

The Calumet City Lodge makes a donation each year to the Easter Seals Foundation, the national charity for the Fraternal Order of Police. They make donations to the Good Hope School, a trade school for developmentally disabled children.

As is tradition with many police organizations, the Calumet City FOP takes care of their own. When a police officer is killed in the line of duty, the Lodge provides for the needs of their surviving family. Donations are also made to the state and national Concerns of Police Survivors (COPS) program.

Also on January 13, 1998, the Fraternal Order of Police, Calumet City Lodge No. 1 honored those who have recently retired from the police. Kelly Matthews served the residents of Calumet City for 24 years from 1973 to 1997. Terrence McDermott served the residents of Calumet City for 26 years from 1971 to 1997. We thank these two dedicated public servants for their fearless service to this community.

Finally, on January 13, 1997 the Fraternal Order of Police, Calumet City Lodge No. 1 installed new officers to preside over this organization. We thank the retiring officers for their service and call upon the new directors to preserve the good name of this organization whose motto is "We serve with Pride."

IN HONOR OF THELMA GAMMELL
ON HER 102ND BIRTHDAY

HON. LORETTA SANCHEZ

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 27, 1998

Ms. SANCHEZ. Mr. Speaker, I would like to take this opportunity to honor a wonderful person and a great American, on her 102nd birthday—Thelma Gammell.

Thelma is a joy to know. Perky, humorous, and filled with the spirit of life. She was born in Miller, South Dakota, and on October 9, 1895. Life was very different then. The United States, itself, was just over 100 years old. Her ancestors had migrated from Wales in 1776, during the Revolutionary War.

Life was very difficult and often hard. Thelma, however, grew up in a family that had good values. They worked hard and they lived the best they could with what they had. Her childhood was filled with horseback riding, dolls and "kitten playmates." The winters on the prairie were long and cold, but Thelma enjoyed playing in the snowdrifts with her sister.

In 1912 Thelma met with her husband, John Gammell. They lived in several states including North Dakota, South Dakota, Montana, Wyoming and Nebraska. They had a son and a daughter who were both born in Wyoming.

In 1937 the Gammells moved to Laguna Beach, California, where John worked as a carpenter and Thelma worked as a pottery designer. After retirement, the Gammells traveled, visiting friends in the Midwest. After her husband passed away in 1967, Thelma became active as a volunteer for the Santa Ana Senior Center and has continued her dedicated service for over 12 years.

Surely her secret to a long life must be her warm and outgoing personality and her joy of life. For Thelma Gammell life had been filled with many wonderful memories. All who know Thelma have been charmed by her presence.

Happy birthday and best wishes for a wonderful year.

PROTECTION OF RELIGIOUS
FREEDOM IN THE WORKPLACE

HON. WILLIAM F. GOODLING

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 27, 1998

Mr. GOODLING. Mr. Speaker, I am pleased to introduce H.R. 2948, legislation that restores real protections to the religious convictions of men and women in the workplace. The Workplace Religious Freedom Act (WRFA) would amend Title VII of the 1964 Civil Rights Act to require employers to make reasonable accommodation for an employee's religious observance or practice unless doing so would impose an undue hardship on the employer. Currently, the courts interpret Title VII to require reasonable accommodation of religious practices only where an employer would not "bear more than a de minimis cost."

This bill is a companion to S. 1124, which was introduced by Senators JOHN KERRY (D-MA) and DAN COATS (R-IN), with an ideologically diverse group of cosponsors.

The version of the WRFA that I introduce today is intended to reflect my concern with the instances of employers unreasonably refusing to accommodate the religious needs of workers. This is not a common problem, but it is still a serious one. This bill is intended as a starting point, and I do not necessarily endorse all of its provisions. I wish to ensure that businesses are not unduly burdened, while ensuring that workers' rights are amply protected. I hope my introduction of this bill will foster a dialogue between the business and religious communities that achieves a bill acceptable to all.

