

ETHICS, LAW, AND THE BUSINESS OF HEALTHCARE

By

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INTRODUCTION

A physician's *practice* of treating patients is undoubtedly an ethical endeavor. From ancient Greek pioneers to contemporary global practitioners, purveyors of the healing arts have recognized that when taking care of patients, the question – *What is the right thing to do here?* – is often infused with psycho-social normative dynamics that surpass the confines of bioscience and technology. In response, a rich and robust ethical tradition has evolved over the millennia to monitor the boundaries of what is professionally and socially acceptable medical practice at the bedside. Healthcare professionals have historically been self-regulated and guided by these robust codes of ethics and professionalism, at the heart of which lies a concern with addressing interests that conflict with those of the individual patient or the more general wellbeing of the community.¹

Yet, in recent years, a chorus of critics has emerged to highlight the toll that a creeping commercialization has taken on those historic, underlying ethical foundations of medical practice in the United States.² In the wake of healthcare's emergence as one of the U.S.'s dominant industries³ and the concomitant deterioration of the profession's commitment to self-regulation,⁴ this Article argues that a physician's *business* of treating patients should similarly be understood as an enterprise with ethical boundaries that requires monitoring by legislators, policymakers and government regulators.⁵

In short, whether in the physician's office, in the clinical examination room, or at the hospital bedside, the delivery of care from one person to another creates a unique relational dynamic historically addressed by codes of ethics and notions of professionalism. This Article argues that these same ethical principles and concerns that shape the practice of medicine between patient and physician should guide those legislators and regulators charged with crafting U.S. healthcare policies that demarcate the ethically responsible boundaries of a physician's business practices. Part I will develop the argument for why a robust consideration of ethics is particularly critical to the governance of the medical business in the United States, where healthcare policy has a long history of being influenced by entrepreneurial, market influences.⁶ Part II will examine the specific case of the physician-owned hospital. These facilities are the example *par excellence* of healthcare delivery business driven by entrepreneurial, market influences where a physician's motivations can become unnecessarily and acutely conflicted by financial incentives that complicate the relational dynamics and delicate balance between the pecuniary interests of the physician, the health interests of the patient, and the social interests of the broader population.⁷ The final Part of the Article will apply the ethical framework discussed in Part I to the physician-owned hospital industry described in Part II. The Patient Protection and Affordable Care Act ("ACA") includes provisions that aggressively regulate the physician-owned hospital industry,⁸ and thus offers a case study in how ethical principles might be included in future efforts to guide health law and policy reforms. While it might be naïve, particularly from the perspective of public choice theory, to conclude that the ACA legislation was driven solely or even primarily by the ethical considerations highlighted in this Article, I will nonetheless argue that this legislation is a useful case study for how a more systematic integration of ethical considerations should guide future efforts to reform U.S. healthcare law and policy around the business practices of physicians.

PART I. ETHICS AND THE BUSINESS OF MEDICINE

As famously noted by Kenneth Arrow, the Nobel laureate economist, 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.⁹ 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.¹⁰ The complex relationship between a patient-consumer and a physician-provider creates a unique transaction experience with few analogues.¹¹ Moreover, 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-

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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 systemic issues of cost and access that inevitably impact upon one's encounter (or even access to an encounter) with his healthcare provider.¹² This third dynamic of the healthcare business reverberates throughout society, as the general health of a population is a requisite condition for sustained economic wellbeing.

These variables differentiate the business of delivering clinical healthcare services from other market transactions in fundamental ways.¹³ 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.¹⁴ A patient, 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,¹⁵ ultimately must rely upon the advice and direction of her healthcare professionals for her wellbeing.¹⁶ 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*. 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.¹⁷ 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.¹⁸ Of course, even the most altruistic caregiver rightly expects to receive some measure of compensation, however, if a patient's ability to rely on her healthcare provider to put her best interests in front of the physician's pecuniary interest is too badly damaged, 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?¹⁹ These concerns, to which I will return in Part III, suggest that recent healthcare reform legislation curbing the expansion of physician-owned hospitals did not go far enough. If one accepts the more robust ethical considerations highlighted in this Article, perhaps a complete ban of these facilities is justified.

The delivery of healthcare is, "at its roots, a helping enterprise,"—a business permeated with the concept of care—that has been historically 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.²⁰ Building upon this more expansive view of the healthcare business as a more traditionally understood helping profession, this first Part of the Article further develops what Troyen Brennan proposed nearly twenty years ago as the goal of "moral consistency" between "the realm of clinical interventions" and "the institutions that provide them."²¹

Attempting to influence the healthcare reform debates that raged during the first half of the 1990s, Brennan argues in favor of an ethical approach to health policy reform that extrapolates from the virtues of traditional 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."²² 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."²³ To prioritize the commitments for this approach to ethical health care 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.²⁴ 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.²⁵ 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;²⁶ 2. An institutional commitment that respects and supports the essential therapeutic relationships between individual patients and providers, while also balancing the reality of systemic resource limitations in the allocation of services;²⁷ 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 the necessity of practicing medicine in a spirit of solidarity and harmony with one another.²⁸

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."²⁹ 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.³⁰ Professor Herzlinger argues that the best prescription for health care 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."³¹ 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.³² If health care 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.³³ While there is much to be admired about "good, old-fashioned American" approaches, an unregulated market 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.³⁴

An interaction with one's physician is simply categorically different than one's interaction with the gal selling hamburgers or the guy handling overnight package delivery. As Mark Hall and Carl Schneider have so neatly summarized, being a consumer of healthcare, i.e., a patient, is particularly difficult because illness disables, pains, exhausts, erodes control, enforces dependence, disorients, baffles, terrifies, and isolates.³⁵ Consider, for example, the dynamics arising in the context of a medical emergency involving one's young child. 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 discovered 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 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 are the hallmarks of the doctor-patient relationship, and they inform a patient's relationship with her healthcare providers.

These scenarios reveal the constitutive elements of what makes encounters with the healthcare system unique from one's daily engagement with other actors and institutions in the marketplace. Typically, the health care 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 many medical facilities. Yet, operating pursuant to principles of profit maximization, many of these same physicians – trained at government expense and paid by government Medicare or Medicaid programs – refuse to treat those who are often the sickest and without alternative, 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."³⁶

So what might future healthcare reforms and regulations guided by a robust concern for ethical issues including, *inter alia*, preservation of the patient's best interest, elimination or reduction of unnecessary conflicts of interest, and just allocation of resources made fairly available throughout society? The remainder of this article will address that question by exploring the specific case of physician-owned specialty hospitals. Heralded by Professor Herzlinger as "the best hope for a higher-quality and higher-productivity healthcare system," these physician-owned facilities were targeted by the recently passed Patient Protection and Affordable Care Act ("ACA") in ways that will sharply curtail their future growth and expansion. The next Part offers some background on these particular healthcare providers and the specific ethical issues these businesses present.

PART II. 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.³⁷ 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, hundreds of millions of dollars in state and federal tax revenues (which nonprofit general hospitals do not pay), and billions 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.³⁸ Moreover, due to differences in staffing levels, employee compensation, and/or 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.³⁹ 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.⁴⁰

An illustrative example of a physician-owned specialty hospital is the Heart Hospital of New Mexico, which opened in 1999.⁴¹ At its inception, local cardiologists owned 41% of Heart Hospital, a stand-alone cardiac center, in partnership with MedCath, Inc., a publicly-traded nationwide operator of cardiovascular clinics.⁴² 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.”⁴³ 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.”⁴⁴

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 62%, while the fee for triple-bypass had been cut by 39%.⁴⁵ Meanwhile, hospitals during this same decade had begun retaining a greater percentage of what Medicare paid. For example, in 1989 hospitals kept approximately 60% 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 85%, with the remainder being paid to the surgeon.⁴⁶ 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.”⁴⁷ 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 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. Neither the climate that fueled the frustration, nor the response of physician-investors was consistent with the hallmarks of ethical health policy Brennan seems to have in mind when he describes “providers [who are] actively cognizant of the nature of their activities (as part of a group process) and the collective impact of their individual actions.”⁴⁸

A. Systemic costs

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.⁴⁹

Additional examples illustrate the concern.⁵⁰ 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.⁵¹ 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.⁵² 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).⁵³ 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.⁵⁴ 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 revenue" between 2002 and 2004.⁵⁵ Similarly, in Ruston, Louisiana, the Lincoln General Hospital saw their 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.⁵⁶

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.⁵⁷ 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.⁵⁸ 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.⁵⁹ 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.⁶⁰ Likewise, the 2005 report issued by Michael Leavitt, Secretary of Health and Human Services, also found that specialty hospitals generally treat a less-sick patient population with "lower severity levels."⁶¹

In late 2005, Georgetown's Jean Mitchell published additional data again comparing the practice patterns of physician-owners of specialty cardiac hospitals to the practice patterns of physician-non-owners treating cardiac patients at competing full-service community hospitals.⁶² A study of Arizona providers conclusively confirmed that physician-owners were treating nearly twice as many cardiac cases as physician-non-owners.⁶³ 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.⁶⁴

At the request of Congress, MedPAC released another report in 2006.⁶⁵ 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.⁶⁶ Second, the 2006 report re-confirmed that patient stays in physician-owned facilities are greater than 20% shorter than patient stays in community hospitals, yet the overall costs of patient care are not less. The report speculated that these increased costs at physician-owned specialty hospitals were a result of different staffing levels, employee compensation, and/or the use of single occupancy rooms equipped for intensive care.⁶⁷

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—findings consistent with what Jean Mitchell had found in her analysis of Arizona's healthcare landscape.⁶⁸ Professor Mitchell's subsequent examination 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 non-owners treating similar cases during the same time frame would further highlight the issue.⁶⁹ 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."⁷⁰ Mitchell found that during the same time period in the same market, dramatic increases in utilization were not seen in the practices of non-owner physicians.⁷¹ 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."⁷²

B. Patient costs

While several tragic and unnecessary deaths in 2005, 2007, and 2009 suggested a possible proliferation of grave patient safety issues throughout the physician-owned specialty hospital industry, absent additional data, it was unclear to government officials how extensive these threats to patient wellbeing might be.⁷³ 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.⁷⁴

However, 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.⁷⁵ Out of the 109 specialty hospitals that the OIG reviewed, only 55% had an emergency department and more than half of these hospitals were equipped with only one emergency bed.⁷⁶ Additionally, while 93% 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 (CMS).⁷⁷ Without the capacity to offer complete, onsite emergency services or the availability of trained personnel, it is not surprising that the OIG report found that 66% of these facilities instruct their staff to dial the 9-1-1 emergency number as an official component of their medical emergency response protocol.⁷⁸ As noted in the OIG's report, examples of emergency policies at some physician-owned specialty hospitals included:

- “9-1-1 will be called to the scene to attempt resuscitation.”
- “After hours, call 9-1-1 for a Code Blue. Upon arrival, [county] EMS will assume responsibility for the patient.”
- “If conditions are such that staff should require additional assistance, 9-1-1 will be contacted.”⁷⁹

Obviously, the recourse to 9-1-1 emergency assistance from the full-service hospital down the street or across town was for the purpose of patient stabilization, as well as patient transfer.⁸⁰ The former use of 9-1-1, i.e., “to obtain medical assistance to stabilize a patient” by 37 of the 109 hospitals 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.⁸¹ In addition to these findings, the OIG’s investigation revealed that 22% 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.⁸² This too constitutes a violation of the CMS’s Conditions of Participation.⁸³

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 this data added to the fire of political criticism 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.

