

The Organized American Medical Profession's Response to Financial Conflicts of Interest: 1890-1992

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UNLIKE OTHER PROFESSIONS SUCH AS LAW, business, and public service, medicine has not made financial conflicts of interest a key element in its ethical codes. Until the 1980s, the medical profession did not even address financial conflicts of interest *explicitly*, and the term was not part of medical discourse. Since then a public debate has ensued over the apparent clash between medicine as an expensive article of commerce and as a profession. This culminated in 1989 when Congress enacted restrictions on physician referral of Medicare patients to clinical laboratories in which referring doctors had a financial interest (a practice called self-referral) (Iglehart 1990).¹ The restrictions took effect in 1992. The American Medical Association (AMA) and other medical groups maintained that government intervention was unwarranted because professional self-regulation and ethical codes adequately address the problem. The issue is contentious and is likely to come before Congress again.

These problems are often discussed as if they arose only since the creation of a "new medical industrial complex" (Relman 1980). However, financial conflicts of interest are not new for doctors. In this article I will

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¹ Omnibus Budget Reconciliation Act (OBRA) of 1989. P.L. 101-239, Title 6.

survey the history of physicians' conflicts of interest and the organized profession's response and examine two influential groups with differing perspectives: the AMA and the American College of Surgeons (ACS). They offer a window on the views of physicians in the United States and current debate over physician professionalism, conflicts of interest, and physician self-referral.

My historical analysis reveals that over the last century the organized medical profession never developed a normative or regulatory framework to address conflicts of interest effectively. Although they did form policies for specific conflicts of interest, such as fee-splitting, physicians' dispensing of drugs they prescribe, and other self-referral practices, the medical establishment's response weakened over time in the face of these conflicts, which, rather than diminishing, may even have become more serious.

This history shows the inadequacy of organized medicine in coping with financial conflicts of interest. Between the 1890s and the 1950s, the AMA first ignored fee splitting and other questionable commercial practices, then denounced them, but was never able effectively to enforce its policies. From midcentury until 1991, as new, more extensive and sophisticated commercial practices emerged, the organization's public stance weakened, its guidelines were chipped away, and the few clear prohibitions in its codes were abandoned in favor of subjective standards. The AMA revised its ethical codes to allow practices previously forbidden. The ACS was more outspoken, but also lacked the means to enforce its ethics. Faced with new legal strictures against fee splitting and professional approbation, physicians developed substitutes: financial incentives for patient referrals. These took many forms, but basic conflicts of interest remained.

Partly in response to public concern and proposed federal regulations, the AMA developed conflict-of-interest guidelines in 1986, and a 1991 opinion of the AMA Council on Ethical and Judicial Affairs declared that *most* physician self-referral was inappropriate. However, in 1992 the AMA House of Delegates contradicted this opinion and stated that self-referral is appropriate if ownership is disclosed. Moreover, the AMA still favors approaching these issues through voluntary ethical codes, setting aspirational goals, promoting a patient-centered ethos, providing education, and relying on the discretion and good will of individual physicians. It has been reluctant to accept public, enforceable standards.

It treats conflicts of interest as matters of *personal* ethics, a subject over which well-intentioned individuals can, and often do, disagree.

Assumptions and Approach

My argument assumes that the Hippocratic Oath exacts from physicians an ethical obligation to act in the interest of patients, indeed to make the patient's interest their first consideration (Reiser, Dyck, and Curran 1977). I also rely on the legal definition of conflict of interest, which entails two ingredients:

1. an individual with an obligation, fiduciary or otherwise
2. the presence of conflicting interests that may undermine fulfillment of the obligation

Physicians have a conflict of interest when their interests or commitments compromise their loyalty to patients or the exercise of independent judgment on patients' behalf. Two main types exist:

1. conflicts between a physician's personal interests (often financial) and the interests of the patient
2. conflicts that divide a physician's loyalty between two or more patients or between a patient and a third party (Kipnis 1986; Finn 1977)

My focus is on financial conflicts of interest.

As defined in law, conflicts of interest are distinct from breaches of obligation. Although law or ethics may require not entering into conflict-of-interest situations, this is only as a measure to prevent acts wrong in themselves. Conflicts of interest can influence action, but are not acts and do not ensure disloyalty. They do, however, increase the risk that physicians may abuse their trust. The least serious possible breach entails professional neglect: a compromised physician might not perform at his or her customary high level of competence, diligence, or effectiveness. At worst, physicians may knowingly exploit their position or harm patients. Extreme disloyalty obviously presents the more dramatic danger and is easier to identify. Situations that compromise independence, loyalty, or judgment more subtly, or even unintentionally, occur more

frequently—and are harder to recognize. Yet even compromised clinical judgment can bias physicians' advice and imperil patients.

Although early codes of ethics do not use the term “conflict of interest,” medical association reports discuss financial issues such as payment of commissions, fee splitting, dispensing of drugs, and ownership of medical facilities. These practices exemplify conspicuous conflicts. If the organized profession were to address any conflicts of interest through self-regulation, one would expect it to address these. Its response is thus a test case. Because the record does not yield good quantitative evidence, we cannot measure the extent of these activities, but we can indicate the evolution and range of various commercial practices as well as the permutations of the response by organized medicine. Moreover, these core conflicts are analogous to many financial conflicts being discussed today, such as physician self-referral.

I divide the problems and responses into three main periods: (1) 1890 to 1950; (2) 1950 to 1980; and (3) 1980 to the present. These are convenient demarcations that coincide with broad trends in the transformation of the organized profession's basic attitudes to financial conflicts of interest, largely in response to changes in social conditions and institutions.

Conflicts of Interest and the AMA and ACS Response: 1890 to 1950

Early Codes of Ethics

When the AMA was established in 1847, its members were state medical societies, medical colleges, hospitals, and other regional institutions, all of which sent delegates to the founding conference. Today, individual physicians are AMA members, but only state medical societies and medical specialty associations are represented in the House of Delegates, the policy-making body. Constituent organizations are autonomous and not required to adopt AMA policy (American Medical Association 1986c). However, physicians who are members of the AMA are instructed to follow the Principles of Medical Ethics as standards of conduct (Hirsh 1984). Within the AMA, the Judicial Council, established in 1873 (renamed the Council on Ethical and Judicial Affairs in 1985), interprets the principles. It also hears appeals for members disciplined by state medical societies.

The AMA adopted its first code of ethics at its national conventions

in 1846 and 1847 (Reiser, Dyck, and Curran 1977). It affirms that physicians should act in the interest of their patients, not own patents on surgical instruments or medicines, and shun unnecessary visits to patients so as to avoid being suspected of interested motives. Although the code elaborates the physician's "duties" to patients, much of the code concerns proper relations between physicians. The first AMA code was voluntary, adopted by local medical societies if they wished. In 1855, the AMA decided that member state medical societies must adopt the code.

Codes of ethics perform multiple functions. Some historians suggest that the AMA has used its code to "discredit interlopers," to boost the profession's prestige, to stave off attacks, and to discourage external regulation (Konold 1962; Burns 1978). Codes may have helped the medical profession to reduce external competition, to promote an oligopoly status, and to protect prominent physicians against challenges (Stevens 1971; Berland 1975). Nevertheless, codes also establish norms that can protect individual patients. They articulate organizational policies and official standards of conduct, and show how the organized profession frames issues (Konold 1978; Veatch 1978). Reports on difficulties in enforcement provide evidence of actual practices.