The bill is endorsed by a wide range of organizations including: American Jewish Committee, Baptist Joint Committee, Christian Legal Society, United Methodist Church, Presbyterian Church (USA), Southern Baptist Convention, Traditional Values Coalition, Seventh-day Adventists, National Association of Evangelicals, National Council of the Churches of Christ, National Sikh Center, and Union of Orthodox Jewish Congregations. A complete list of the Coalition For Religious Freedom In The Workplace is attached for the record.

I look forward to a healthy debate over this legislation and its ultimate passage in a form which fairly balances the legitimate needs of both employees and employers.

COALITION FOR RELIGIOUS FREEDOM IN THE
WORKPLACE

Agudath Israel of America; American Jewish Committee; American Jewish Congress; Americans for Democratic Action; Anti-Defamation League; Baptist Joint Committee on Public Affairs; Center for Jewish and Christian Values; Central Conference of American Rabbis; Christian Legal Society; Church of Scientology International; Council on Religious Freedom; General Conference of Seventh-day Adventists; Guru Gobind Singh Foundation; Hadassah-WZOA; International Association of Jewish Lawyers and Jurists; and Jewish Council for Public Affairs.

National Association of Evangelicals; National Council of the Churches of Christ in the USA; National Council of Jewish Women;

National Jewish Coalition; National Jewish Coalition; National Jewish Democratic Council; National Sikh Center; North American Council for Muslim Women; People for the American Way; Presbyterian Church (USA), Washington Office; Rabbinical Council of America; Southern Baptist Convention Ethics and Religious Liberty Commission; Traditional Values Coalition; Union of American Hebrew Congregations; Union of Orthodox Jewish Congregations; United Church of Christ Office for Church in Society; United Methodist Church General Board on Church and Society; and United Synagogue of Conservative Judaism.

WHY PHYSICIAN REFERRAL LAWS
ARE IMPORTANT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 27, 1998

Mr. STARK. Mr. Speaker, the January 9th *Federal Register* contains the regulations implementing the 1993 Physician Referral laws, designed to reduce or eliminate the incentives for doctors to over-refer patients to services in which the doctor has a financial relationship.

Study after study after study has shown that when doctors have such a financial relationship, they tend to order more services and more expensive services. The Physician Referral laws try to stop this form of fraud, waste, and abuse.

Members may hear complaints about the law and regulations from some physicians. Following is a portion of an *amicus* brief filed in the case of *Thompson v. Columbia/HCA* December 12, 1996 by three of America's most distinguished and illustrious physicians—Dr. Arnold Relman, Dr. C. Everett Koop, and the late Dr. James S. Todd, former Executive Vice President of the American Medical Association. The *amicus* explains eloquently why this law is needed to help ensure the trust of the American people in their physician community.

I hope Members will keep in mind the important ethical and moral issues described by these three outstanding doctors.

STATEMENT OF INTEREST

Amicus, Arnold S. Relman, M.D., is Professor Emeritus of Medicine and of Social Medicine at the Harvard Medical School, Cambridge, Massachusetts. Dr. Relman is also the Editor in Chief Emeritus of the *New England Journal of Medicine*, the official organ of the Massachusetts Medical Society, which has been published continuously since 1812. For more than fifteen years, Dr. Relman has written extensively on the ethical, social, and practical implications of physician self-referral, compensation, and ownership arrangements of the type described in the present Complaint.

Amicus, C. Everett Koop, M.D., served as the United States Surgeon General under Presidents Reagan and Bush from 1981 to 1989. After the completion of his government service, General Koop has maintained an active role in the national debate on healthcare policies, priorities, and perspectives.

Amicus, James S. Todd, M.D., recently retired as Executive Vice President, American Medical Association.