PART III. A CASE STUDY FOR ETHICAL HEALTHCARE POLICY

Legislative efforts addressing the constellation of issues raised by physician-owned hospitals can be traced to the Medicare Anti-Fraud and Abuse Statutes of the 1970s and early 1980s that attempted to eliminate perverse incentives that were resulting in overutilization and concomitant rising costs.⁸⁴ In 1989 Congress directed the Office of the Inspector General to study the “referring-physician ownership of, or compensation by, entities providing items or services for which Medicare may make payment; the range of such arrangements and the means by which they are marketed to physicians; the potential of such ownership or compensation to influence a physician’s decision about referrals and to lead to inappropriate use; and the practical difficulties involved in enforcing actions against such arrangements that violate current anti-kickback provisions.”⁸⁵ The OIG’s report provided the data necessary to cement growing concerns over the practice of some physicians who were maintaining an ownership interest in health service centers to which they referred their Medicare and Medicaid patients. Congress soon passed the “Ethics in Patient Referrals Act,” which had been sponsored by U.S. Representative Fortney H. (Pete) Stark, and primarily targeted self-referrals to facilities furnishing clinical laboratory services.⁸⁶ The reforms were expanded in 1993 to cover self-referrals to facilities offering additional health services, including inpatient and outpatient hospital services.⁸⁷

Together, these efforts to prohibit physician self-referral would become more widely known as the Stark Laws.⁸⁸ Intended to prevent physicians from making patient referrals to any institution in which the physician enjoyed any financial connection, legislative compromises resulted in the insertion of an exception that would permit physicians to own an interest in a general facility if the “financial interest was in the entire hospital and not merely in a distinct part or department of the hospital.”⁸⁹ Such compromise was possible because it was assumed by Congress that physicians with an ownership interest in a “whole hospital” – offering a diversity of services – would be less likely to have clouded judgment due to the dilution of potential economic gains in the context of a full-service, general hospital.⁹⁰ This exception notwithstanding, the Stark Laws were clear in their prohibition against physicians with an ownership interest in a distinct hospital subdivision being able to refer their Medicare patients to that subdivision.⁹¹

By capitalizing on the “whole hospital exception” in the Stark Laws, laws that otherwise were clear in their prohibition of similar physician self-referral schemes, the number of physician-owned specialty hospitals, often similar in size and scope to hospital departments, tripled to 100 between 1990 and 2003.⁹² Premised upon this rapid growth and anecdotal media reports indicating an unfair competitive disadvantage for full-service community hospitals, as well as concerns about conflicts “inherent in physician self-referral,”⁹³ in December 2003 Congress instituted an eighteen-month moratorium on construction of physician-owned specialty facilities not already in existence or development on November 10, 2003.⁹⁴ When the congressional moratorium expired on June 8, 2005, the Centers for Medicare and Medicaid Services (CMS) extended the moratorium through administrative action until January 2006 so that it could “review its procedures for enrolling specialty hospitals in the Medicare program” and “undertake a series of steps to reform Medicare payments that may provide specialty hospitals with an unfair advantage” over community hospitals.⁹⁵ In 2007, the House of Representatives passed the Children’s Health and Medicare Protection Act of 2007, which included a provision that would have eliminated the whole hospital exception for new or expanded physician owned hospitals – without any exceptions.⁹⁶ Nearly identical measures were passed in 2008, one by the House⁹⁷ and the other by the Senate,⁹⁸ with the only differences being exceptions for physician-owned hospitals to expand their capacity. None of these bills were successfully enacted, and it would be 2010 before Congress would act to regulate the approximately 265 physician-owned specialty hospitals operating around the United States that had essentially “taken a ‘subdivision of a hospital’ and made it a free-standing hospital in order to circumvent the prohibition in

the physician self-referral laws [otherwise] prohibit[ing] self-referral when the ownership is ‘merely a subdivision of a hospital.’”⁹⁹

On March 23, 2010, President Barack Obama signed “The Patient Protection and Affordable Care Act,” (“ACA”), which included a section subtitled, “Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals,” (“Section 6001”) into law.¹⁰⁰ Although the details are described below, Section 6001 essentially amends the Medicare Act to prohibit new or expanded physician owned hospitals from filing Medicare claims if a financial relationship exists between the referring physician and the hospital receiving the government reimbursement. “[F]erociously complex,” the 2,000 page systematic health care overhaul was heralded as “the most significant piece of domestic legislation to emerge from Washington in decades.”¹⁰¹ For advocates of physician-owned specialty hospitals, however, the “illogical and unfortunate” legislation was predicted to “virtually destroy over 60 hospitals” that were currently under development and stifle any future growth of those facilities already in existence.¹⁰² Predictably, interested parties opposed to physician-owned specialty hospitals viewed Section 6001 as “a good one that will stem the tide of an entrepreneurial approach to medicine that is potentially fatal.”¹⁰³

A. What does Section 6001 do?

Section 6001 of ACA amends Section 1877 of the Social Security Act, i.e., the Stark Laws, in ways that impact both physician-owned specialty hospitals already in existence, as well as those under development.¹⁰⁴ For those hospitals currently operating with Medicare certification, the new law prohibits increases to the number of operating rooms, procedure rooms, and beds for which the hospital is licensed, unless narrow exceptions can be met.¹⁰⁵ Moreover, the legislation addresses conflict of interest concerns by requiring disclosures to make the operation of these facilities more transparent.¹⁰⁶

In this same spirit of transparency, the new law also requires physician-owned hospitals to make available to the Department of Health and Human Resources a detailed annual report on the identity of investors, as well as the nature and extent of all investment terms.¹⁰⁷ Additionally, these facilities will have to disclose all ownership and investment interests to specific patients, as well as post general disclosure notices on websites and public advertising alerting the public to the hospital’s status as physician-owned.¹⁰⁸

Finally, the reforms also address concerns related to the legitimacy of a physician’s investment and patient safety. In a sub-section entitled “ensuring bona fide investment,” the legislation curbs the ability of these facilities to expand the pool of physician-investors, while also explicitly forbidding an array of fraudulent investment terms and conditions.¹⁰⁹ The law addresses safety by requiring all hospitals without 24-hour on-site physicians to secure signed consent from patients.¹¹⁰ Moreover, facilities relying on dialing 9-1-1 emergency services supplied by other, full-service area hospitals will have to provide baseline stabilization treatments and have the capacity to transfer patients to full-service hospitals without reliance upon 9-1-1 emergency transfer services.¹¹¹

B. Legal challenge to ACA’s Section 6001

On June 3, 2010, Physician Hospitals of America (“PHA”) and Texas Spine & Joint Hospital (“Texas Hospital”) initiated litigation to enjoin the Secretary of the United States Department of Health and Human Services (“HHS”) from implementing and enforcing Section 6001 on the grounds that the legislation was unconstitutional.¹¹² PHA is the trade association representing the interests of 166 physician-owned hospitals in 34 states.¹¹³ The Texas Hospital is a twenty-bed facility that specializes in joint replacement, spine surgery, total knee replacement, and back and neck surgery.¹¹⁴ At the time of Section 6001’s passage, Texas Hospital had spent nearly \$3 million on an expansion project to increase facility capacity.¹¹⁵ The total expansion project was forecast to exceed \$30 million, with financing “anchored in expected Medicare reimbursements.”¹¹⁶ The plaintiffs’ suit requested declaratory and injunctive relief and advanced a theory that Section 6001 is not rationally related to a legitimate purpose nor is it justified by a factual basis, thereby violating their due process and equal protection rights under the Fifth Amendment. In addition to plaintiffs’ contention that no factual basis exists to support Section 6001, they further argued that Section 6001 was enacted merely to provide a competitive business advantage to general and full-service hospitals.¹¹⁷

In defense of Section 6001, HHS set forth four justifications: 1) Physician ownership leads to overutilization of services; 2) physician ownership results in greater healthcare expenditures; 3) referral patterns undermine public and community hospitals, which provide uncompensated care and other services not usually offered by physician-owned hospitals; and 4) physician owned hospitals do not offer adequate emergency care.¹¹⁸ Although the plaintiffs challenged the evidence relied upon by Congress when reaching its conclusions and advanced their theory that Section 6001 was only passed as “the product of a backroom deal brokered for the benefit of the American Hospital Association,” the Court noted that it “is not in the business of passing judgment on the wisdom or appropriateness of legislative action.”¹¹⁹ Moreover, the Court noted that precedent only permitted overturning a statute under the rational basis standard when “the legislative facts on which the classification is apparently based could not reasonably be conceived to be true by the government decisionmakers.”¹²⁰ In reviewing Section 6001 and its legislative history, the Court concluded that concerns over physician ownership and evidence that such arrangements create incentives for unnecessary referrals does constitute a rational basis for the law.¹²¹

Plaintiffs also alleged that Section 6001 constitutes a regulatory taking of their real property and capital investment, as well as their ability to bill Medicare for additional patients they would treat in new or expanded hospitals.¹²² The Court noted the fact that physician-owned hospitals are not economically viable without the ability to bill Medicare for self-referrals, yet concluded that the loss of the ability to bill Medicare for self-referred patients does not constitute an impermissible taking.¹²³

Section 6001, as the Court highlights, does not prohibit physician owners from building or expanding a hospital or from seeking Medicare reimbursements for health services that do not result from a physician-owner referral.¹²⁴ Moreover, physician-owned hospitals are not forbidden by Section 6001 from continuing to self-refer when patients or their private insurers are paying the bill. Thus, the Court concluded that because Section 6001 does not proscribe, limit, or otherwise interfere with the Plaintiffs' use of their real property, the legislation does not result in a regulatory taking of real property.¹²⁵

Additionally, Plaintiffs argued that Section 6001 would create enormous financial hardship because Texas Hospital would have to forfeit its \$3 million investment and other PHA-affiliated hospitals would lose "over \$5 billion of investments" made toward new construction and expansion projects, all predicated upon their ability to bill Medicare for self-referred patients.¹²⁶ Yet the Court found that Plaintiffs could have "no *reasonable* expectation that the Medicare program would remain unchanged."¹²⁷ Rather, the history of Medicare – a "voluntary program which the government may alter at any time" – is marked by numerous changes in benefit policies, and, furthermore, the specific changes contained in Section 6001 had been considered and "almost enacted" by Congress in 2007 and 2008.¹²⁸ Physician owned hospitals were clearly on notice that reforms efforts to close the "whole hospital exception" loophole were afoot, and any financial decisions taken in the direction of expansion or further investment was a calculated risk on the part of physician-investors.