Fee Splitting and Other Commissions: Definitions and Variations

Fee splitting in the United States started in the 1890s, when physicians began accepting payments from apothecaries and medical supply firms for prescribing their merchandise. The practice, Donald Konold argues in his history of the medical profession's regulation of ethics, became prevalent among general practitioners and surgeons after 1900 (Konold 1962).

Early in the century, the AMA came to regard fee splitting as the heart of a group of related, improper commercial practices—including paying "commissions," "drumming," and "steering." It also looked askance at doctors owning pharmacies, dispensing or patenting medical products, and advertising, and condemned these practices until the 1950s.

The term "commissions" is roughly equivalent to the contemporary term "kickback," that is, payment by one party to another for having referred business or otherwise produced income for the payer. A 1913 report of the AMA Judicial Council defined commissions as "'rake offs,'

or pro rata moneys for referring patients or for favors received, and not for medical and surgical services rendered by the receiver" (AMA Proceedings: June 1913). Fee splitting constitutes a commission, but refers in particular to payments made by physicians to one another. Early on the AMA defined fee splitting as "the sharing by two or more men [sic] in a fee which has been given by the patient supposedly as the reimbursement for the services of one man alone" (AMA Proceedings: June 1913). Subsequent definitions equated fee splitting with commissions (AMA Proceedings: 1929). Starting in the 1950s, some medical articles started to use the term "kickback" for fee splitting and commissions (Whitman 1953; Meyers 1960; Jurkiewicz 1985). "Drumming" consisted of using agents to obtain patients, sometimes by fraud and other deceptive means (Vaughan 1910; Lydston 1900). Typically, drummers were paid a commission by physicians. Hotels and resorts would at times receive payments directly from physicians to recommend them to clients. Proprietors would praise the virtues of their resident physician and disparage the names of any others. Or resorts would permit drummers to frequent their lounges posing as guests. Physicians relied on news agents, bar keepers, clerks, medical students, priests and preachers, and "traveling men" as drummers (Lord 1911). "Steering" was akin to drumming. Physicians who referred patients to colleagues were called "steerers," but the term was also applied to lay people—in the employ of physicians—who performed the same function.

Doctors sometimes used the term "fee splitting" to refer to *any* situation in which a commission is paid, or in which physicians engage in self-referral. This less precise way of speaking reflects a correct intuition: the boundaries between these different practices are hazy. Although the medical profession has not used the term "conflicts of interest" until recently, some doctors sensed the issue. More recently, the medical profession has drawn distinctions between various practices, but these often obscured the underlying problem.

The proceedings of the AMA House of Delegates from 1900 through the mid-1950s indicate the AMA's awareness that commissions thrived in many forms. Classic fee splitting occurred as payment by one physician to another for referral of patients. Another commission practice consisted of so-called stock ownership, which paid physicians returns in proportion to the amount of work they referred to a clinic or laboratory (AMA Proceedings: April 1926). A further variation consisted of appointing and paying physicians as "associate directors" of a medical

clinic; in return, they referred patients to the clinic (AMA Proceedings: December 1952). AMA reports noted that doctors received rebates from optical companies (AMA Proceedings: June 1947) and other payments from manufacturers of mechanical aids in return for recommending products (AMA Proceedings: June 1935, May 1936). Surgeons and physicians sometimes demanded commissions from manufacturers of surgical appliances (AMA Proceedings: June 1915).

The Prevalence of Fee Splitting

In 1899, G. Frank Lydston, a prominent Chicago physician, published an exposé of fee splitting and commissions in the *Philadelphia Medical Journal* (Lydston 1899). Lydston recounted that at a social gathering he had asked the wife of a colleague whether her husband's practice was going well. She replied that it was, but that most of his income came from the 50 percent commission he received from patient referrals. She suggested that Lydston should follow the lead of other surgeons and split his fees as well.

Lydston was surprised to learn of the practice. To test its prevalence, he wrote letters to "nearly all the representative surgeons" of Chicago, posing as a rural general practitioner who offered to refer patients in return for a 50 percent commission. He then published a sample of replies, removing the names. Lydston reported that over 60 percent accepted the practice, although some responded by bargaining over the percentage to be paid. At least one surgeon said he would pay the 50 percent commission in return for the referring physician "assist[ing] in the operation." Lydston felt that this was a greater evil than physicians who accepted fee splitting outright, evidently because it was a subterfuge. In a follow-up article, Lydston wrote that drummer doctors were ethically superior to those who merely took a commission because they were at least honest about what they did (Lydston 1900).

Fee splitting outraged Lydston. He also thought that the deception of patients was wrong. He suggested that the profession should resolve the issue and, if fee splitting were deemed ethical, it should be acknowledged, and all physicians should participate on equal terms. Lydston noted that fee splitting occurred not only among physicians. Undertakers, "the postmedical adjunct to the profession," he reported, sometimes paid 25 percent commissions to physicians who steered business their way. Lydston concluded with a glum note.

'Tis but a step to the undertaker's—a short step indeed from some commission men's operating tables—so let us arrange for a fixed standard of percentages all around. (1899)

In a follow-up article, Lydston (1900) charged that “cases in which operation is unnecessary are being operated on” for a divided fee. He claimed to be able to prove that such cases were “auctioned off to the highest bidder.” The charge that fee splitting led to unnecessary surgery was repeated by many others in later years.

The AMA surveyed prominent physicians in 1912 to determine the extent of secret commissions, and found that they existed in every state, although their prevalence varied by region (AMA Proceedings: June 1913). The report identified three ways in which commissions were paid:

1. by surgeons to physicians for referring patients
2. by pharmacists or medical and surgical appliance suppliers to physicians ordering their supplies on behalf of patients
3. by hospitals and sanatoriums to physicians who admitted patients

Rebates were so widespread, the report noted, that many hospitals openly offered commissions in circulars; physicians would routinely inquire whether they were to receive 15 or 20 percent (Lydston 1899). Thirteen percent of the physicians surveyed believed that receiving secret commissions was justifiable, 9 percent were doubtful, and 77 percent considered it inappropriate (AMA Proceedings: June 1913).

In 1914 the AMA Judicial Council again investigated reports of fee splitting by sending a survey to medical suppliers. The council found that many surgeons and other physicians demanded commissions from suppliers of surgical appliances such as artificial limbs, trusses, and belts. According to the council, the practice was pervasive—and disgraceful (AMA Proceedings: June 1915). Letters received by the council from suppliers described the practice as “graft” and “radically wrong and deceptive.” One letter scoffed at the medical profession for the discrepancy between its professed standards and practice. Concluded the medical supplier: “As long as the majority of physicians ask [sic] for commissions, . . . it is impossible for us to consider that medical ethics are against this custom” (AMA Proceedings: June 1915). Some firms op-

posed paying commissions but competitive pressures prevented them from ending the practice. They blamed the medical profession for demanding payments in secret while publicly denouncing commissions.