Doctors Relman, Koop, and Todd have no personal financial interest in this litigation. Their desire to participate as *amici curiae*

arises instead from their deeply felt concern for the implications that physician self-referral and compensation arrangements may have on the delivery of medical services to the American people and the ethical issues arising from those arrangements. *Amici* steadfastly maintain that a physician's economic self interest must remain subordinate to his or her primary, unalloyed obligation as a patient's trusted advisor, agent, and healer to place the patient's interests above all others.

The self-referral and compensation arrangements at issue in this case threaten to erode traditional medical ethics, undermine public trust, and create irreconcilable conflicts of interest at a time when the public at large will be ill-served thereby. They offer a unique perspective on the consequences to physicians, their patients, and the system of healthcare in this country that are threatened by self-referral and compensation arrangements such as those described in this suit.

SUMMARY OF ARGUMENT

The fundamental ethical precept, upon which the system of medical practice has been founded, is that the patient's interests must take precedence over all other considerations, and certainly, over any financial or other personal interests of the patient's physician. Patients in need of medical care turn to their physicians to act as their agent in deciding what is needed. The patient must trust and depend upon the physician to serve only the patient's interest above all others.

The self-referral and physician compensation arrangements described in the United States' Complaint threaten to undermine this fundamental principle of medical ethics. Doctors who associate themselves with healthcare corporations as employees, contractors, or limited partners with financial ties to healthcare businesses have an unavoidable conflict of interest. The type of business arrangements described in the Complaint threaten to obscure the separation between business and professional aims. No longer are physicians the trustees solely for their patients' interests; they become in addition agents for a corporate enterprise which regards patients as customers. Economic incentives to withhold services, to overuse them, or to choose particular medical products are inconsistent with the duty of the physician to act as an unselfish trustee and agent for the patient.

Both the Medicare Anti-Fraud and Abuse Act and the Stark Acts are bulwarks against the continued erosion of the physician's fiduciary obligation in the face of increasing economic temptation. Physicians cannot ethically serve in the capacity of their patients' fiduciary or representative in selecting services offered by the healthcare industry, where they also have the type of financial interests in that industry as described in the United States' Complaint.

Self-referral has a demonstrable practical dimension beyond its ethical aspects. A growing body of evidence reveals that self-referral often leads to the overuse of services and excessive costs. Statistical studies buttress the commonsense conclusion that self-referral and compensation arrangements can result in the inappropriate utilization of services for the physician's economic benefit. To the extent that those services are submitted and paid under Medicare, they are also to the United States' detriment.

I. SELF-REFERRAL UNDERMINES THE MOST FUNDAMENTAL PRINCIPLE OF MEDICAL ETHICS

Amici do not profess to have personal knowledge of the allegations in the instant complaint describing a variety of financial relationships between defendants below and the physicians, who have allegedly accepted

the benefits of those arrangements. Those allegations are accepted as true, in the particular procedural context of this appeal. The Complaint alleges that, to induce referrals of Medicare and other patients, physicians, in a position to make referrals to the defendant healthcare providers were:

(a) offered a preferential opportunity not available to the general public to obtain equity interests in defendants' healthcare operations;

(b) offered loans with which to finance their capital investments in those equity interests;

(c) paid money, under the guise of "consultation fees" or similar payments to guarantee the physicians' capital investment in those equity interests on a risk-free basis;

(d) paid "consultation fees", "rent" or other monies to induce physicians to practice and refer patients to particular hospitals or facilities;

(e) given payments based on the amount of business provided by the physician;

(f) provided free or reduced rate rents for office space;

(g) provided free or reduced-rate vacations, hunting trips, fishing trips, or, other similar recreational opportunities;

(h) provided with free or reduced-cost opportunities for additional medical training;

(i) provided income guarantees; and

(j) granted preferred superior or exclusive rights to perform procedures in particular fields of practice.

This conduct is alleged to have violated both the Medicare Anti-Fraud and Abuse Act and the self-referral statutes known as the Stark Act. The prohibitions of the Stark Act are rather clear: where a physician has a statutorily defined investment or ownership interest in, or a compensation arrangement with, an entity, the physician may not refer Medicare patients to that entity, which in turn may not present or receive payment for any Medicare claims for patients so referred.