On March 31, 2011, the Court granted the Defendant's Motion for Summary Judgment and dismissed all Plaintiffs' claims.¹²⁹ The Plaintiffs have elected to appeal the court's ruling to the 5th Circuit, and legislative challenges that would repeal Section 6001 have been introduced in the U.S. House of Representatives.¹³⁰

C. In what ways does the reform legislation reflect ethical healthcare policy?

1. Nonmaleficence¹³¹

Considered narrowly, the medical ethics mandate to "do no harm" applies to the treatment an individual physician provides for an individual patient at the bedside. Yet, more broadly applied, the principle can be used to interrogate the systems and institutions that comprise the healthcare delivery mechanisms throughout society, and to determine whether a systemic harm is being perpetrated. In the context of physician-owned, specialty hospitals – or any component of the health care system – two questions are operative: 1. Are individual patients being harmed? and 2. Are broader, perhaps less immediately recognizable, harms being done to the health care system and/or the professionals who inhabit it?¹³²

The question of harm that may be done to individual patients is not easily answered. On the one hand, mistakes can happen in these physician-owned facilities, and without the adequate emergency facilities or appropriately trained personnel available, routine complications can result in unnecessary patient deaths.¹³³ Clearly, in some physician-owned hospitals, cost-saving measures were recklessly instituted, and some patients paid the ultimate price. Yet, proponents of the industry argue that three individual patient deaths are outliers, and the vast majority of patients receive quality care and enjoy an above-average hospital experience. Indeed, popular media and government report support the view that patient satisfaction at physician-owned facilities is generally high, in some instances higher than it is in competitor full-service, community hospitals.¹³⁴ Moreover, provisions of Section 6001 are clearly intended to compel more rigorous oversight of patient issues from the Centers for Medicare & Medicaid Services. Yet, the nonmaleficence analysis is incomplete if it concludes with the individual experience of those patients equipped with private insurance or Medicare who are fortunate enough to experience one of these five-star facilities.

Considered in a broader context and recalling Brennan's modified Rawlsian thought experiment, there do appear to be systemic harms perpetrated by these physician-owned facilities that necessitate regulations consistent with ethical healthcare policy. Take, for instance, the patterns of care at physician-owned specialty hospitals relative to Medicaid patients. The March 2005 and 2006 reports by MedPAC provide empirical evidence that physician-owned specialty hospitals are "less likely to treat Medicaid patients than community hospitals in the same areas and that physician-owned specialty hospitals tended to treat healthier patients."¹³⁵ In fact, according to the 2006 MedPAC data, Medicaid patients represented only 3% of the discharges at physician-owned heart hospitals and only 2% of the discharges at physician-owned orthopedic and surgical hospitals.¹³⁶ At non-physician-owned heart hospitals, the share of Medicaid patients was 7%, while non-physician-owned orthopedic and surgical hospitals averaged a patient population consisting of 3% Medicaid eligible. These findings were consistent with the Government Accountability Office 2003 report finding that community hospitals treated twice as many Medicaid patients as did physician-owned specialty hospitals.¹³⁷ These statistics and the investigations that yielded them led MedPAC to conclude that "[o]ther specialty hospital decisions such as location, mission, emergency room capability, and physician financial incentives to avoid Medicaid patients may have contributed to the lower Medicaid shares at physician-owned hospitals."¹³⁸

Section 6001 includes specific provisions addressing this discrepancy in treatment patterns relative to Medicaid patients between physician-owned and non-physician-owned facilities. Going forward, any physician-owned facility seeking to expand its capacity will have to match or outpace the percentages of Medicaid patients being treated at non-physician-owned facilities. This legislative solution seems consistent with the priorities of an ethical health policy, because it seeks to end the harm being done by physician-owned facilities that may have been otherwise tempted to avoid treating patients that are potentially both sicker and less likely to result in high profit margins. Specifically, these provisions of the new law attempt to fix the competitive harm created by an unfair playing field where physician-owned specialty hospitals can exploit the "whole hospital exception" and operate with little concern for treating Medicaid patients, while this less profitable care is relegated to the full-service hospital across the street. At a minimum, this provision of the new law addresses concerns that physician-

owned specialty hospitals foster a two-tiered health care system – one for the wealthy and well-insured and one for those of lower socio-economic status. To the extent that physician-owned facilities were incentivized to pursue treatment opportunities with patients that would yield higher profits, while relegating others to a second-class network of treatment facilities, such incentives were eliminated as of March 23, 2010.

Yet, one wonders whether a more robust appreciation for ethical concerns might have prompted reformers to go a step further. The mandate to treat a higher percentage of Medicaid patients is only triggered in the event the physician-owned facility seeks to expand capacity. Arguably, an opportunity was missed to even the playing field in those communities where physician-owned specialty hospitals have skimmed the more lucrative patients away from full service facilities that are also engaged in charity care. Given the fact that public money, in the form of Medicare reimbursements, provides the operating capital for these for-profit enterprises, it would perhaps be even more fair and reasonable to require existing physician-owned facilities to increase their percentage of care to underserved populations as a retroactive condition for continued participation in the Medicare program.

2. Conflicts of Interest

In addition to the ethical concerns over unnecessary harms that threaten individual patients, an entire class of non-Medicare-eligible patients, and full-service hospitals, another fundamental ethical concern addressed by the new legislation is the issue of a physician's conflicting pecuniary interests. Throughout the history of healthcare this conflict of interest, which is to a certain extent unavoidable, has been at the heart of medical ethics and professionalism norms (especially in America, where the entrepreneurial, money-making potential of healthcare delivery has been well-documented).¹³⁹ At some level a conflict will always exist between a physician's need for personal income and the patient's need for medical treatment.¹⁴⁰ Thus, the question may simply boil down to whether or not physician-owned hospitals exacerbate or reduce this inherent conflict. On May 17, 2006, in a Senate Finance Committee hearing considering the issue of physician-owned specialty hospitals, Senator Charles Grassley asked the question this way: Do these health facilities “serve the best interests of the patients being treated by them, or [do] they serv[e] the best interests of the physicians who own and operate them?”¹⁴¹

Appropriating an ethical healthcare policy framework might reformulate the question to ask specifically whether these institutions promote a patient-centered commitment that reinforces the physician's ethical duty or do these facilities only further confuse the physician's judgment when making determinations about treatments and tests that may or may not be necessary? Given the abundance of evidence demonstrating repeated patterns of over-utilization when physicians have an economic self-interest,¹⁴² physician-owned facilities necessitate a high level of regulatory scrutiny. Thus, the provisions of Section 6001 that require annual reporting to federal regulators specifying the identity of all physician owners or investors and the nature and extent of their ownership interest are reasonable measures in the right direction. Providing information to the government that will facilitate the monitoring of physician practice patterns is a reasonable requirement for participation in a federal reimbursement program, and it should aid in efforts to monitor physician-owned facilities. Moreover, additional requirements included in the legislation that mandate full disclosure to specific patients and explicit public notice on all websites and advertising, are likewise reasonable regulations that theoretically serve both to intensify the public oversight of the industry and also to inform individual patients and the public consistent with the ethical and common law duty to ensure that medical treatment only commence after informed consent has been secured.¹⁴³

Yet, decades of critics have argued that legal regulations requiring informed consent do not necessarily result in better-informed patients.¹⁴⁴ Nothing in the ACA reforms can guarantee that patients, many of whom may have compromised capacity,¹⁴⁵ will appreciate the conflict created by physician-investor, self-referral schemes. Additionally, one is left to wonder how such a disclosure might undermine a patient's or a community's general sense of trust in the medical profession. Could a more widespread public knowledge of physician-ownership actually intensify cynicism and undermine efforts to encourage the public to develop long-term, trusting relationships with healthcare providers? Given the dual uncertainties over whether disclosure will actually adequately inform and empower patients, as well as the concern over public backlash if physicians are broadly viewed to be driven by pecuniary interests, one wonders if an outright, retroactive ban would be the *most* ethical policy reform in this area. After all, some measure of conflicting financial interest is unavoidable. Physicians must eat. Staff must be paid. Medical school loans are a reality. Yet, physician-owned hospitals unnecessarily create an additional layer of pecuniary conflict that policy makers, guided by the ethical concerns raised in this Article, could reasonably decide to ban retroactively and completely, consistent with the original intent of the Stark legislation.

3. Bona fide, transparent ownership

Proponents of physician-owned specialty hospitals are tireless in making their claims that their entrepreneurial efforts are consistent with the best ideals of a competitive, free-market environment that rewards efficiency and innovation. Additionally, their insistence that a motivation beyond profit-taking can be found in a good-faith desire for greater physician autonomy and freedom from large hospital and conglomerate bureaucracies is compelling. Indeed, it is completely reasonable for physicians to desire professional freedom from the frustrations of administrative hassles and clinical empowerment to exercise control and develop specific competencies over those practice dynamics that will result in the highest levels of patient care. The desire to “own” their own practice, in the sense of controlling it, seems both reasonable, and consistent with enduring ethical concerns over individual autonomy and self-determination on the part of professional healthcare providers.

Yet, American medicine's history of kickback deals and fiscally reckless self-referral practices renders it difficult to see only this silver lining of hospital ownership that proponents proffer.¹⁴⁶ Copious amounts of data confirm that financial interests influence medical decision-making.¹⁴⁷ Hence, those provisions of Section 6001 designed to monitor whether physician ownership deals will indeed be "bona fide investments" appear to be justified by the concerns of a healthcare policy guided by ethical considerations. Indeed, abuse of patients (through the ordering of extraneous tests or procedures) or abuse to the system (through increasing Medicare costs and waste of finite resources) could more easily occur if a physician felt obligated to co-investors in the hospital who had: offered investment terms to the physician more favorable than those offered to non-physician owners; provided a loan to entice the physician to invest; guaranteed or subsidized a loan related to the physician's acquisition of an ownership interest; distributed a dividend or other return on any basis other than one directly proportional to the physician's investment share; or provided an opportunity for a physician to purchase or lease property under the control of the hospital on terms more favorable than those offered to an individual who is not a physician owner.

Each of these potential deal points, arguably completely ethical in the context of negotiations and transactions in most other industries, is forbidden by Section 6001. However, such regulations, viewed through the lens of ethical healthcare policy concerns, are easily justified on the rational basis that in their absence it would be too easy for investment-related concerns and motivations to cloud the physician's judgment and result in adverse consequences to an array of stakeholders, including the individual patient and the broader population that rightly expects prudent financial decisions with regard to finite public resources. As noted throughout this Article, people who become patients are frequently in uniquely vulnerable conditions, and the care they expect and deserve to receive should not be influenced by some lingering sense of payback or obligation felt by the physician towards his investment partners in a jointly-owned hospital facility.

Assuming that (1) these investment restrictions can adequately safeguard the legitimacy of physician ownership in these facilities, (2) sufficient transparency protocols can be put in place that allow for regulator oversight of potential over-utilization and assure appropriate patient consent that permits informed decision making, (3) fair competition can be promoted with regard to the socioeconomic demographics and illness severities of the patient population, and (4) corners are not cut with regard to emergency services and patient safety, then Section 6001 will have reformed this industry in ways that highlight ethical priorities for future reform efforts. Yet, these are not trivial assumptions, and one is left to wonder whether the copious amount of negatives associated with physician-owned hospitals simply outweighs their potential for positive contributions to the healthcare system. A more robust and aggressive attempt at healthcare reform driven by ethical considerations suggests a complete closure of the "whole hospital exception" loophole and retroactive removal of Medicare certification from those facilities currently operating may have been the more prudent course.¹⁴⁸

CONCLUSION

"Ethics in its broadest sense," Professor Larry Churchill observes, "concerns how we live and the choices we make."¹⁴⁹ Brought to bear in the context of practical policy deliberations, such normative reflections facilitate review of the array of values in play and the commitments of the various participants. Contemplation of ethical concerns, ultimately, makes it possible to understand more fully the operative principles underlying stakeholders' positions, as well as their implications and likely consequences if adopted. To the extent health policy decisions must negotiate inherent conflicts of interest, the prioritization of competing goods, and the distribution of benefits and burdens among those who are vulnerable and have disparate bargaining power, the explicit guidance of ethical considerations should be more robustly adopted by those charged with oversight, governance, and continuing reform of our healthcare system.