The Judicial Council ruled that physicians who demanded commissions from medical suppliers were “analogous to a man demanding commission from the buyer and seller of a piece of property [a practice which] . . . is not tolerated legally.” And the council added:

Physicians cannot be partners in the business house of instrument makers nor honorably act as their sale agents when dealing with their own individual patients, and cannot, therefore, ethically partake of the profits of the manufacture and sale of their goods. They cannot, therefore, honorably receive a secret rake-off from the instrument maker for goods sold to any patient. (AMA Proceedings: June 1915)

According to the AMA, the situation had not improved by 1924. A report of the Judicial Council opens: “Whispered reports and even open statements to the effect that the practice of fee-splitting prevails in many places have been heard with increasing frequency during the last year to two” (AMA Proceedings: June 1924). The report makes provisions for situations in which county medical societies support so many fee splitters that it is impossible for them to enforce AMA ethical standards. When this occurred, the state councilor was obligated to alert the state board of councilors and to revoke the county medical society charter, establishing a new one in the name of a physician well known for being ethical.

In 1930, the AMA Judicial Council reported a new practice: physicians were becoming members of cooperative diagnostic laboratories and receiving payment in proportion to the amount of work they referred (AMA Proceedings: 1930). It declared the practice unethical. In later years, the AMA declared that profits from diagnostic clinics should be paid only to those who performed services (Hirsh 1984). In the late 1930s, the Judicial Council cited “widespread complaints” concerning the division of fees between hospitals and doctors, and rebates and commissions between ophthalmologists and opticians. The council condemned the practice, but had no power to control these abuses (AMA Proceedings: 1934).

Fee splitting did not subside during World War II. AMA reports noted that articles in the popular press exposed rebates to physicians

and called on local medical societies to take appropriate action against physicians who violated the AMA Principles of Medical Ethics (AMA Proceedings: June 1942). No evidence exists of effective countermeasures. Quite the contrary. The Moreland Commission, set up to investigate workmen's compensation graft in New York in 1944, heard testimony that kickbacks to physicians, ranging from 15 percent to 50 percent, were pervasive (Bleakley and Stichman 1944). The testimony indicated that physicians, both private practitioners and those working for workmen's compensation, received kickbacks from surgeons, X-ray labs, sellers of surgical appliances, opticians, and specimen labs.

The Initial Professional Response

A vigorous debate ensued within the profession on whether fee splitting and other commissions were acceptable. Defenders claimed that the practice did not affect their recommendations. They also argued for its necessity, stating that general practitioners could not receive fair fees because patients did not understand the value of their work, whereas surgeons could extract whatever the market would bear. In their view, general practitioners merely used surgeons to collect fees for work general practitioners had performed in diagnosis and care before or following surgery (Evans 1912).

Those opposed claimed that fee splitting often led referring physicians to shop for the highest payer, even to solicit bids by mail (Lydston 1899). Such practices, they claimed, are inconsistent with promoting the patient's interest because they prompt referring physicians to ignore medical skill or qualification (*Journal of the American Medical Association* 1898). Critics charged that fee splitting led to unnecessary surgery (Lydston 1900; Brettauer 1911; Morris 1911; Pryor et al. 1911; Bowman 1919; American College of Surgeons 1918). Surgeons opposed to fee splitting contended that if general practitioners wanted more income they should have the courage to demand higher fees directly and they should educate patients about the value of their services (Vance 1899).

Well-publicized corruption in public and private affairs in the late nineteenth and early twentieth centuries undoubtedly reinforced the lenient attitudes toward these practices. Yet many physicians considered fee splitting plain graft (Lord 1911). One who discussed fee splitting in 1906, under the title "Graft in Medicine," attributed its prevalence to corruption that had "touched every department of social and govern-

mental life" (Morfit 1906). He pleaded for physicians to join the "revolt against dishonesty."

However, the medical profession's objection to fee splitting is cast in a different light when compared with other ethical code provisions regarding interference by colleagues. In the early twentieth century, physicians viewed the "stealing" of patients by colleagues as the most serious ethical violation. This concern was reflected in medical codes as late as the 1970s in provisions on treating patients under the care of another physician, precedence when several physicians are called to a patient, criticism of other physicians, and social calls on patients of another physician (AMA Ethical Opinions: 1965, 1969). Objections to fee splitting may have revealed physicians' greater concern with "unfair" competition than with patient welfare.

In 1900 the AMA House of Delegates considered a resolution stating that receiving or giving commissions or dividing fees under any guise was unethical, and that members found guilty should be expelled. The House rejected the resolution, however, convinced that the AMA would not be able to resolve the truth in such cases (American Medical Association 1900). In 1902, however, the House of Delegates resolved that members of a county medical society proven guilty of fee splitting *without* patient knowledge be held guilty of misconduct and that the county medical society be allowed to expel them (American Medical Association 1902). A year later the AMA issued a revised code of ethics, declaring it unprofessional to pay, receive, offer, or solicit commissions in return for recommending patients (AMA Principles: 1903). The AMA explicitly removed itself from the business of policing its members by declaring that its revised code was merely an advisory document, and maintained this policy until 1913 (AMA Principles: 1903; Konold 1962). Supporters of the code believed it preferable to appeal to professional ideals and honor—not to enforce standards outright. Some advocated education as a remedy for unethical behavior. Others proposed friendly counsel to any doctor who "made mistakes." One medical journal editor suggested that character alone should be the foundation of ethical conduct (Konold 1962).

A dramatic case indicates the laxness of the AMA and local medical societies in enforcing prohibitions against fee splitting. In 1904, two Chicago physicians again exposed the prevalence of fee splitting. They sent letters to 100 doctors in Chicago that said they wished to bring a wealthy patient to that city for a consultation, and requesting a 25 per-

cent commission. Many accepted and the responses were published in the *Chicago Daily Tribune*. The Chicago Medical Society responded by disciplining the physicians who exposed the fee splitters, not the physicians who accepted the offer (Davis 1938).

Nonetheless, efforts to stop fee splitting continued, and were strengthened during the Progressive Era by President Theodore Roosevelt's campaign against corruption in public and private life (Link and Leary 1978; Wiebe 1967). At least one physician called Roosevelt's speeches a positive step against fee splitting (Lord 1911). The subject was discussed frequently in medical journals (Vance 1899; Evans 1912).

In his 1906 AMA presidential address, William Mayo described fee splitting as a "crying evil" (Mayo 1906). Yet the AMA took no significant action. In its 1912 report, the Judicial Council said fee splitting led physicians to make referrals based on income received from referrals, not on the qualifications of surgeons, thus tempting physicians to operate unnecessarily. According to the report, it was immaterial whether the physician was paid for each referral for medical supplies or earned the difference between wholesale and retail price. In both cases, the physician exploited patients by charging them without providing services. The AMA reiterated this view in 1912 (AMA Principles: 1912).

Following the 1912 report, the AMA tried to regulate ethical conduct, threatening to expel members found guilty of *secret* fee splitting either with other physicians or with medical suppliers (AMA Proceedings: June 1912, June 1913; Konold 1962; Fishbein 1947). Fee splitting was reckoned acceptable so long as it was disclosed. Once again, however, enforcement was left to local medical societies, which were generally unwilling or unable to discipline physicians (Davis 1960). Some explicitly *condoned* the practice (Erie County Medical Society 1910). Indeed, state medical societies rarely decertified local medical societies for failing to uphold AMA standards. As Oliver Garceau, a political scientist writing about AMA discipline, noted, "A voluntary Association cannot afford to contribute too lavishly to its own dismemberment" (Garceau 1961).

