstanding policy that "physicians are not entitled to derive a profit which results directly or indirectly from services rendered by other health-care providers who are not their employees or agents."

Dr. Relman believes that patients lack the medical knowledge to question the details of a physician's recommendation—such as which particular testing center is best, or even if the procedure is warranted. "The patient has a very powerful incentive not to want to question or challenge the doctor," Dr. Relman says.

The patient may even draw the wrong conclusion from the disclosure, says Dr. E. Haavi Morreim, Associate Professor of Ethics at the University of Tennessee College of Medicine. The patient might think that the diagnostic facility is merely an extension of the physician's office, Dr. Morreim says. Alternatively, the patient might view the disclosure as a reassurance: "I own it, so it must be good."

"Even if the patient understands that there is a potential conflict, he may be in too awkward a position to do anything about it," says Dr. Morreim. "If the patient wants to remain with this physician, he may feel that he does not have a lot of choice. He may feel that he doesn't want to insult the physician by implying that the referral is underhanded, and he may not want to harm the physician economically by 'buying from the competition.'"

Moreover, says Dr. Relman, even if the patient decides to go to a facility other than the one that the physician recommends, a needless procedure has still been performed.

Utilization and Costs

Over utilization of expensive medical procedures is one of the primary objections of opponents to limited partnerships. At the heart of this argument are two 1983 studies, one conducted by the Health Care Financing Administration, the other by Blue Cross/Blue Shield of Michigan, which found that physicians with a financial interest in a laboratory tend to prescribe tests more often, and that tests performed by such laboratories tend to be more expensive, compared with physicians who have no such financial interest.

LAB USE AND COST VS. OWNERSHIP

	Avg. payment per patient	Avg. no. tests per patient
MD-Owned	$44.82	6.23
Range:	$21.33-$123.18	3.42-20.72
Non–MD-Owned	$25.48	3.76
Range:	$7.15-$30.33	1.67-4.68

Source: 1983 study by Michigan Blue Cross and Blue Shield comparing data from 20 physician-owned laboratories in Michigan with data from 20 non–physician-owned labs in that state.

"In almost all the studied laboratories, the data demonstrate that physicians with an ownership interest in an independent laboratory are responsible for substantially higher utilization with respect to number of recipients referred and number of tests performed than are physicians without an ownership interest," concluded the 1983 Health Care Financing Administration report, which studied health-care costs in Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin.

Yet even given the problems with self-referrals, many believe that legislation—especially the legislation proposed by Rep. Stark—is not the answer.

"It's an attempt to use an elephant gun to swat a potential mouse," says Martin Gaynes, an attorney in Washington, D.C., who has set up many limited partnerships and who publishes a newsletter on Medicare fraud and abuse.

"The people who are drafting this legislation have in mind a particular kind of abuse," says Mr. Gaynes. "If the bill were aimed only at that kind of arrangement, my reaction would be different. The problem is that the wording of this bill would incorporate a whole range of investments in which the defects don't exist."

For example, says Mr. Gaynes, the proposed legislation allows a physician to purchase radiography equipment, put it in his or her office, and run patients through it. But the bill forbids a group of physicians who share a building from jointly purchasing radiography equipment and sharing the revenue it generates.

"Every argument that Blue Cross or Stark might make to overutilization is just as valid," in the first case as in the second, says Mr. Gaynes. But, he adds, such arguments are not put forth because "the government is not supposed to tell physicians how to practice medicine."

Another problem that Mr. Gaynes sees with the Patient Referrals Act of 1989 is that it makes no distinction between diagnostic procedures and therapy. "You can make an argument that the existence of a financial interest by a physician might make him use or order a particular diagnostic tool that he wouldn't have ordered before . . . but when you are talking about therapeutic machines, that argument becomes much less tenable. . . . What drives a doctor to order a therapy is the cancer," Mr. Gaynes says, not ownership in a limited partnership that offers therapeutic services.

Dr. Morreim sees the issue differently: The problem with legislation, she says, is it is inflexible. "It tends to sacrifice individual case flexibility in order to achieve certainty and clarity."

Instead of passing new statutes, those interested in curbing the practice of unethical referrals to limited partnerships should turn to the civil courts, Dr. Morreim says, where longstanding precedents exist to punish physicians who place their own interests before those of the patient.

To Dr. Morreim, the principal danger of the legislation is that "it puts the government in between physicians and patients." The legislation makes the government responsible for protecting patients from their physicians.

E. HAAVI MORREIM, Ph.D.

Yet tenants such as informed consent and a physician's responsibility to provide "due care" have been established and supported by the courts for years.

"We allow patients to make extraordinarily sophisticated medical decisions. Presumably, that right should extend to making their economic decisions. This legislation would forbid a patient to buy from the provider of his choice, if it happened to be the case that the provider is owned by his physician."

"Legislation to prohibit self-referrals or restrict ownership will not make the conflict of interest problem go away," she adds. "It will reshape the problem, but it will not eliminate it."