FOOTNOTES

¹ The substantive basis of the first American Medical Association code of medical ethics was THOMAS PERCIVAL, *MEDICAL ETHICS; OR A CODE OF INSTITUTES AND PRECEPTS, ADAPTED TO THE PROFESSIONAL CONDUCT OF PHYSICIANS AND SURGEONS* (1803). See generally DONALD E. KONOLD, *A HISTORY OF AMERICAN MEDICAL ETHICS 1847-1912* (1962).

² See John H. McArthur & Francis D. Moore, *The Two Cultures and the Health Care Revolution*, 277 *JAMA* 985, 985 (1997) (arguing that while traditions of commercialism and professionalism both share a central role in the evolution of social institutions in the United States, "threats" exist to the "quality and scope of medical care" when "the tradition of medical professionalism is overtaken by the commercial ethic and by corporations seeking profit for investors from clinical care of the sick."); JEROME P. KASSIRER, *ON THE TAKE: HOW MEDICINE'S COMPLICITY WITH BIG BUSINESS CAN ENDANGER YOUR HEALTH* (2005) (describing the wide-spread and pernicious impact of money on the practice of medicine); MAGGIE MAHAR, *MONEY-DRIVEN MEDICINE: THE REAL REASON HEALTH CARE COSTS SO MUCH* (2006) (noting that medicine involves a "transaction based on trust" and documenting the tensions between free markets and the delivery of healthcare services); Joseph J. Fins, *Commercialism in the Clinic: Finding Balance in Medical Professionalism*, 16 *CAMBRIDGE Q. HEALTHCARE ETHICS* 425, 425 (2007) ("There is a palpable malaise in American medicine as clinical practice veers off its moorings, swept along by a new commercialism that is displacing medical professionalism and its attendant moral obligations."); William S. Andreck, *Commodified Care*, 16 *CAMBRIDGE Q. HEALTHCARE ETHICS* 398 (2007) (examining the characteristics of healthcare commodification in the context of medical care and exploring its effects on the doctor-patient relationship); Larry R. Churchill, *The Hegemony of Money: Commercialism and Professionalism in American Medicine*, 16 *CAMBRIDGE Q. HEALTHCARE ETHICS* 407 (2007) (exploring the cultural meaning attached to money and its pervasive force throughout

medical research, education, and the delivery of health services); Marc A. Rodwin, *Medical Commerce, Physician Entrepreneurialism, and Conflicts of Interest*, 16 CAMBRIDGE Q. HEALTHCARE ETHICS 387 (2007) (tracing the historical development of medical commerce in the United States from the late 18th century through the early 21st century, and arguing that the primary problem of commercialism in medicine today is the conflict of interest that arises when loyalty to patients and the exercise of independent professional judgment is compromised by physician entrepreneurship); Jacob Needleman, *A Philosopher's Reflection on Commercialism in Medicine*, 16 CAMBRIDGE Q. HEALTHCARE ETHICS 433, 437 (2007) (advocating for reflection among physicians as to "how . . . the money factor . . . impact[s] the human values often assumed to define the art of medicine, understood as the work of always and in everything giving first priority to the health and well-being of the individual patient[.]"); Arnold S. Relman, *The Problem of Commercialism in Medicine*, 16 CAMBRIDGE Q. HEALTHCARE ETHICS 375, 376 (2007) ("We have a dysfunctional healthcare system, dominated by investor-owned businesses and by market competition that has created a new commercialized environment. It is a system incompatible with the needs of community and personal medical care and with the values of medical professionalism that have traditionally shaped the behavior of our physicians. But we also have a new generation of physicians too ready to accept the replacement of professional values by market dogma—too willing to believe that medical care is just another economic commodity, of which they are simply "providers." All in all, this bodes ill for the future of U.S. healthcare, which is becoming intolerably expensive, inequitable, and insensitive to the needs of our society."); Bernard Lown, *The Commodification of Health Care*, PNHP 2007 NEWSLETTER (Physicians for a Nat'l Health Program, Chicago, IL), at 40 ("Health care in America . . . has been transformed into a for-profit enterprise in which physicians are 'health care providers,' patients are consumers, and both subserve corporate interests. The effect has been to convert medicine into a business, deprofessionalize doctors and far worse, depersonalize patients."); Arnold S. Relman, *Medical Professionalism in a Commercialized Health Care Market*, 298 JAMA 2668 (2007); CARL ELLIOTT, *WHITE COAT BLACK HAT: ADVENTURES ON THE DARK SIDE OF MEDICINE xi* (2010) ("A series of social and legislative changes have transformed medicine into a business, yet because of medicine's history as a self-regulating profession, no one is really policing it.").

³ With federal and state government spending included, total health-related expenditures are currently in the neighborhood of \$2.5 trillion per year, accounting for greater than one-sixth of the U.S. economy. Timothy Stoltzfus Jost, *Global Health Care Financing Law: A Useful Concept?* 96 GEO. L.J. 413, 414 (2008) ("The United States spent almost one sixth of its Gross Domestic Product (GDP) on health care in 2003; this was more than it spent on food, transportation, housing, or any other expenditure." citing U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES, 2007, at 435 tbl.656 (126th ed. 2006)).

⁴ The diminished influence of professional societies and the decline in their systemic self-regulation can also be traced to the U.S. Supreme Court's decision in *Goldfarb v. Virginia State Bar* and the ensuing series of antitrust lawsuits and Federal Trade Commission decisions. See Rodwin, *supra* note 2, at 392-93 (citing *In re Am. Med. Ass'n*, 94 F.T.C. 701, 801 (1979); *In re Mich. Optometric Ass'n*, 94 F.T.C. 342 (1985); *In re Am. Acad. of Ophthalmologists*, 108 F.T.C. 25 (1986); *Wilk v. Am. Med. Ass'n*, 895 F.2d 352 (7th Cir. 1990)).

⁵ Mattia Gilmartin and Edward Freeman acknowledge that many think "health care is not a business, never has been a business, and should not be operated as a business." Citing healthcare's significant percentage of gross domestic product and the "corporatization of the American health care sector" that dominated the latter half of the twentieth century, Gilmartin and Freeman dismiss the notion and make the assertion that this Article assumes: "health care is solidly a business endeavor." Mattia J. Gilmartin & R. Edward Freeman, *Business Ethics and Health Care: A Stakeholder Perspective*, 27 HEALTH CARE MGMT. REV. 52, 53-54 (2002) (citing generally ROSEMARY STEVENS, *IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY*, 1989). See also Mary Rorty, Patricia Werhane, & Ann Mills, *The Third Face of Medicine: Ethics, Business and Challenges to Professionalism*, in *ETHICS AND THE BUSINESS OF BIOMEDICINE* 215 (Denis G. Arnold ed., 2009) ("But the consensus at the beginning of this century is that indeed, if not merely a business, medicine is also a business."); LEONARD J. WEBER, *BUSINESS ETHICS IN HEALTHCARE: BEYOND COMPLIANCE* 5 (2001) ("Healthcare is a business but it is not just like every other business."); Sara L. Beckman & Michael L. Katz, *The Business of Health Care Concerns Us All: An Introduction*, 43 CAL. MNGM'T REV. 9, 11 (2000) ("Where there is a strong backlash or not against reliance on market forces in health care, the business of health care is going to remain a business, and a complicated one."); KENMAN L. WONG, *MEDICINE AND THE MARKETPLACE: THE MORAL DIMENSIONS OF MANAGED CARE* 66 (1998) ("Medicine has always been about someone's financial gain. . . . To some degree, medicine has always been a commodity."). Moreover, to paraphrase the U.S. Supreme Court's discussion of professionalism and the practice of law, it simply cannot be denied that in the modern world, the activities of physicians play an important part in commercial intercourse, notwithstanding the profession's historic claim that profit is not the goal. *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787 (1975).

⁶ For a brief history of how entrepreneurial, market influences have contributed to the evolution of healthcare delivery in the United States, see Joshua E. Perry, *An Obituary for Physician-Owned Specialty Hospitals*, HEALTH LAW., DEC. 2010, at 24, 24-25. As early as 1912, "ruinous competition" and the practice of medicine as "competitive business for profit" were widespread concerns. James P. Warbasse, *What is the Matter with Medical Profession?* 6 LONG ISLAND J. MED. 271-275 (1912) cited in Donald W. Light, *Ironies of Success: A New History of the American Health Care "System,"* 45 J. HEALTH & SOC. BEHAVIOR 1, 1 (2004). An American Medical Association survey of 6000 physician, conducted in the early 20th century,

revealed that entrepreneurial, market-oriented approaches to medical practice in the form of kickbacks and commissions were not uncommon. MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTERESTS* 24-26 (1993). At the outset of the 21st century, a motley mix of free market forces, government bureaucracies, and legal rules and regulations drive most policies and procedures in the broad and complex healthcare sector of the nation's economy. Of course, this triumvirate dominates most commercial sectors of U.S. business activity, from trading floors in New York to automobile production in Michigan to industrial agriculture in California, yet healthcare's deep connection with ethical traditions and concern over the best interests of the patient set it apart from most other industries. *See generally* Arrow, *infra* note 9, at 948-954.

⁷ For an additional example of entrepreneurial advances in healthcare delivery that raises similar concerns about misaligned interests between taking profits and treating patients in the specific context of end-of-life care, see generally Joshua E. Perry & Robert C. Stone, *In the Business of Dying: Questioning the Commercialization of Hospice*, 39 J. LAW, MED. & ETHICS 224 (2011).

⁸ Pub. L. No. 111-148, 124 Stat. 119 §§ 6001, 10601 (Mar. 23, 2010). The ACA was amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 § 1106 (Mar. 30, 2010) (to be codified at 42 U.S.C. § 1395nn).

⁹ *See generally* Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

¹⁰ *See* Lois Shepherd & Mark A. Hall, *Patient-Centered Health Law and Ethics*, 45 WAKE FOREST L. REV. 1429, 1447 (2010) ("The high stakes involved in medical care cause a shared vulnerability."); Sandra H. Johnson, *Test-Driving "Patient-Centered Health Law"*, 45 WAKE FOREST L. REV. 1475, 1487 (2010) ("A model of mutuality would see both patient and doctor as vulnerable and emotional, and as knowledgeable and skilled. . . . [D]octors are quite vulnerable to emotions such as fear, anger, and sadness in working with patients and in confronting illness. . . . [P]atients may, in fact, have superior knowledge.").

¹¹ The attorney-client relationship offers a notable analogue. Arrow notes the existence of "strong institutional similarities between the legal and medical-care markets," but beyond the particular relationship that might exist between certain types of attorneys and clients (i.e., criminal defendants, parties to divorce and child custody proceedings), the healthcare transaction between doctor and patient is unique in terms of demand frequency, product uncertainty, supply conditions, and pricing. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 948-954 (1963). *See also* Joshua E. Perry, *The Ethical Costs of Commercializing the Professions: First-Person Narratives From the Legal and Medical Trenches*, 13 U. PA. J. L. & SOC. CHANGE 169, 197-201 (2010) (presenting empirical qualitative evidence arguing that attorneys and physicians – both of whom have constitutive commitments to put the interests of others ahead of their own – share similar moral distress around issues related to commercialization of their professions).