The Fight by the American College of Surgeons Against Fee Splitting

The ACS, founded in 1913 in order to raise the clinical and *ethical* standards of surgery, took a more active stand against fee splitting than the AMA. Members had to sign an oath pledging to shun "unwarranted

publicity, dishonest money-seeking and commercialism” and to “refuse utterly all secret money trades with consultants and practitioners” (Davis 1960).

The ACS tried to eradicate fee splitting. From 1918 to 1952, as part of its hospital standardization and accreditation program, it required the staffs of hospitals wishing certification to sign resolutions pledging not to split fees. This met with resistance. Even the ACS found it hard to stop fee splitting—and critics charged that some of its members accepted fees (Davis 1960). In 1924, the Eclat Society, an organization of young surgeons, accused the ACS of not disciplining all fee splitters and overlooking fee splitters in its own hospital standardization program. The ACS regents denied they could identify any fee splitters, but admitted that some had deliberately disregarded the pledge (Davis 1960). In later years, ACS officials would admit that fee splitting flourished in spite of their efforts (MacEachern 1948; Meyers 1955).

Although the ACS had judiciary committees that reviewed complaints and expelled members who were found to split fees, the names of these members were not published, which diminished the deterrent. Fee splitting was also hard to police because the ACS had no institutional framework to identify fee splitters. Evidence sufficient to expel members proved hard to come by (Davis 1960).

The ACS took a stronger stance against fee splitting than the AMA. The difference may have reflected a different moral vision. It is also possible that fee splitting affected surgeons’ interests more directly: the most typical case of fee splitting was payment from surgeons to referring general practitioners. Rosemary Stevens suggests that the more prominent surgeons within the ACS membership opposed fee splitting because they had sufficient referrals without financial inducements, unlike surgeons who were less well known (Stevens 1971).

The Immediate Postwar Situation

One journalist called the prewar efforts to deal with fee splitting by pledges, codes, and laws only as effective as prohibition during the 1920s (Williams 1952). However, the years immediately following World War II saw a renewal and a consolidation of efforts to eliminate fee splitting. Starting in 1946, the Surgical Society of Columbus, Ohio, required members to submit their tax returns, books, and office records for annual auditing to ensure compliance with their pledge on refraining from splitting fees. In two magazine articles a journalist affiliated

with the ACS reported that these methods all but eradicated fee splitting in Columbus, and also reduced the volume of unnecessary surgery (Williams 1948, 1952). Even in that city there were holdouts. The Internal Revenue Service (IRS) helped to enforce the ban. It had reportedly allowed split fees as a necessary deductible business expense until 1946, when the local medical society wrote to them that the practice could no longer be considered “necessary” because it had all but ceased to exist. Apparently, Columbus was the first city in which the IRS did not allow split fees as a business expense (Williams 1952).

In 1947, an AMA committee on rebates followed the example of the Columbus Surgical Society, recommending that local medical societies employ auditors to examine randomly 10 percent of their membership as a way to enforce AMA policy against accepting rebates (AMA Proceedings: June 1948). There is no indication in AMA reports that this advice was followed, and the plan was not mentioned in official reports again. It seems that the efforts of the Columbus Surgical Society were atypical. The assistant director of the ACS wrote in 1948 that the practice of fee splitting was still widespread and “almost universal . . . in some communities” (MacEachern 1948). He attributed it to the “let-down in moral sensibilities which seems frequently to follow war,” and suggested that it would be useful to enlist the aid of the Better Business Bureau and government agencies in enforcing fee-splitting prohibitions. A journalist surveying physicians in six cities reported their claim that between 50 percent and 90 percent split fees (Williams 1948). Eventually even the surgical society in Columbus stopped the auditing program that had been instrumental in enforcing its anti-fee-splitting policy. Records explaining the change are unavailable, but a 1992 publication commemorating the society’s one-hundredth anniversary states that it moved to a system of spot audits when auditing fees became expensive, and eventually stopped “because of escalating costs and lack of need” (Hamilton 1992).

The AMA reiterated its policy against fee splitting in its 1947 Principles of Medical Ethics, which, unlike previous versions, included a single section on paying commissions, patenting appliances, receiving rebates on prescriptions, and sale of appliances (AMA Principles: 1947). Combining these topics into one discussion suggested that the AMA thought these practices were closely related. However, it is debatable whether the medical profession adhered to the new standards. That same year, the AMA Judicial Council reported having received many inquiries about rebates from suppliers, and added:

By far the largest number of requests for information or for approval were received from ophthalmologists who have submitted every conceivable plan to circumvent the section of the Principles of Medical Ethics concerning rebates. . . . The Council has the impression that these or similar plans are at present openly used in various parts of the country. Nevertheless, the Council is constrained to advise all members of the Association that, no matter how prevalent these practices may have become, they are still unethical. Another scheme presented to the Council would permit doctors owning the stock of a drug company to refer their patients to this company and divide the profits from the sale of the drugs. . . . (AMA 1947)

The Commercial Transformation: the 1950s to 1980

Changing Conditions and Practices

The 1950s brought changes to medical care finances and physician practices that were reflected in the organized profession's policies. At the beginning of the 1950s, the AMA maintained and even strengthened its official stand on fee splitting and related commercial practices. By the end of the decade, however, its official stand had weakened: practices were deemed ethical that had not been so regarded before. Conflicts ensued within the medical profession, but they were eventually forgotten, if not resolved, and the profession addressed fee splitting less frequently, sidestepping the problem of enforcement by again placing the onus on individual physicians.

Why was it that the organized medical profession all but stopped discussing fee splitting and commercial practices by the end of the 1950s? And why did the AMA actually weaken its stance? It seems reasonable that the profession would discuss fee splitting less if the practice diminished. But if fewer physicians split fees, why would the organized profession back away from its traditional anti-fee-splitting stance rather than adopt a stronger ethical posture? The two phenomena are at odds.

At least four factors could account for the discrepancy. Increased income security may have caused fee splitting to diminish. So, too, might have legal changes, such as the IRS policy disallowing deduction of split fees as business expenses and state laws rendering fee splitting illegal. The development of new ways of structuring economic incentives for referrals might have reduced fee splitting. Finally, shifting ethical standards may have caused the organized professional to discuss fee splitting less. Let us consider these possibilities more closely.

In the 1950s, the medical profession grew in prestige and financial power. Private health insurance, which had begun in the 1930s, boomed during World War II and the years afterwards. With the spread of health insurance coverage to a substantial segment of the population, physicians found a secure source of payment. The Hill-Burton Act of 1946, bolstered by increased funding in the 1950s and 1960s, encouraged hospital construction and also supported physicians by providing them with modern workshops. A doctor shortage meant more than enough work for most physicians. These conditions reduced pressure on physicians to make ends meet. Fee splitting was thus less necessary—or less urgent.