The policies and values implicated by the type of conduct prohibited under the Stark Act are revealed in the very title of the law as originally submitted by Representative Fortney "Pete" Stark: the House bill was entitled the "Ethics In Patient Referrals Act." Representative Stark chose his title well, for fundamental principles of medical ethics are unavoidably implicated by self-referral and remuneration arrangements that can tempt physicians to consider their own income above their patients' medical needs and to tap third-party payors (including the government) for excessive or unnecessary costs.

A. Patient Loyalty is the Most Fundamental Ethical Obligation

From its earliest origins, the profession of medicine has steadfastly held that physicians' responsibility to their patients takes precedence over their own economic interests. Thus the oath of Hippocrates enjoins physicians to serve only "for the benefit of sick. . . ." In modern times this theme has figured prominently in many medical codes of ethics. The international code of the World Medical Organization, for example, says that "a doctor must practice his profession uninfluenced by motives of profit." The American Medical Association declared in 1957, in its newly revised Principles of Medical Ethics, that "the principal objective of the medical profession is to render service to humanity." It went on to say, "in the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients."

The practice of medicine is based on this special relation between the doctor and patient. In this way, medical care is different

from ordinary commercial transactions. Patients may choose their doctors, their hospitals, or the kind of insurance coverage they want, but when they need medical care, the physician acts as their agent in deciding what is needed. The patient, in turn, is virtually totally dependent upon the physician's decision, and so must trust the physician to do the right thing.

This trust, which physicians are sworn to honor, is the essence of the relationship between doctor and patient. The patient's interest takes precedence over all other considerations, and certainly, over any financial or other personal interests of the physician. The American Medical Association has been very firm and explicit on this last point. The 1981 edition of the *Opinions and Reports of the Judicial Council of the AMA* unambiguously says: "under no circumstances may the physician place his own financial interest above the welfare of his patient. The prime objective of the medical profession is to render service to humanity. Reward or financial gain is a subordinate consideration."

Physicians are parties to a social contract, not merely a business contract. Physicians are not vendors, and are not merely free economic agents in a free market. Society has given physicians a licensed monopoly to practice their profession protected in large part against competition from other would-be dispensers of health services. Physicians enjoy independence and the authority to regulate themselves and set their own standards. Much of their professional training is subsidized. Virtually all the information and technology they need to practice their profession has been produced at public expense. Those physicians who practice in hospitals are given without charge the essential facilities and instruments they need to take care of their patients. Most of all, physicians have the priceless privilege of enjoying their patients' trust and playing a critical part in their lives when they most need help. All this physicians are given in exchange for the commitment to serve their patients' interests first of all and to do the very best they can.

B. Economic Pressures Arising From the Transformation of the Medical Practice Environment

Although the relation between doctor and patient is not in essence a market place transaction, it certainly can be influenced by economic considerations and by the financial and organizational arrangements through which medical care is provided. Until recently, the dominant arrangement was fee-for-service sole or small partnership private practice.

Until the past decade or two, this system for physician compensation has enjoyed the general confidence and support of the American public. There were several reasons for this. First, the behavior of most doctors was influenced by the ethical code of organized medicine, which clearly said that the whole system was based on the doctor's commitment to the patient's interests. Moreover, it was unethical for the doctor to do anything that was unnecessary. Until recently, there were few opportunities for physicians to do anything that was unnecessary. Until 40 or 50 years ago, the great majority of doctors in practice in this country were primary care givers, who had only a modest and inexpensive array of procedures and remedies. There was little for the physician to do beyond examining, counseling, and comforting. When specialists were used, the referrals usually came from the primary care physician, so self-referral by specialists was not a problem. Finally, until recently, doctors had more patients than they could handle. They had no incentive to do more than was necessary for any patient because there were

plenty of patients available and much work to do. As long as physicians were in relatively short supply, there was no pressure on them to offer their patients more than essential services.