¹² The discussion in this article is limited to the "transaction" between a patient-consumer and the physician-provider. A comprehensive application of this article's thesis to the sweeping landscape that constitutes the broader, systemic business of healthcare is beyond the scope of this article. However, 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 offers a variety of future explorations of the framework this article suggests is critical. *See generally* Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963, 963-965 (1980). 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 1970s in the wake of Medicare/Medicaid passage in 1965. *See* E. RICHARD BROWN, *ROCKEFELLER MEDICINE MEN: MEDICINE AND CAPITALISM IN AMERICA* 203 (1979) (It was, however, the mid-1960s creation of Medicare and Medicaid that would feed "the market competition between hospitals and the avariciousness of hospital administrators, construction companies, banks, the medical supply industry, and others who could get their hands into the public till."). 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 health-care services to patients for a profit." Writing in 1980, he was not concerned about the former. *Id.* at 963. Twenty-seven years later, he remains very concerned about his view of "the future of U.S. healthcare, which [he argues] is becoming intolerably expensive, inequitable, and insensitive to the needs of our society." *See* Relman, *The Problem of Commercialism in Medicine*, *supra* note 2, at 376.

¹³ *See* Arrow, *supra* note 9, at 948-58; Marc J. Roberts & Michael R. Reich, *Ethical Analysis in Public Health*, 359 THE LANCET 1055, 1057 (2002) (" . . . [H]ealth is generally viewed as special or different from most other things produced by the economy."). *See generally* NORMAN DANIELS, *JUST HEALTH CARE* (1985) (arguing that healthcare is "special" because of its impact on individual access to opportunity in a free society) and Norman Daniels, *Justice, Health, and Healthcare*, 1 AM. J. BIOETHICS 2, 3 (2001) (building upon Rawls's theory of justice as fair equality of opportunity, Daniels states that "by keeping people close to normal functioning, healthcare preserves for people the ability to participate in the political, social, and economic life of their society. It sustains them as fully participating citizens—normal collaborators and competitors—in all spheres of social life.").

¹⁴ See generally Perry, *supra* note 11 (discussing the service component and relational aspects at the heart of historic notions of professionalism); Troyen A. Brennan, *An Ethical Perspective on Health Care Insurance Reform*, 19 AM. J.L. & MED. 37, 48 (1993) (“Indeed, traditional medical ethics insisted that physicians do everything possible for the individual patient, independent of political or economic constraints.”).

¹⁵ See Johnson, *supra* note 10, at 1475 (“The health-law reform movement of the 1970s asserted the primacy of the individual patient’s moral agency, autonomy, and choice. . . . This reform movement was patient centered in that it elevated the power and status of the individual patient in the physician-patient relationship and revealed that the relevant norms in decision making about medical treatment were not owned by medicine alone, but rather were social and individual moral questions.”).

¹⁶ See Arrow, *supra* note 9, at 949 (“medical care belongs to the category of commodities for which the product and the activity of production are identical . . . [and, therefore] the customer cannot test the product before consuming it, . . . [creating] an element of trust in the relation.”).

¹⁷ See generally Heather Elms, Shawn Berman, & Andrew C. Wicks, *Ethics and Incentives: An Evaluation and Development of Stakeholder Theory in the Health Care Industry*, 12 BUSINESS ETHICS Q. 413, 425 (describing the case of *Ching v. Gaines* and concluding that economic incentives can encourage physicians to behave in ways inconsistent with the ethical norms of the profession).

¹⁸ See *infra* note 35 and accompanying text. This notion that “being a patient” is a unique ontological position is a key component to this Article’s claim that ethical considerations driven by concerns over the patient’s best interest should inform healthcare law and policy reforms in the absence of industry self-regulation and overt exploitation of statutory loopholes.

¹⁹ Kenneth Arrow, *Reflections on the Reflections*, in UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE (Peter J. Hammer et al., eds., 2003) (“I am not denying that moral authority may be based on illusions, and that those illusions will be carefully fostered. But I want to emphasize that social norms [e.g., expectations that a physician does not make treatment decisions premised on pecuniary self-interest] are based on . . . perceived mutual gains, and that one must be wary of assuming that these perceptions are not based as much on reality as on other perceptions.”).

²⁰ Brennan, *supra* note 14, at 38. (1993). See generally Wendy K. Mariner, *Business vs. Medical Ethics: Conflicting Standards for Managed Care*, 23 J.L. MED. & ETHICS 236, 238 (1995).

²¹ Brennan, *supra* note 14, at 48. Aiming his argument more specifically at the problems associated with access to healthcare by the uninsured, Professor Brennan explicitly argued that “an ethics of health policy should share some common themes with traditional medical ethics.” *Id.* Brennan notes the difficulty of merging a traditional medical ethics that requires physicians to “do everything possible for the individual patient” with an ethics of health care policy that has as “its central paradigm the limits on medical care resources.” *Id.* at 48-49. See also Larry R. Churchill, *What Ethics Can Contribute to Health Policy*, in ETHICAL DIMENSIONS OF HEALTH POLICY 51, 61 (Marion Danis, Carolyn Clancy, & Larry R. Churchill eds., 2002). However, Professor Churchill notes that in the current U.S. context of market-driven medicine, “health policy has no purpose beyond the separate purposes of the individual actors, and the only appropriate role of specific health policies, rules, and regulations is to make the bargaining process among providers and consumers at all levels devoid of fraud and abuse.” *Id.* Churchill’s broader normative view is that health policy should be driven by the dual ends of two ethical concerns, security and solidarity, developed in his 1994 book, *Self-Interest and Universal Health Care: Why Well-Insured Americans Should Support Coverage for Everyone*.

²² Brennan, *supra* note 14, at 50. As articulated in the seminal work on biomedical ethics, “the principle of nonmaleficence asserts an obligation not to inflict harm on others.” TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 113 (5th ed. 2001). Beneficence refers to those actions of kindness, mercy, and charity that are performed for the benefit of others. BEAUCHAMP & CHILDRESS at 166.

²³ Brennan, *supra* note 14, at 50.

²⁴ *Id.* (citing JOHN RAWLS, A THEORY OF JUSTICE 118-150 (1971)). Another formulation of Rawls in this context is offered by Kenman L. Wong, who appropriate Rawls via Edward Freeman to suggest that a fairness-oriented stakeholder approach would guide physicians to make decisions for patients irrespective of the financial consequences at stake. KENMAN L. WONG, MEDICINE AND THE MARKETPLACE: THE MORAL DIMENSIONS OF MANAGED CARE 131 (1998) (citing R. Edward Freeman, *A Stakeholder Theory of the Modern Corporation*, in TOM L. BEAUCHAMP AND NORMAN E. BOWIE, EDs., ETHICAL THEORY AND BUSINESS, 5th ed. 72 (1997)).

²⁵ Brennan, *supra* note 14, at 50.

²⁶ *Id.* at 51. Brennan highlights the hallmarks of trust, selflessness, and virtue that distinguish the physician-patient relationship from most other marketplace encounters, but argues that ethical health policy must consider “the good” of this isolated relationship “in light of the good of all patients.” *Id.*

²⁷ *Id.* Again, Brennan is writing with a particular focus on the systematic inequities of access that result in either inadequate care or no care at all for significant numbers of Americans. A “sphere of medical care” that fails to reflect the “commitment, altruism, and selflessness of medical ethics,” he writes, is “highly offensive to the altruism of healing.” *Id.* at 51-52.

²⁸ *Id.* at 51-53. Here Brennan is challenging mere “non-interference” among physician practice groups and suggesting that physicians will have to coordinate cooperative efforts to provide patient care in a system that will only face increasing economic constraints. *Id.* at 52.

²⁹ Brennan, *supra* note 14, at 53-54. Brennan also addresses the objections of those concerned that “the morality of the clinical relationship cannot be exported to the institutional level.” He responds by asserting that his integration of medical ethics with liberal notions of justice is necessary for preservation of the physician-patient relationship and the unique identity of health care institutions. *Id.*

³⁰ See generally REGINA E. HERZLINGER, MARKET-DRIVEN HEALTH CARE: WHO WINS, WHO LOSES IN THE TRANSFORMATION OF AMERICA’S LARGEST SERVICE INDUSTRY 157-199 (1997); REGINA E. HERZLINGER, WHO KILLED HEALTH CARE? AMERICA’S \$2 TRILLION MEDICAL PROBLEM – AND THE CONSUMER-DRIVEN CURE 59-90 (2007). See also Lawrence P. Casalino, Kelly J. Devers, & Linda R. Brewster, *Focused Factories? Physician-Owned Specialty Facilities*, HEALTH AFF., Nov./Dec. 2003, at 56. Clark C. Havighurst has also been a vocal proponent of market-based approaches to reform. See generally *The Changing Locus of Decision Making in the Health Care Sector*, 11 J. HEALTH POL., POL’Y & L. 697 (1986) and *The Professional Paradigm of Medical Care: Obstacle to Decentralization*, 30 JURIMETRICS 415 (1990).

³¹ 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). For their proponents, 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.

³² *Id.* at 2377. Even Maggie Mahar, a critic of Herzlinger and so-called “market-driven healthcare,” notes that it is “indisputable” that the reimbursement system is flawed. MAGGIE MAHAR, MONEY-DRIVEN MEDICINE: THE REAL REASON HEALTH CARE COSTS SO MUCH 40 (2006). Indeed, the Medicare Payment Advisory Commission issued a report to Congress in March 2005 recommending that DRG payment and reimbursement codes be adjusted for heart and orthopedic procedures. MEDICARE PAYMENT ADVISORY COMMISSION [MEDPAC], REPORT TO THE CONGRESS, PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED 40 (Mar. 2005).

³³ See Herzlinger *supra* note 31, at 2378; REGINA E. HERZLINGER, MARKET-DRIVEN HEALTH CARE: WHO WINS, WHO LOSES IN THE TRANSFORMATION OF AMERICA’S LARGEST SERVICE INDUSTRY 167 (1997).

³⁴ Gilmartin and Freeman, who are otherwise quite persuasive in their defense of the potential value of entrepreneurial influences in healthcare delivery, endorse Herzlinger’s “focused factory” argument without recognizing the tension created for adherence with their first principle: stakeholder cooperation. They state, and I agree, that “[c]apitalism works because entrepreneurs and managers put together and sustain relationships among customers, suppliers, employers, financiers, and communities.” Gilmartin & Freeman, *supra* note 5, at 59-61. Yet, the “stakeholder cooperation” exemplified by their discussion of public health initiatives in Ann Arbor does not hold together in the case of physician-owned specialty hospitals, which have proliferated in the last decade with seemingly little concern for the best interests of the community or cooperation with their fellow healthcare providers. See *infra* notes 38-72 and accompanying text.

³⁵ Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 650-651 (2008) (citing Raymond Tillis, *Commentary: Leave Well Alone*, 318 BRIT. MED. J. 1756, 1757 (1999) (“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.”)).

³⁶ Brennan, *supra* note 14, at 54.