Changes in law may also have deterred fee splitting. Between 1914 and 1953, 22 states passed statutes making fee splitting illegal. Wisconsin led the way with legislation that made fee splitting a misdemeanor punishable by forfeiture of the diploma of any surgeon who gave a commission (Stevens 1971). These state laws might have reduced the incidence of fee splitting, although the AMA claimed it did not (Davis 1960). In addition, the IRS continued its policy, which began in Columbus, Ohio, in 1946, prosecuting physicians who deducted fees as “necessary business expenses.” The policy was enforced more generally in the 1950s. The position of the IRS was that such payments went against public policy and therefore could not be considered legitimate business expenses. One lawsuit, appealed to the U.S. Supreme Court, held that public policy against fee splitting had not been established in North Carolina, so disallowance of the deduction was unwarranted there.² In response, the ACS offered to testify before Congress, saying that fee splitting violated medical ethics and thus public policy.

Legal restrictions on fee splitting may also have spurred the growth of alternative practices. For example, one way to bypass the disallowance of deducting split fees for business expenses was for surgeons to hire referring physicians as assistants (Whitman 1953). New institutions also performed similar referral-generating functions. Medical schools launched practice plans that fed patients to their hospitals and physicians. Hospitals developed programs to encourage physician loyalty and referrals.

Despite these four factors that might have caused fee splitting to diminish, it did not disappear. The ACS and others attested to it as a

² *Lilly v. Commissioner of Internal Revenue Service*, 343 U.S. 90, 72 S. Ct. 497 (1952).

continuing problem in the 1950s and 1960s (American College of Surgeons 1967). Substantial evidence from congressional investigations documents physicians paying and receiving kickbacks since the early 1970s (Jesillow and Pontell 1992; U.S. Congress 1976, 1977a,b).³ With the inauguration of Medicare and Medicaid in 1966, the federal government gathered data and monitored the behavior of providers, including Medicare and Medicaid fraud, exposing the prevalence of kickbacks (the new term for fee splitting and other commissions). Scandals led to federal legislation prohibiting kickbacks in the Medicare program in 1972. When this legislation proved insufficient, the definition of kickback was expanded, and the legislation was strengthened in 1977, 1980, and 1987 (Hyman and Williamson 1988).

Because fee splitting apparently did not cease and similar new practices emerged, one might infer that the AMA spoke about it less because ethical standards changed, making splitting fees a less serious, perhaps insignificant, breach. When the profession first condemned fee splitting and commissions, strictures also existed against advertising and profiting from patents on medical devices. Some medical ethics scholars now believe that enforcement of the latter was unethical because it restricted market competition (Brennan 1991). The restrictions were lifted after a series of antitrust and consumer protection lawsuits were filed against the AMA in the 1970s and settled in the 1980s.

Today government policy promotes competition in medical markets and uses financial incentives to back goals. Many hospitals discount prices for health maintenance organizations (HMOs), which refer a high volume of patients to them. Also, many payment schemes link doctors' income to their clinical choices and referrals. HMOs use physician risk sharing to reward frugal use of referrals and diagnostic tests. Physician investment in medical facilities creates incentives for doctors to refer patients. Viewed in this context, prohibitions against fee splitting could appear anachronistic. At any rate, from the 1960s on physicians were less likely to agitate against fee splitting, denounced as "evil" in the past (Mayo 1906; Lord 1911). The line between the permissible and the impermissible grew fine indeed.

³ H. Rep. No. 231, 92nd Congress, 2d Sess., reprinted in (1972) *U.S. Code Cong. & Ad. News* 4989; H. Rep. No. 393, 95th Cong., 1st Sess., reprinted in (1977) *U.S. Code Cong. & Ad. News* 3039.

Pressure for Change Splits the Organized Medical Profession

In 1952, the AMA Judicial Council noted increasing requests “for interpretations of principles of medical ethics . . . which reflect desire to increase income through devious means,” including physician ownership of pharmacies and ophthalmologists employing opticians (AMA Proceedings: December 1952). Paul Hawley, director of the ACS, declared that some doctors were attempting to “re-code medical ethics in a way which will legitimize practices which have, for many years, been regarded as inimical to the interests of patients, and so are condemned” (Hawley 1952).

From 1953 on, AMA members made several proposals to amend the Principles of Medical Ethics in ways that chipped away at fee splitting and commercial restrictions (AMA Proceedings: June 1953, June 1954). Ophthalmologists sought permission to sell eyeglasses. Several other resolutions would have allowed physicians to dispense drugs. One proposal would allow doctors in group practice to divide income according to a *percentage* arrangement, presumably allowing income from referral within a practice to be shared (AMA Proceedings: December 1953). A journalist observed that some physicians even advocated *allowing* fee splitting (Williams 1948).

Despite pressures to liberalize the Principles of Medical Ethics to allow previously forbidden commercial practices, the AMA maintained its code provisions against fee splitting and related practices early in the 1950s. As the decade progressed, however, the AMA defined fee splitting more narrowly, and passed judgment more softly and less frequently. It also attempted to silence members who opposed fee splitting and abandoned its traditional hostility to physicians as entrepreneurs who engage in self-referral. Although it is hard to say what produced this change, a special report by the AMA on the causes of fee splitting in 1955 observed that fee splitting was driven by economic circumstances and was not easily stopped. “Little hope” remained, said the committee, “of ending the practice with plans imposing more oaths, rules, restrictions, CPA audits, and inspections” (AMA Proceedings: June 1955).

The ACS responded differently to these pressures; it launched an anti-fee-splitting campaign, often clashing with the AMA. The ACS issued two reports on fee splitting in 1951, and in 1952 waged a publicity

campaign that included round-table discussions with the ACS regents and the press on ethics and fee splitting. As part of this campaign, Dr. Hawley, an AMA member and director of the ACS, gave an interview to *U.S. News and World Report*; he said that fee splitting was prevalent and led to unnecessary surgery. The same claim was reiterated in the medical and popular press (*U.S. News and World Report* 1953; Deutsch 1947; Williams 1948, 1952; Daseler 1955). *Colliers* published an article in 1953 called "Why Some Doctors Should be in Jail" (Whitman 1953). *The Bergen Evening Record*, a newspaper of Hackensack, New Jersey, declared, "Fee-splitting has been like venereal disease was a few years ago; it existed, but nice people did not talk about it" (quoted in Whitman 1953).

The response of AMA members to the ACS campaign was swift and vehement. The Chicago medical society initiated disciplinary proceedings against Loyal Davis, a prominent member of the ACS, for speaking out against fee splitting without obtaining their permission (Davis 1960; AMA Proceedings: June 1953). AMA members introduced 11 resolutions condemning the Hawley interview (AMA Proceedings: June 1953). These resolutions, many prefaced with angry denunciations, attacked Hawley and the ACS and called for disciplining or censuring Hawley and others. Other resolutions called for "controlling public expressions of [AMA] members," and also called on the AMA to mount a publicity campaign showing that AMA members were opposed to fee splitting and "reassuring the public that, although a single infraction of medical ethics is serious, still, such unethical practices are the exception rather than the rule," a statement contradicted by earlier AMA reports.

The AMA Committee on Legislation and Public Relations deferred action on the resolutions against Paul Hawley, stated that few doctors violated the Principles of Medical Ethics, and referred the matter to the Judicial Council. The Judicial Council never responded explicitly. However, a 1954 Judicial Council report mentioned the publicized discussion of fee splitting and "recommend[ed] a moratorium from the constant discussion of 'principles' about fees. . . ." (AMA Proceedings: June 1954). Although not an official policy, the statement reflected AMA practice. Until the 1980s, fee splitting was neglected, except for reports complaining that ACS public statements on fee splitting harmed the profession (AMA Proceedings: November 1961; June 1962).