Over the past fifty years, the system of medical practice in this country has irrevocably changed, putting new stresses on the previously simple satisfactory relationship between doctor and patient. One of the first and most important developments was the rise of specialism with a concomitant increase in the relative and absolute number of specialists. This, in turn, has led to the fragmentation of medical care and to less personal commitment by physicians to patients. We have changed from a system that had over 70% primary care physicians to one that has nearly 70% specialists.

Another major force that has changed the nature of the doctor-patient relation is the explosive development of medical technology. There are now a vastly increased number of things that doctors can do for patients—many more tests, many more diagnostic and therapeutic procedures, and many more identifiable, billable items to be reimbursed by the third-party payors. The increase in specialization and technological sophistication has itself raised the price of services and made the economic rewards of medicine far greater than before. With third-party payors, either medical insurers or the government, available to pay the bills, physicians have powerful economic incentives to recruit patients and provide expensive services. The multitude of tests and procedures now available provide lucrative opportunities for extra income, which in turn inevitably encourages an entrepreneurial approach to medical practice and overuse of services.

Another major factor in the transformation of the system has been the appearance of investor-owned healthcare businesses. Attracted by opportunities for profit resulting from the expansion of private and public health insurance, these new businesses (which have been called the "medical-industrial complex") have built and operated chains of hospitals, clinics, nursing homes, diagnostic laboratories, and many other kinds of health facilities. They prospered by encouraging physicians to use their facilities during an era when almost all medical services were paid for on a fee-for-service basis. This is still largely true for physicians' services under Medicare.

It must therefore be recognized that healthcare is becoming a business. Pressures from insurers and third-party payors for containment of costs, the growing presence of investor-owned healthcare corporations, and competition for market share among the country's overbuilt and underused hospitals are transforming the American healthcare system into an industry. In that environment, many doctors have associated themselves with healthcare corporations as employees, contractors, and limited partners.

C. Self-Referral Undermines The Physician's Fiduciary Responsibilities

Whether investors, employees, contractors, or limited partners, doctors with financial ties to healthcare businesses have a conflict of interest. And therein lies the ethical quandary, which Representative Stark sought to address in the Ethics in Patient Referrals Act: economic imperatives may weaken what should be a strong fiduciary relationship between doctor and patient. A physician cannot easily serve his patients as trusted counselor and agent when he has economic ties to profit-seeking businesses that regard those patients as customers. In entering into these and similar business arrangements, physicians are trading on their pa-

tients' trust. The kind and character of financial arrangements, incentives, and business deals described in the present Complaint clearly serve the economic interests of physicians and owners. Whether they also serve the best interests of patients is not so clear. Whether they violate the Medicare Anti-Fraud and Abuse Act or the Stark Act prohibitions against payment of remuneration for the referral of Medicare or Medicaid patients or for the purchase of supplies for these patients is beyond the purview of this brief; however, at a minimum these legal concerns imply that the government recognizes the potential risk to the public interest when physicians make deals with businesses.

The type of business arrangements described in the Complaint take physicians into uncharted waters, where conflicts of interest abound and the separation between business and professional aims is obscured. No longer are physicians the trustees solely for their patients' interests; they become in addition agents for a corporate enterprise which regards patients as customers. Economic incentives to withhold services, to overuse them, or to choose particular medical products are inconsistent with the duty of the physician to act as an unselfish trustee and agent for the patient.

The tension between economics and ethics has been reflected in the deliberations of the American Medical Association. In December, 1991, the Council on Ethical and Judicial Affairs of the AMA advised physicians to avoid self-referral, except where there is a demonstrated need in the community for the facility and alternative financing is not available. While acknowledging the mounting evidence of excessive costs and rates of use in jointly owned for-profit facilities, the Council emphasized its primary concern for the integrity of the profession. The following passage from the report expresses its essential message: "At the heart of the Council's view of this issue is its conviction that, however others may see the profession, physicians are not simply business people with high standards. Physicians are engaged in the special calling of healing, and, in that calling, they are the fiduciaries of their patients. They have different and higher duties than even the most ethical business person. * * * There are some activities involving their patients that physicians should avoid whether or not there is evidence of abuse."