³⁷ OFFICE OF INSPECTOR GENERAL, U.S. DEP’T OF HEALTH & HUMAN SERVICES, PUB. NO. OEI-02-06-00310, PHYSICIAN-OWNED SPECIALTY HOSPITALS’ ABILITY TO MANAGE MEDICAL EMERGENCIES i (2008). According to the GAO’s 2003 report, 70% of specialty hospitals are owned to some degree by physicians, with an average ownership interest in excess of fifty-percent, although on average individual physicians own less than 2 percent of the business. See U.S. GEN. ACCT. OFFICE, GAO-03-683R, SPECIALTY HOSPITALS: INFORMATION ON NATIONAL MARKET SHARE, PHYSICIAN OWNERSHIP, AND PATIENTS SERVED 1 (Apr. 2003)). The vast majority of physician-owned specialty hospitals share similar characteristics. Nationwide, eighty-three percent of these facilities can be found in states without “certificate of need” regulations, with the greatest concentration in seven states: Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota, and Texas. See FED. TRADE COMM’N & U.S. DEP’T OF JUST., IMPROVING HEALTH CARE: A DOSE OF COMPETITION 18 n.82 (2004). Certificate of need (CON) laws arose in the 1960s in response to concerns regarding oversupply of medical services. The state-based laws basically required those entities wishing to build new medical facilities or existing hospitals wishing to increase their number of beds to demonstrate that there was an unmet medical need within the geographic region to be served. Although Ronald Reagan’s election in 1980 “ushered in a decade of emphasis on market solutions to health care,” which resulted in the repeal of many CON statutes, thirty-eight states still retain some measure of CON oversight. Sujit Choudhry, Niteesh K. Choudhry, & Troyen A. Brennan, *Specialty Versus Community Hospitals: What Role For the Law?* HEALTH AFF. (WEB EXCLUSIVE), Aug. 9, 2005, at W5-361, W5-366. See generally David N. Heard, Jr., *The Specialty Hospital Debate: The Difficulty of Promoting Fair Competition Without Stifling Efficiency*, 6 HOUS. J. HEALTH L. & POL’Y 215, 234-239 (2005); Lawrence P. Casalino, Kelly J. Devers, & Linda R. Brewster, *Focused Factories? Physician-Owned Specialty Facilities*, HEALTH AFF., Nov-Dec. 2003, at 56, 57; Laretta Higgins Wolfson, *State Regulations of Health Facility Planning: The Economic Theory and Political Realities of Certificates of Need*, 4 DEPAUL J. HEALTH CARE L. 261, 262

(2001). According to the Government Accounting Office (GAO), greater than 90 percent of the specialty hospitals that have opened in the United States since 1990 are for-profit operations. See U.S. GEN. ACCT. OFFICE, GAO-04-167, SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, SERVICES PROVIDED, AND FINANCIAL PERFORMANCE 1-41 (Oct. 2003)). By comparison, 20 percent of general hospitals are for-profit. See John K. Iglehart, *The Emergence of Physician-Owned Specialty Hospitals*, 352 NEW ENG. MED. J. 78, 79 (2005). The particular specialty hospital genre with which this article is particularly concerned is marked by a focus on short-term, acute infirmities and a for-profit status, characterized by joint ownership among the physicians who practice in the facility. But see Louis Shapiro, *The Specialty Myth: A Venerable Niche Hospital Is Model of Quality Care*, MODERN HEALTHCARE, Aug. 25, 2008, at 54 (discussing New York's Hospital for Specialty Surgery, a non-profit, academic musculoskeletal hospital founded in 1863, that provides orthopedic and rheumatologic services, research, and charity care, and proves the point that "there really is no specialty hospital 'industry,' and that among the models of niche facilities are many that contribute greatly to innovation in healthcare delivery and ensure the highest levels of quality and outcomes.").

³⁸ Out of the 25 specialty hospitals surveyed by the Government Accountability Office, 21 were found to have a less acute mix of patients than full-service hospitals. See U.S. GEN. ACCT. OFFICE, GAO-03-683R, SPECIALTY HOSPITALS: INFORMATION ON NATIONAL MARKET SHARE, PHYSICIAN OWNERSHIP, AND PATIENTS SERVED (Apr. 2003)) ("For example, 3 percent of the patients in the 10 most common diagnosis categories at one Texas orthopedic hospital were classified as severely ill. A higher proportion—8 percent—of the patients in the same diagnosis categories were classified as severely ill at the 51 general hospitals in the same urban area. A cardiac hospital in Arizona provides a similar example. About 17 percent of the patients in that hospital's most common diagnosis categories were classified as severely ill. In contrast, 22 percent of the patients in the same diagnosis categories who were treated at the 26 general hospitals in the same urban area were classified as severely ill."); see also Allen Dobson & Randall Haught, *The Rise of the Entrepreneurial Physician*, HEALTH AFF. (WEB EXCLUSIVE), Oct. 25, 2005, at W5-494, W5-495 (acknowledging that it is well-documented that "patients at specialty hospitals are less severely ill than patients at comparable nonspecialty community hospitals," but suggesting that "[p]hysician referral patterns are complex, and plausible market reasons exist as to why specialty hospitals do not treat the sickest patients.").

³⁹ MEDICARE PAYMENT ADVISORY COMMISSION [MEDPAC], REPORT TO THE CONGRESS, PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED 8-10 (Aug. 2006). The MedPAC study found that at orthopedic/surgical specialty hospitals, "adjusted inpatient costs per discharge were 117% of the national average." *Id.* at 9. 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. *Id.* at 20. "Whether the increase in surgeries stems from increased capacity, from the financial incentives for physicians to self-refer patients to facilities they own, or a combination of these factors, increases surgeries can lead to increased Medicare spending." *Id.* at 21. These findings of greater costs to the Medicare system were bolstered by a follow-up academic study that compared 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 non-owners treating similar cases during the same time frame. See Jean M. Mitchell, *Do Financial Incentives Linked to Ownership of Specialty Hospitals Affect Physicians' Practice Patterns?* 46 MED. CARE 732 (2008); see also John M. Hollingsworth, et al. *Physician-Ownership of Ambulatory Surgery Centers Linked to Higher Volume of Surgeries*, HEALTH AFF., Apr. 2010, at 683 (analyzing five common surgical and diagnostic procedures and finding "a significant association between physician-ownership and higher surgical volume); Bruce Siegel, Holly Mead, & Robert Burke, *Symposium: Private Gain and Public Pain: Financing American Health Care*, 36 J.L. MED. & ETHICS 644, 649 ("Not surprisingly, the approximately 130 physician-owned specialty hospitals have been associated with much higher rates of costly elective surgery, such as spinal fusion, and with performing surgeries on relatively healthier patients."). The research 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." During the same time period in the same market, dramatic increases in utilization were not seen in the practices of non-owner physicians. While recognizing the possible limitations of her study, given the fact that it relied only on data from one area of the country, the study's author 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." See Mitchell at 736-37; accord Brahmajee K. Nallamothu, et al. *Opening of Specialty Cardiac Hospitals and Use of Coronary Revascularization in Medicare Beneficiaries*, 297 JAMA 962, 962-968 (2007) (providing data showing a correlation between the opening of a specialty cardiac facility and significant increases in the market utilization rates of coronary revascularization services); Atul Gawande, *The Cost Conundrum*, THE NEW YORKER, June 1, 2009 (investigating the extreme differences between Medicare reimbursement rates in two Texas markets – Medicare spent twice the national average per enrollee in 2006 – and concluding that the higher rates were directly attributable to patterns of overutilization driven by a "culture of money" where over time the "medical community came to treat patients the way subprime-mortgage lenders treated home buyers: as profit centers").

⁴⁰ Ron Winslow, *Coronary Bypass: Fed-Up Cardiologists Invest in Own Hospital Just for Heart Disease: They'll Regain Autonomy, But Critics See a Grab For Most- Profitable Care—A Showdown in Albuquerque*, WALL ST. J., June 22, 1999, at A1. Clearly, physician-owned specialty hospitals reflect rational and opportunistic business savvy on the part of those cardiac

and orthopedic surgeons who have led the charge in their proliferation. These medical centers represent an entrepreneurial, market-based innovation in the delivery of specialized health care that offers a number of benefits to providers and individual patients. Yet, the services that physicians perform in relationship with potentially vulnerable individual patients, as well as the broader potential patient population, create unique variables in the marketplace that require ethical considerations. In the domain of healthcare delivery, public policies must look beyond customer satisfaction surveys and economic self-interests.

⁴¹ *Id.*

⁴² *Id.* In May 2011, MedCath Inc., citing financial losses dating back to 2009, announced a plan to dissolve and distribute all remaining assets to shareholders. Ely Portillo, *Charlotte-based hospital chain plans to dissolve*, THE CHARLOTTE OBSERVER (May 11, 2011).

⁴³ See Winslow, *supra* note 40 at A1.

⁴⁴ *Id.* (“‘The money in medicine is in cardiac surgery,’ says James Hinton, chief executive of Presbyterian Health Services, the hospital’s parent. ‘Cardiology is unquestionably profitable. That’s what they’re going after.’”). *Id.* In fact, not only are cardiac surgeries and treatments individually lucrative for physicians, but they are the life blood of many full-service hospitals, “account[ing] for more than 20% of a hospital’s revenue and sometimes 50% of profits, supporting hospitals’ less-lucrative endeavors.” *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.* Additionally, physicians lamented a lack of nursing support and other staffing issues over which they felt powerless, especially in the context of increasingly “sprawling health ‘systems.’” *Id.*

⁴⁸ Brennan, *supra* note 14, at 52. Although a complete discussion is beyond the scope of this article, the practice of “economic credentialing,” which was the retaliatory move made by some community hospitals to revoke admitting privileges in response to those entrepreneurial physicians who struck-out and started competing hospital, would certainly be an additional detour on the path towards the type of community orientation being described. See generally Robert Steinbuch, *Placing Profits Above Hippocrates: The Hypocrisy of General Service Hospitals*, 31 U. ARK. LITTLE ROCK L. REV. 505, 506-507 (2009).

⁴⁹ Kelly J. Devers, Linda R. Brewster, & Paul B. Ginsburg, *Specialty Hospitals: Focused Factories or Cream Skimmers?* ISSUE BRIEF (Ctr. for Studying Health Sys. Change, Washington, D.C.), Apr. 2003, at 2 (“The spate of specialty hospital construction is unnerving general hospitals, which worry that the new facilities will draw away profitable patients and undermine their ability to achieve the volume needed to provide high-quality, low-cost specialty services and to cross-subsidize other basic services. . . . [C]ardiology services can account for 25 percent of all hospital stays and 35 percent or more of community hospitals’ revenue.” (citing ANNE ELIXHAUSER, ET AL., PROCEDURES IN U.S. HOSPITALS, 1997 (2001) and Michelle Rogers, *The MedCath Threat*, HEALTHLEADERS, Apr. 25, 2002.)).

⁵⁰ See generally FED. TRADE COMM’N & U.S. DEP’T OF JUST., IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004). The joint report cited to several testifying experts who articulated concerns that specialty hospitals would “siphon off the most profitable procedures and patients, leaving general hospitals with less money to cross subsidize other socially valuable, but less profitable, care.” *Id.* at 21. As one expert noted, “it is the profitable services they are taking away that jeopardizes a hospital’s capability of providing unprofitable services.” *Id.*

⁵¹ Hilary Hylton, *The Hospital Wars*, TIME, Dec. 5, 2006.

⁵² *Id.*

⁵³ John K. Iglehart, *The Emergence of Physician-Owned Specialty Hospitals*, 352 NEW ENG. MED. J. 78, 81 (2005).

⁵⁴ *Id.* at 81.

⁵⁵ *Id.*

⁵⁶ Hilary Hylton, *The Hospital Wars*, TIME, Dec. 5, 2006.

⁵⁷ U.S. GEN. ACCT. OFFICE, GAO-03-683R, SPECIALTY HOSPITALS: INFORMATION ON NATIONAL MARKET SHARE, PHYSICIAN OWNERSHIP, AND PATIENTS SERVED 23 (Apr. 2003)).

⁵⁸ *Id.* at 33.