The AMA and ACS also differed on whether to support state anti-fee-splitting laws. The AMA had officially supported such legislation in

1948 (AMA Proceedings: November 1948). However, it reversed itself in 1953 when the ACS proposed that the AMA Board of Trustees urge its House of Delegates to support state legislation against fee splitting in states that had no laws. The AMA did not support such efforts, saying that legal prohibitions had not accomplished anything (Davis 1960).

The AMA's Retreat from Prohibitions

The pressure for change led the AMA to reinterpret and redraft its Principles of Medical Ethics. To be sure, it purported to preserve fundamental values. But in revising its principles, the AMA permitted practices previously prohibited by eliminating strictures against physicians who dispensed medical products, owned medical facilities, and entered into joint ventures with medical suppliers and providers. To see the change one need only contrast the AMA restatement of its traditional position in the early 1950s with the positions it took after 1955.

For example, a resolution in 1950 required that the Council on Medical Education expel any hospital from its approved list if the hospital discovered that a staff physician had engaged in unethical conduct but did not remove the physician (Hirsh 1984). In 1952, the Judicial Council declared that physicians may not serve as associates in clinics *and* receive compensation for referring patients to the same clinics (AMA Proceedings: 1952). In 1953, the Judicial Council proclaimed it unethical for physicians to have a financial interest in pharmacies or to profit from the sale of devices or remedies they prescribed (AMA Proceedings: December 1953).

In 1954 the House of Delegates adopted revised Principles of Medical Ethics, which were more stringent than ever before. The principles deemed unethical "any inducement (for referral) other than the quality of professional services" (AMA Proceedings: June 1954). These inducements included not only split fees but also loans, favors, and gifts. The prohibition was not limited to *secret* payments, but included any "emoluments with or without the knowledge of the patient" (AMA Proceedings: June 1954). In addition the principles also stated that it was unethical for physicians to "engage in barter or trade in appliances or devices or remedies prescribed for patients."

As time passed, these positions were whittled away. First in 1955, to allow dispensing of drugs; in 1957, to allow physicians to dispense drugs and devices if it was "in the best interests of the patient"; in 1959 and

1961, ownership of pharmacies was permitted “as long as there is no exploitation of the patient” (AMA Proceedings: November 1954, June 1955, December 1959, November 1961, June 1962). The AMA did not explicitly give carte blanche to physicians; some dispensing could be regarded as unethical. However, no guidance or explanation was given to the question of how to distinguish the ethical from the unethical.

In 1957, the AMA revised and shortened its Principles of Medical Ethics. The 1912 version’s 3,000 words, composed of 48 sections, were reduced to 10 sections and 500 words. The 1957 principles weakened standards. For example, the earlier principles had stated that physicians should limit their professional income to medical services. The 1957 version allowed services “rendered under their supervision.” This change permitted physicians to hire allied health professionals, like physical therapists, and to profit from referring patients to these colleagues working in their office.

Despite the injunction to act in patients’ interests and not exploit them, the new standard constituted a retreat from previous policy. In the past, clear rules delineated proper and impermissible conduct. The new standards left individual doctors to their own consciences. Although the language of the new policies may sound impressive, in effect it allowed a low standard of conduct. No other professional group has declared it to be ethical to exploit clients or to act contrary to their interests. By allowing doctors to judge their own conduct, the changes reversed previous AMA policy.

Alternatives to Fee Splitting

Let us now consider in more detail the innovations in practice that emerged during this period as alternatives to fee splitting. The three main ones were employing referring physicians, practicing itinerant surgery, and changing institutions and medical practices.

Employing Referring Physicians. As early as 1899, G. Frank Lydston had described the practice of referring physicians assisting in surgery as a cover for fee splitting (Lydston 1899). Although the ACS maintained its public opposition to the practice, the AMA was swayed by its supporters in 1960 (AMA Proceedings: November 1962; American College of Surgeons 1960a). Proponents of the practice argued that it was different from fee splitting—and ethical—because the payment would not be secret, and physicians would only be paid for services they performed.

In 1952 a physician named W.L. Downing even promoted the practice as a way to *eliminate* fee splitting. He argued that if surgeons

utilize the general practitioner in caring for their surgical patients . . . in diagnosis, counseling, operative assistance and care and charge a joint fee and divide it equitably with their full knowledge, 'fee splitting, secret division for mere reference' will soon be a thing of the past. (Downing and Hawley 1952)

Apparently, Dr. Downing's advice was followed. In Massachusetts, in the late 1950s, Blue Shield developed fee schedules to pay 15 percent of the surgical fee to compensate physicians who assisted in surgery and 15 percent to pay physicians who performed follow-up care (McCann 1958). This plan accommodated interests pushing for fee splitting, although regulating the practice. Presumably, surgeons would use the "deduction and allocation" procedure only when they could not perform aftercare, or when they performed the surgery away from their main hospital, where they would have staff to assist. In such cases, paying referring physicians to assist in surgery might be deemed a necessary exception. However, it was unlikely that these procedures could be confined to the exceptional cases. The ACS opposed the Massachusetts "reform," saying it "greatly restricts the application of the traditional definition of fee-splitting" (American College of Surgeons 1959). Robert Meyer, executive assistant director of the ACS, said that kickbacks had been replaced with similar practices, particularly hiring referring physicians as surgical assistants who performed pre- and postoperative care (Meyers 1960).

Itinerant Surgeons. The other practice akin to traditional fee splitting that started around 1960 was "itinerant surgery": the custom of calling a distant surgeon to perform surgery while leaving the pre- and postoperative care to those who summoned the surgeon. Itinerant surgery provided additional work for participating surgeons and also for the hospitals that provided the patients and called in the surgeon. The ACS argued that in most circumstances itinerant surgery promoted poor quality of care because surgery was not coordinated with postoperative care; surgeons were not available for consultation afterward; competent surgical teams and assistants did not work together; and local community hospitals that engaged in the practice did not develop their own staff of surgeons (American College of Surgeons 1960b, 1962). Al-

though “itinerant surgery” subsided, in the 1980s the practice re-emerged under the rubric of “outreach surgery” (Hanlon 1989).

Institutional Changes in Medical Practice. For-profit medical schools were widespread in the nineteenth century and commercial ties distorted their educational functions; they did not adequately train physicians. After the Flexner report in 1910, which promoted medical schools as scientific and educational institutions, medical schools were reluctant to become the base for so called faculty-practice plans—under which faculty practiced part time in affiliated hospitals and clinics (Flexner 1910). In the mid-1950s, however, the exponential growth of medical school faculty-practice plans constituted an increasingly important source of revenue for medical schools and their affiliated hospitals (MacLeod and Schwartz 1986). Between 1960 and 1985, the number of faculty-practice plans increased almost 20-fold, from 6 to 118. Faculty-practice plans provided a steady flow of patients to hospital-affiliated surgeons, thus dispensing with the need for surgeons to pay kickbacks for referrals.