This is, of course, the central point about fiduciary responsibility: people in important positions of trust should not put themselves in situations that inevitably raise questions about their motives and priorities, regardless of whether they actually behave in accordance with the trust. Even though physicians may believe they are doing what is best for the patient, there will still be the appearance of conflicting interests with a resulting erosion of public confidence in the physicians' motivation, a confidence that has unfortunately already been weakened by a growing public opinion that doctors are too interested in money and charge too much. Since trust is vital to good care, these public perceptions could lead to a deterioration in the quality of care as well as a change in the public's attitude toward the medical profession.

Both the Medicare Anti-Fraud and Abuse Act and the Stark Acts are bulwarks against the continued erosion of the physician's fiduciary obligation in the face of increasing economic temptation. The public gives doctors special advantages and privileges in exchange for their commitments to put the public's interests ahead of any personal economic gain. The involvement of practicing physicians accepting compensation for the referral of patients raises serious doubts about this commitment. Physicians should

be fiduciaries or representatives for their patients in evaluating and selecting the services offered by the healthcare industry. They cannot ethically serve in that capacity where they also have the type of financial interests in that industry as described in the United States' Complaint.

II. SELF-REFERRAL LEADS TO OVERUSE OF SERVICES AND EXCESSIVE COST

Self-referral has a demonstrable practical dimension beyond its ethical aspects. A growing body of evidence reveals that when physicians are paid on a fee-for-service basis self-referral leads to the overuse of services and excessive costs. A 1992 study evaluated the effects of self-referral arrangements in radiation therapy facilities in Florida, where at least 40% of all practicing physicians were involved in some kind of self-referral. That study found that the frequency and costs of radiation therapy at such centers were 40% to 60% higher in Florida than in the rest of the United States, where only 7% of the facilities were joint ventures. Another 1992 study, using information collected by the Florida Healthcare Cost Containment Board, found that visits per patient were 39% to 45% higher in physical therapy centers owned by referring physicians and that such facilities had 30% to 40% higher revenues. The study also found that licensed therapists in non-physician owned centers spent about 60% more time per visit treating patients than those in physician-owned centers.

A California study in 1992 compared physicians who referred patients to facilities in which they had ownership interests to other physicians. Physician-owners were found to have referred patients for physical therapy 2.3 times as often as others. Of the MRI scans requested by physician owners, 38% were found to be medically unnecessary, as compared with 28% by other physicians. Two studies focusing on diagnostic imaging services identified the same patterns. Physicians who owned imaging systems were found to have used diagnostic imaging in the treatment of elderly patients significantly more often than other physicians while generating 1.6 to 6.2 times higher average imaging charges per session of medical care. An earlier study found that self-referring physicians generally used imaging examinations at least four times more often than other physicians, with the charges for self-referred imaging usually being higher. Earliest of all was the 1989 study conducted under the auspices of the Inspector General of the Department of Health and Human Services, which found that Medicare patients of doctors who had financial interests in clinical laboratories received 45% more laboratory services than Medicare patients generally.

None of this evidence is particularly surprising; it merely confirms that when physicians are paid on a fee-for-service basis, the lure of economic gain is directly correlated to the use of medical services. At a minimum, then, self-referral adds to the cost of medical care; more ominously, it may increase patient risk and diminish quality of patient care. Both the individual interests of patients, and the wider interests of the tax paying public, are best served by stringent enforcement of the prohibitions against self-referral embodied in the Medicare Anti-Fraud and Abuse Act and the Stark laws.

III. CONCLUSION

Amici therefore submit this brief in support of reversal of the district court's judgment of dismissal.