⁵⁹ *Id.* at 23. Despite the loss of profitable Medicare patients, community hospitals surveyed by the MedPAC investigators managed to avoid large declines in total profit margins through a variety of efforts, including cutting staff and expansion into other profitable areas, such as imaging, rehabilitation, pain management, and neurosurgery. *Id.*

⁶⁰ *Id.* at 23.

⁶¹ Although the report rejected a conclusion that specialty hospitals were necessarily guilty of unfairly “cherry-picking” their patients. MICHAEL O. LEAVITT, STUDY OF PHYSICIAN-OWNED SPECIALTY HOSPITALS REQUIRED IN SECTION 507(C)(2) OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003 61 (2005).

⁶² Jean M. Mitchell, *Effects of Physician-Owned Limited Service Hospitals: Evidence from Arizona*, HEALTH AFF. (WEB EXCLUSIVE), Oct. 25, 2005, at W5-481, W5-482.

⁶³ *Id.* at W5-484.

⁶⁴ *Id.* at W5-485, W5-486.

⁶⁵ MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS, PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED (Aug. 2006). MedPAC was following-up on their 2005 report, which had been mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. While the 2005 report had analyzed data from 2002, the follow-up report examined an expanded set of physician-owned specialty hospitals from 2003 and 2004. During that time period, the number of physician-owned hospitals had almost doubled. *Id.* at 3. The 2006 report focused on 25 cardiac and 16 orthopedic/surgical hospitals.

⁶⁶ *Id.* at 7.

⁶⁷ *Id.* at 8-10. The MedPAC study found that at orthopedic/surgical specialty hospitals, “adjusted inpatient costs per discharge were 117% of the national average.” *Id.* at 9.

⁶⁸ *Id.* at 20. “Whether the increase in surgeries stems from increased capacity, from the financial incentives for physicians to self-refer patients to facilities they own, or a combination of these factors, increases surgeries can lead to increased Medicare spending.” *Id.* at 21.

⁶⁹ Jean M. Mitchell, *Do Financial Incentives Linked to Ownership of Specialty Hospitals Affect Physicians’ Practice Patterns?* 46 MED. CARE 732 (2008); see also John M. Hollingsworth, et al. *Physician-Ownership of Ambulatory Surgery Centers Linked to Higher Volume of Surgeries*, HEALTH AFF., Apr. 2010, at 683 (analyzing five common surgical and diagnostic procedures and finding “a significant association between physician-ownership and higher surgical volume); Bruce Siegel, Holly Mead & Robert Burke, *Symposium: Private Gain and Public Pain: Financing American Health Care*, 36 J.L. MED. & ETHICS 644, 649 (“Not surprisingly, the approximately 130 physician-owned specialty hospitals have been associated with much higher rates of costly elective surgery, such as spinal fusion, and with performing surgeries on relatively healthier patients.”).

⁷⁰ Mitchell, *supra* note 69, at 736; accord Brahmajee K. Nallamothu, et al., *Opening of Specialty Cardiac Hospitals and Use of Coronary Revascularization in Medicare Beneficiaries*, 297 JAMA 962, 962-968 (2007) (providing data showing a correlation between the opening of a specialty cardiac facility and significant increases in the market utilization rates of coronary revascularization services); Atul Gawande, *The Cost Conundrum*, THE NEW YORKER, June 1, 2009 (investigating the extreme differences between Medicare reimbursement rates in two Texas markets – Medicare spent twice the national average per enrollee in 2006 – and concluding that the higher rates were directly attributable to patterns of overutilization driven by a “culture of money” where over time the “medical community came to treat patients the way subprime-mortgage lenders treated home buyers: as profit centers”).

⁷¹ Mitchell, *supra* note 69, at 736.

⁷² *Id.* at 737.

⁷³ Karen Auge, *Death adds to debate on doc-owned hospitals*, THE DENVER POST, Aug. 9, 2009, at A1; Bennett Roth, *Texas Case Raises Alarm on Specialty Hospitals*, THE HOUSTON CHRONICLE, Feb. 10, 2007, at A1; Nigel Jaquiss, *Doctors, Inc.: The Challenges Facing Oregon’s Only Doctor-Owned Hospital*, WILLAMETTE WEEK (Oct. 19, 2005), <http://week.com/editorial/3150/6856>. However, tragic and unavoidable deaths arising from physician error or hospital accidents are not limited to the environment of the physician-owned specialty facility. Indeed, since the Institute of Medicine’s report on medical errors was published over a decade ago, copious evidence has demonstrated that preventable deaths are not exceptional events in medical facilities, including full-service hospitals with emergency departments on site and trained emergency physicians on the premises around the clock. See generally LINDA T. KOHN, JANET M. CORRIGAN, & MOLLA S. DONALDSON, INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 26 (1999) (arguing that preventable adverse events in medical facilities are a leading cause of death in the United States); Lucian L. Leape & Donald M. Berwick, *Five Years After To Err is Human: What Have We Learned?*, 293 JAMA 2384, 2385 (2005) (noting a proliferation of subsequent studies exploring widespread preventable medical injuries and hospital-acquired infections, and suggesting that the 1999 IOM report may have “substantially underestimated the magnitude of the problem”). Importantly, however, these three preventable deaths did not occur in traditional, full-service hospitals. These deaths took place in settings where the physicians and surgeons—entrusted with the ethical duty and professional mandate to put the patient’s best interest in front of investor-provider profit margins—had a simultaneous economic self-interest in the profits generated by the facility in which they chose to operate on their patients.

⁷⁴ Press Release, Physician Hospitals of America (“PHA”), Physician Owned and Operated Hospitals Get Top Rankings From Consumer Reports, but They Remain on the Healthcare Reform Chopping Block (Aug. 11, 2009) (on file with author). Such a response from patient satisfaction surveys is not surprising when these facilities are heralded for their upscale food, private rooms, and pleasant waiting areas with “muted colors, comfortable seating, soft lighting, and quality artwork.” See Jessica Zigmond, *Betting Big On Doc Ownership*, MODERN HEALTHCARE, Dec. 11, 2006 at 6 (quoting Kamran Nezami, a founder of University Hospital Systems, a private, for-profit company that specializes in the recruitment of physician-investors and the development of physician-owned hospitals describing his flagship facility, University General Hospital in Houston, Texas); MICHAEL O. LEAVITT, STUDY OF PHYSICIAN-OWNED SPECIALTY HOSPITALS REQUIRED IN SECTION 507(C)(2) OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003 51 (2005) (patients in focus groups commented very positively on all the “extras,” e.g., the food, the rooms, the waiting areas, the lower noise level, and the treatment of family members, that they encountered in the physician-owned specialty hospital environment). Thus,

any critique of these facilities must inevitably confront what for some is the final arbiter of the debate, i.e., the patient survey data showing high levels of satisfied “customers.” For proponents of a competitive medical marketplace, the customer is always right, and the satisfaction and positive experiences reported by a majority of patients at these physician-owned specialty hospitals is a significant justification for their continued existence.

⁷⁵ OFFICE OF INSPECTOR GENERAL, U.S. DEP’T OF HEALTH & HUMAN SERVICES, PUB. NO. OEI-02-06-00310, PHYSICIAN-OWNED SPECIALTY HOSPITALS’ ABILITY TO MANAGE MEDICAL EMERGENCIES i – 23 (2008).

⁷⁶ *Id.* at 9. Medicare’s Conditions of Participation (CoP) do not require that hospitals have emergency departments, although many states do mandate “emergency treatment rooms.” *See, e.g.*, TEX. HEALTH & SAFETY CODE § 241.026 (2009).

⁷⁷ *Id.* at 10. Additionally, interviews with administrators of the physician-owned specialty hospitals that were investigated by the OIG revealed that only 28% of these facilities have physicians onsite 24 hours a day, 7 days a week. Notably, the Conditions of Participation do not require hospitals to have physicians physically on the premises at all times. *Id.* at ii.

⁷⁸ *Id.* at 12.

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.* at 3-4, 12 (*citing to* Memorandum from CMS to State Survey Agency Directors, “Provision of Emergency Services – Important Requirements for Hospitals,” S&C-07-19 (Apr. 26, 2007) (“A hospital is not in compliance with the Medicare CoPs if it relies on 9-1-1 services as a substitute for the hospital’s own ability to provide services otherwise required in the CoPs. This means, among other things, that a hospital may not rely on 9-1-1 services to provide appraisal or initial treatment of individuals in lieu of its own capability to do so.”)). Reliance upon 911 to transfer patients is a practice that is permitted by Medicare. *Id.* at 4, 12.

⁸² *Id.* at 14.

⁸³ *Id.* at 3. (*citing to* Memorandum from CMS to State Survey Agency Directors, “Provision of Emergency Services – Important Requirements for Hospitals,” S&C-07-19 (Apr. 26, 2007)). *See also* 42 C.F.R. § 482.55(b)(2) (2010) (“There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.”) and 42 C.F.R. § 482.12(f)(2) (2010) (“If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate.”).

⁸⁴ *See Perry, supra* note 6, 26-27 (detailing the legislative reforms that criminalized physician kickbacks for referring Medicare and Medicaid patients to diagnostic and medical testing facilities). For citations to research demonstrating the correlation between economic incentives and overutilization of medical services, see James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J.L. & MED. 205, 207 (1996), Jean M. Mitchell, *Physician Joint Ventures and Self-Referral: An Empirical Perspective*, in CONFLICTS OF INTEREST IN CLINICAL PRACTICE AND RESEARCH 219-317 (Roy G. Spece, Jr., David S. Shimm, & Allen E. Buchanan, eds., 1996), and RODWIN, *supra* note 6, at 215. Blumstein and Rodwin cite to numerous studies confirming the notion that economic incentives result in overutilization. The data are conclusive on the question of whether or not financial interest influences medical decisions. The answer is a resounding yes.

⁸⁵ OFFICE OF INSPECTOR GEN., OAI-12-88-01410, DEPT. OF HEALTH & HUMAN SERV., FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES 11 (1989).

⁸⁶ Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, Sec. 6204, 103 Stat. 2106, 2236 (1989) (codified at 42 U.S.C. Sec. 1395nn).

⁸⁷ Omnibus Reconciliation Act of 1993, Pub. L. No. 103-66, Sec. 13562, 107 Stat. 312, 596-605 (1993) (codified at 42 U.S.C. Sec 1395nn).

⁸⁸ For additional background on the particular evidence establishing the connections between physician investments in health care clinics and concomitant increases in utilization and service costs that fueled Stark’s legislative efforts, see OFFICE OF INSPECTOR GEN., OAI-12-88-01410, DEPT. OF HEALTH & HUMAN SERV., FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES 11 (1989); Jean M. Mitchell & Elton Scott, *Evidence on Complex Structures of Physician Joint Ventures*, 9 YALE J. ON REG. 489, 497 (1992).

⁸⁹ 42 C.F.R. § 411.356 (c)(3)(iii) (2010). The exception was intended to accommodate rural hospitals where such ownership arrangements were already in place. *See H.R. REP. NO. 111-443*, pt. 1, at 355 (2010).

⁹⁰ U.S. GEN. ACCT. OFFICE, GAO-03-683R, SPECIALTY HOSPITALS: INFORMATION ON NATIONAL MARKET SHARE, PHYSICIAN OWNERSHIP, AND PATIENTS SERVED 2 (Apr. 2003).

⁹¹ 42 U.S.C. Sec. 1395nn(d)(3)(c).

⁹² *See Iglehart, supra* note 37, at 78 (*citing* U.S. GEN. ACCT. OFFICE, GAO-04-167, SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, SERVICES PROVIDED, AND FINANCIAL PERFORMANCE 1-41 (Oct. 2003)).