Hospitals, of course, are not immune from using kickbacks to get physicians to admit patients, even today (Bogdanich and Waldholz 1989).⁴ Starting in the 1950s, however, hospitals evaded kickback restrictions with functional equivalents: financial incentives for referrals. An example shows how past practices were mimicked. In the 1940s some surgeons developed “feeders” by paying doctors just starting a practice 110 percent of their fee for referrals initially and then, over time, reducing the rate until it reached the standard 50 percent split (Williams 1952). The surgeon subsidized young physicians with a loss-leader, and achieved long-term loyalty and referrals.

Similarly, in the mid-1950s, hospitals established ties with practitioners that subsidized their practices and prompted them to refer patients. They provided physicians in private practice with office space in buildings in or near the hospitals, often with subsidized rent. The use of such incentives—moderate at first—took off after the creation of Medicare and Medicaid in 1966 increased hospital funding. When physicians had incentives to admit patients to a hospital, affiliated surgeons reaped the benefit: they received a steady flow of patients without having to pay for them.

⁴ *United States of America v. Russell Furth*. March 11–14, 1986. U.S. D.C. (S.D. Texas, Houston Division) Doc. No. H-85-721 (transcript).

By the late 1970s many hospitals guaranteed up to three years' income for physicians in private practice as part of so-called recruitment programs. They also loaned doctors money at subsidized rates, paid for office space or administrative expense, invited physicians to invest in joint ventures that gave doctors a stake in hospital outpatient or diagnostic facilities, and offered other financial perks. Later, some hospital chains even sold shares to local physicians so they would have a stake in the hospital's financial profits (Rodwin 1993).

The AMA's Response

As new ways of organizing medical practice made it possible for physicians to earn income from their referral decisions and bypass traditional fee splitting, the AMA continued to retreat from its earlier official condemnation of physician ownership and self-referral. Until 1980 the Judicial Council still stated that physicians should limit professional income to medical services they provided or supervised (AMA Reports: 1969, 1977). Yet in 1965, the Judicial Council said it was proper for physicians to invest in nursing homes or similar facilities, providing patients could choose their doctor (AMA Proceedings: 1965; Hirsh 1984). In 1969, a resolution was introduced that would have declared it unethical for physicians to own stock in firms that owned or operated hospitals to which physicians could steer patients (AMA Proceedings: November 1969). The House of Delegates directed the matter to the Judicial Council, which concluded that physician-owned hospitals provided benefits to patients and that it was improper to declare a class of physicians unethical by a resolution without investigation of all the individual facts and circumstances. The lack of AMA restrictions effectively encouraged physicians to form joint ventures with hospitals and benefit from referrals to hospital facilities and clinical decisions that cut costs.

In 1976, the AMA entertained resolutions that would require their House of Delegates to adopt ethical guidelines relating to physician ownership of expensive diagnostic technology (AMA Proceedings: June 1976). After studying the matter, however, the AMA decided not to develop specific guidelines. It approved physician ownership, stipulating only that "physician ownership of equipment should not involve abuse or exploitation of the physician-patient relationship" (AMA Proceedings: June 1977).

The Ethics of Markets: 1980 to 1992

The Physician as Entrepreneur

After Ronald Reagan's election in 1980, the federal government promoted greater use of market competition in the medical care sector. The use of market forces was seen as a way to reduce medical care spending that would be more effective than regulatory controls (Altman and Rodwin 1988). Once again, the AMA revised its Principles of Medical Ethics by eliminating code provisions that regulated competition among physicians or addressed other commercial issues. Their move to revise was in reaction to court decisions in the late 1970s and early 1980s that ended the professional exemption from antitrust liability and to the chilling effect of private antitrust suits brought by disciplined physicians against the ACS.⁵ The 1980 AMA Principles dropped the injunctions against fee splitting and earning income outside of services performed. No mention was made of other economic issues, such as dispensing drugs and appliances, ownership of pharmacies and other providers, or deriving income from patents. Today's principles contain no statement on the issues that were a focus of the AMA ethical concerns for nearly 80 years. Antitrust law now prevents the AMA from restricting advertising and certain other commercial practices. It does not require that the AMA abandon all its ethical positions; nor does it prevent the AMA from developing comprehensive conflict-of-interest policies (Arquit 1992; Moreland 1992).

The AMA may contend that its policy has not changed because many of its previous positions can be found in the opinions published by its Council on Ethical and Judicial Affairs. However, the fact that the AMA removed portions from the principles diminishes their importance; the reassigned parts are no longer treated as fundamental. Furthermore, as the AMA revised its ethical opinions, some have been dropped or circumscribed.

These revisions helped to undermine previously accepted values. As hospitals began using financial inducements to secure physician compliance with their economic goals, older fee-splitting restrictions appeared

⁵ *Goldfarb v. Virginia State Bar Association*, 421 U.S. 773 (1975); *American Medical Association v. Federal Trade Commission*, 638 F. 2d 448 (1980) affirmed, 101 S. Ct. 3107 (1982); *Koefoot v. American College of Surgeons*, 652 F. Supp. 882 (1986); 692 F. Supp. 843 (1988).

to be antiquated. In 1984, the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), which had taken over the ACS hospital accreditation program in 1952, eliminated its stipulation that hospital bylaws require physicians to pledge not to split fees. This policy, initiated by the ACS in 1918 as a means to promote both quality of care and professional ethics, had been neglected since the commission's assumption of control of the hospital standardization program in 1952 because the commission's focus was on standards of technical performance. From 1952 to 1983 the commission included anti-fee-splitting requirements in its model bylaws, but did not require that hospitals adopt such policies. When the Joint Commission stopped writing model bylaws in 1983, it reinstated the anti-fee-splitting requirement as a standard. Yet the following year, the commission dropped the standard and stopped trying to guide ethics (M. Conklin and P. Van Schoonhoven, Joint Commission 1990: personal communication).

In this climate it was easy to develop other means to receive patient referrals that bypassed classic fee splitting and instead relied on self-referral. Physicians who would potentially refer patients were offered limited partnerships in ventures with physicians, hospitals, and other providers. Self-referral was more subtle than a kickback. Referring limited partners did not make money for each referral; these physicians did, however, have a financial stake in the enterprise, and earned income if it turned a profit. They avoided kickbacks but were subject to similar referral incentives.

In the 1980s, the medical profession and the public alike became increasingly concerned over the growth of for-profit health providers and the role of the physician as an entrepreneur. Arnold Relman, editor of the *New England Journal of Medicine*, called attention to "The New Medical-Industrial Complex" (Relman 1980). The first prominent physician to declare that physicians *had* "conflicts of interest," he argued that the medical profession needed to develop ethical guidelines (Relman 1985b). He also suggested that physicians should not be entrepreneurs, or at least not engage in economic self-dealing transactions or sell collateral services or products that they prescribe (Relman 1983; 1985a,b; 1986; 1987a,b; 1988). The Institute of Medicine produced two volumes on for-profit medicine (Gray 1983, 1986). Dr. Relman and economist Uwe Reinhardt engaged in a series of dialogues and letters on

the business and professional aspects of medicine; the language of conflicts of interest entered medical discourse (Relman and Reinhardt 1986).