⁹³ 151 CONG. REC. S4938 (May 11, 2005) (statement of Sen. Grassley). Sen. Charles Grassley was speaking in support of “The Hospital Fair Competition Act,” which he and Sen. Max Baucus were sponsoring. This proposed legislation would, *inter alia*, “[c]lose the ‘whole hospital’ loophole by prohibiting new specialty hospitals from having ownership or investment interest from physicians who refer Medicare or Medicaid patients to the hospital, effective June 8, 2005.” *Id.* Effectively,

this bill would permanently extend the moratorium and cease any growth in the industry, while allowing existing facilities to continue operating. Much of this bill's substance would ultimately be incorporated into "The Patient Protection and Affordability Act of 2010."

⁹⁴ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, § 507, 117 Stat. 2295-97 (2003). The law included an exemption for facilities either already in operation or under development, i.e., complete architectural plans, secure funding, requisite state government approvals.

⁹⁵ Press Release, Centers for Medicare & Medicaid Services, CMS Outlines Next Steps As Moratorium on New Specialty Hospitals Expires (June 9, 2005) (on file with author). Because of an additional extension pursuant to Section 5006(c) the Deficit Reduction Act of 2005, the suspension of Medicare enrollment of new physician-owned specialty hospitals would not be finally lifted until August 8, 2006.

⁹⁶ H.R. 3162, Sec 651, 110th Cong. (1st Sess. 2007) (as passed by House, Aug. 1, 2007).

⁹⁷ See Paul Wellstone Mental Health and Addiction Equity Act, H.R. 1424, Sec 106, 110th Cong. (2d Sess. 2008) (as passed by House, Mar. 5, 2008).

⁹⁸ S. Amdt. 4803 to H.R. 2642, Sec. 6002, 110th Cong. (2d Sess. 2008) (as passed by Senate, May 22, 2008).

⁹⁹ H.R. REP. NO. 111-443, at 4 (2010).

¹⁰⁰ 42 U.S.C.S. § 1395nn (Lexis, through P.L. 111-191), P.L. 111-148, § 6001 (a), 6003 (a), 124 Stat 684, 697, 1005. The "fixes" bill, Health Care and Education Reconciliation Act of 2010, P.L. 111-152, § 1106, 124 Stat. 1049 was passed seven days later on March 30, 2010. The most significant provision of the "fixes" bill relative to the physician-owned hospital industry was the extension from August 1, 2010 until December 31, 2010 for facilities in development to secure Medicare certification.

¹⁰¹ *Early Diagnoses of the New Law*, N.Y. TIMES, Mar. 30, 2010, at D2.

¹⁰² Press Release, *Quality Hospitals Being Destroyed, Thousands of Healthcare Jobs at Risk, Rural and Inner City Patients to Lose Access to Local Care*, Physician Hospitals of America, Mar. 24, 2010 (on file with author); see also Mike Sherry, *Kansas City-area specialty hospitals say health reform bill will stunt their growth*, KANSAS CITY BUS. J., (Mar. 26, 2010), <http://www.bizjournals.com/kansascity/stories/2010/03/29/story2.html> ("That is what they are trying to do – kill the industry.").

¹⁰³ David Hogberg, *ObamaCare Will Effectively Bar New Physician-Owned Hospitals*, INVESTOR'S BUS. DAILY, (Mar. 24, 2010, 7:25PM), <http://www.investors.com/NewsAndAnalysis/Article.aspx?id=528337> (quoting Ellen Pryga, director of policy at the American Hospital Association).

¹⁰⁴ For the approximately 60 physician-owned facilities under construction or in some stage of development as of the ACA's passage, the new law sets a deadline of December 31, 2010, for these facilities to secure status as a Medicare-eligible provider. 42 U.S.C.S. § 1395nn (i)(1)(A) (Lexis 2010). See generally David Hogberg, *ObamaCare Will Effectively Bar New Physician-Owned Hospitals*, INVESTOR'S BUS. DAILY, (Mar. 24, 2010, 7:25PM), <http://www.investors.com/NewsAndAnalysis/Article.aspx?id=528337>. Of course, nothing in the Physician-Owned Hospital Limitation Law would prevent these facilities from being completed and treating non-Medicare patients after December 31, 2010, but without Medicare-provider status, these facilities would be reliant upon self-paying and privately-insured patients.

¹⁰⁵ 42 U.S.C.S. § 1395nn (i)(1)(B) (Lexis 2010). The exception clause sets February 1, 2012 deadline for the Secretary of the Department of Health and Human Services (HHS) to create a process by which either "applicable" or "high Medicaid" physician-owned specialty hospitals may apply, once every two years, for permission to expand their capacity by up to 100%. 42 U.S.C.S. § 1395nn (i)(3) (Lexis 2010).

¹⁰⁶ 42 U.S.C.S. § 1395nn (i)(1)(C) (Lexis 2010).

¹⁰⁷ 42 U.S.C.S. § 1395nn (i)(1)(C) (Lexis 2010).

¹⁰⁸ *Id.*

¹⁰⁹ 42 U.S.C.S. § 1395nn (i)(1)(D)(i-vii) (Lexis 2010).

¹¹⁰ 42 U.S.C.S. § 1395nn (i)(1)(E)(i) (Lexis 2010).

¹¹¹ 42 U.S.C.S. § 1395nn (i)(1)(E)(ii) (Lexis 2010). These safety mandates were first required by the Center for Medicare and Medicaid Services in 2007. See Medicare Program, Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates, 72 FR 47130, 47413 (Aug. 22, 2007)(to be codified at 42 C.F.R. § 489.20(v)).

¹¹² Complaint for Declaratory and Injunctive Relief at 1, *Physicians Hospitals of America v. Sebelius*, No. 6:10-00277-MHS, (E.D. TX. June 3, 2010).

¹¹³ *Id.* at 2.

¹¹⁴ *Id.* at 3. Texas Hospital was rated number one in the state of Texas in 2009 for spine surgery by the Eleventh Annual HealthGrades Hospitals in America Study. *Id.*

¹¹⁵ *Id.* at 3.

¹¹⁶ *Physicians Hospitals of America v. Sebelius*, No. 6:10-cv-277, at 2-3 (E.D. TX. Mar. 31, 2011).

¹¹⁷ *Id.* at 15.

¹¹⁸ *Id.* at 15, 19.

¹¹⁹ *Id.* at 21.

¹²⁰ *Id.* at 21-22 (citing *Vance v. Bradley*, 440 U.S. 93, 111 (1979), *Ferguson v. Skrupa*, 372 U.S. 726, 730 (1963), and *Shelton v. City of College Station*, 780 F.2d 475, 479 (5th Cir. 1986) (en banc)).

¹²¹ *Id.* at 24.

¹²² *Id.* at 24-25.

¹²³ *Id.* at 28.

¹²⁴ *Id.* at 28.

¹²⁵ *Id.* at 28.

¹²⁶ *Id.* at 28-29.

¹²⁷ *Id.* at 29.

¹²⁸ *Id.* at 29.

¹²⁹ *Id.* at 35.

¹³⁰ Press Release, Physician Hospitals of America and Texas Spine and Joint Hospital Appeal Federal Court Decision (May 31, 2011) (on file with author). H.R. 1186 would repeal Section 6001, and H.R. 1159 would repeal Section 6001 and 6002, which requires physicians to report ownership and investment interests. See Andis Robeznieks, *Fight and Flight: Some Physician Investors Getting Out of Hospital Ownership While Others Stay Their Course*, MODERN HEALTHCARE, Apr. 4, 2011, at 28.

¹³¹ See Beauchamp & Childress, *supra* note 22.

¹³² See generally Perry *supra* note 11 (describing empirical data suggesting that issues related to commercialism in medicine are frequent and serious causes of moral distress in the professional lives of physicians).

¹³³ See *supra* Part II(b).

¹³⁴ See *supra* note 74 and accompanying text.

¹³⁵ OFFICE OF INSPECTOR GENERAL, U.S. DEP'T OF HEALTH & HUMAN SERVICES, PUB. NO. OEI-02-06-00310, PHYSICIAN-OWNED SPECIALTY HOSPITALS' ABILITY TO MANAGE MEDICAL EMERGENCIES 5 (2008).

¹³⁶ MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS, PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED 7 (Aug. 2006).

¹³⁷ *Id.* at 8.

¹³⁸ *Id.* at 8.

¹³⁹ See *supra* notes 2, 5-7, 12 and accompanying text.

¹⁴⁰ As Kenman Wong observes, "whenever money changes hands, the prospect of a conflict of interest is insidiously present." See WONG, *supra* note 24 at 68.

¹⁴¹ Glenn G. Lammi, *Hospitals & Physician Ownership: Legal and Health Care Issues Warrant Careful Scrutiny*, LEGAL OPINION LETTER (Washington Legal Found., Washington, D.C.), May 30, 2008.

¹⁴² See *supra* notes 84, 88 and accompanying text. See generally Jean M. Mitchell, *Effect of Physician Ownership of Specialty Hospitals and Ambulatory Surgery Centers on Frequency of Use of Outpatient Orthopedic Surgery*, 145 ARCHIVES SURGERY 732 (2010) (concluding that financial incentives linked to ownership of either specialty hospitals or ambulatory surgery centers influence physicians' practice patterns); Maureen Kwiecinski, Comment, *Limiting Conflicts of Interest Arising From Physician Investment in Specialty Hospitals*, 88 MARQ. L. REV. 413 (2004).

¹⁴³ See generally GEORGE J. ANNAS, THE RIGHTS OF PATIENTS (3d ed. 2004).

¹⁴⁴ Joan H. Krause, *Can Health Law Truly Become Patient Centered?* 45 WAKE FOREST L. R. 1489, 1491-1496 (2010) ("Informed consent law manages to stand, simultaneously, as both the clearest hope for a truly patient-centered legal doctrine and the clearest example of its shortcomings. . . . Despite decades of case law, statutes, and commentary . . . there is scant evidence that the legal rules mandating informed consent actually work."). See generally Harlan M. Krumholz, *Informed Consent To Promote Patient-Centered Care*, 303 JAMA 1190, 1190 (2010); Janet L. Dolgin, *The Legal Development of the Informed Consent Doctrine: Past and Present*, 19 CAMBRIDGE Q. HEALTHCARE ETHICS 97, 102 (2010); JESSICA W. BERG, ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 188 (2d ed. 2001); RUTH R. FADEN & TOM L. BEAUCHAMP WITH NANCY M. P. KING, A HISTORY AND THEORY OF INFORMED CONSENT 53-101 (1986); Jay Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137 (1977).

¹⁴⁵ See *supra* note 35 and accompanying text.

¹⁴⁶ See *supra* note 84 and accompanying text.

¹⁴⁷ Rodwin, *supra* note 6, at 215 (citing eighteen published studies by academic researchers and government regulators between 1970 and 1992 as evidence "that physicians who make referrals to medical facilities that they either own or have a financial interest in recommend more (or more expensive) medical tests and procedures than do physicians without a financial interest.").

¹⁴⁸ Even absent such legislative action, Section 6001 may still result in the physician-owned hospital industry's demise. "Work-arounds" to the ACA Section 6001 reforms are not viewed as viable. Lew Lefko & Cheryl Camin, "Work-Arounds" For Physician-Owned Hospitals: Are They Workable?, HEALTH LAW., Dec. 2010, at 44.

¹⁴⁹ See Churchill, *supra* note 21, at 53.