The AMA Conflict of Interest Guidelines

In response, since 1984 the AMA Council on Ethical and Judicial Affairs has issued numerous reports and opinions addressing conflicts of interest, culminating in 1986 with conflict-of-interest guidelines and a major report defining AMA policy through 1991 (AMA Proceedings: June 1984; American Medical Association 1986b). The reports show that, although the AMA still publicly opposes splitting fees and payments linked directly to referrals, it replaced rules that used objective standards to delineate proper from impermissible conduct with vague prescriptions and subjective standards.

The 1986 AMA conflict-of-interest guidelines adjured physicians to act in their patients' interests; to resolve all conflicts on the patient's behalf; and to make arrangements for alternative care when doctors' interests are incompatible with those of their patients (American Medical Association 1986b). However, the association did not establish criteria to guide this behavior. It allowed, perhaps even indirectly encouraged, physicians to enter situations fraught with conflicts of interest, placing the burden on doctors to act properly. Physicians who wondered whether they should change their behavior did not have guidance in an extensive or systematic set of rules, examples, cases, or a bureau—such as the American Bar Association provides lawyers—to give advice on conflicts of interest.

The 1986 AMA guidelines relied almost exclusively on disclosing conflicts to patients, except for recommending some protections already legally required. For example, the AMA allowed physician referral to facilities in which they invest, requiring only an "ethical obligation to disclose his ownership . . . to his patient prior to admission or utilization" (American Medical Association 1989a). Rather than discourage physicians from entering into joint ventures that create conflicts, the AMA produced a manual explaining how such arrangements can be structured (American Medical Association 1986a). The only restriction: the doctor must act in the patient's interest. Each doctor was left to determine the patient's interest, using his or her subjective impressions.

Supposedly, disclosure allows patients to choose between their own

physician's facility and an independent one, but it may protect physicians more than patients (Rodwin 1989). Disclosure helps to insulate physicians from liability.⁶ Patients, however, are rarely able to evaluate the information and they do not have significant new options; the advice their physicians provide is still compromised. Conflicts of interest can affect a physician's assessment of whether a medical service is needed—not just who should provide it. Bias in recommending a particular facility is only part of the problem. The more fundamental threat: ownership compromises the doctor's assessment of whether the service is needed.

The AMA's own studies confirm that its disclosure policy is not effective. A 1989 survey of members found that nearly one-third admitted they did not comply with AMA ethical disclosure guidelines (American Medical Association 1989b). Furthermore, in areas where we have more experience with disclosure—such as informed consent—results are also disappointing. Physicians are supposed to disclose the risks and benefits of proposed medical therapies, but studies show that compliance is low, and full disclosure rarely occurs. Even when information is accurate, it is not always accessible.

The AMA conflict-of-interest guidelines did not prohibit physicians from performing any role, entering into any situations, or engaging in any transactions not already of dubious legality. AMA opinions stated that it was unethical for physicians to split fees, or receive payments, for prescribing a product or making a referral. But kickbacks are now prohibited by 36 state laws, as well as by the federal Medicare and Medicaid fraud and abuse statute.⁷ The organization stated that when physicians refer patients to a facility in which they have a financial interest, they must allow the patient to choose an alternative. Patients have this right by law. The AMA opposed direct hospital incentive payments to physicians under Medicare to reduce medical services. Such payments are illegal for Medicare patients (AMA Proceedings: June 1984). Where the law was silent, the AMA shunned restrictions and opted for *laissez faire*.

⁶ *Cipollone v. Liggett Group, Inc.*, *U.S. Law Week*, 60:4703-4717 (U.S. S.Ct., June 23, 1992); 789 F 2d 181 (3rd Cir. 1986). *Humes v. Clinton*, 792 p.2d 1032 (1990). *East Penn Mfg. Co v. Pineda*, 578 A.2d 1113 (D.C. Ct App. 1990).

⁷ 42 U.S.C. Section 139nn(b), as amended by P.L. 100-93; 101 Stat 680 (1987); 42 U.S.C. Sections 1320a-7b(b). Omnibus Budget Reconciliation Act of 1989. P.L. 101-239, Title 6.

The AMA guidelines are, in effect, voluntary. The AMA has no procedures for monitoring compliance or for investigating professional misconduct. The strongest sanction the AMA can impose is to revoke membership, a power rarely exercised and not particularly onerous because AMA membership is not necessary to practice medicine; fewer than one-half of American physicians are members.

Moreover, the AMA itself is unlikely to revoke membership for violation of its ethical codes; it leaves that to state medical societies. The AMA will revoke membership for only the most egregious wrongs: if physicians have been convicted of fraud or a felony involving professional misconduct or moral turpitude; if their licenses have been revoked by a state medical society for incompetence or unprofessional conduct; or if they have been discharged from the armed forces or government employment for incompetence or unprofessional conduct (AMA Proceedings: June 1987). However, the AMA relies on others to notify them of disciplinary actions, and this may not occur. The AMA, which conducts copious annual surveys on physicians' practices, incomes, and other issues, does not even release data on the number of members it has dropped (N. Watson, American Medical Association 1992: personal communication).

In effect, the AMA leaves enforcement of its guidelines and principles to state medical societies and licensing boards. Yet a 1983 AMA survey found that most state medical societies had not disciplined any members in the last five years (Hirsh 1984). To the extent that physicians are ever disciplined, licensing boards oversee it. These boards follow laws set down in state statutes. In general, they focus on medical competence or gross fraud and abuse, but most states also have provisions that allow discipline for "conduct unbecoming of a physician," which can be interpreted to include ethical infractions.

Recent Developments

By 1989 Representative Pete Stark's (D-Cal.) efforts led to federal legislation (OBRA 1989) that prohibited physicians from referring Medicare patients to clinical laboratories in which they invested and required reporting of other self-referrals (Iglehart 1990). The AMA opposed the legislation while the ACS supported it. Representative Stark made clear his desire to extend such restrictions in the future. Numerous empirical studies have now documented the extent of physician ownership and

shown that a direct financial interest by physicians in referrals affects the volume of their referrals (Michigan Department of Social Services 1981; U.S. Department of Health and Human Services 1983; Hillman 1987, 1989; Hillman et al. 1990; Kusserow 1989; Hemenway et al. 1990; Florida Cost Containment Board 1991). Furthermore, an appellate decision in a lawsuit brought under the Medicare anti-kickback statute made clear that many existing physician-owned ventures risk legal liability for physician self-referral (Crane 1992).⁸

Only then, in December of 1991, did the AMA modify its stance. The AMA still declared that self-referral could be ethical and desirable, but it went on to say that the medical profession needed to maintain its professionalism and declared that the practice of self-referral to physician-owned facilities was "presumptively inconsistent" with the physician's obligation to patients where adequate alternative facilities existed (American Medical Association 1991). Although this position made AMA policy conform to emerging legislation while staving off greater prohibitions, it still left loopholes. Physicians could still self-refer if they deemed the alternative facility not "adequate." No effort was made to define what distance a patient would have to travel, or how different a facility would have to be, before it was deemed not equivalent or not suitable as an alternative. Equally important, the AMA has no mechanism to enforce the new policy.

How does one explain the AMA's recent switch? Although some groups within the AMA oppose self-referral as an end in itself, quite possibly the move is a political stance to stave off federal regulation and promote physician autonomy. One AMA report suggests as much. After discussing federal legislation first proposed in 1988 by Representative Stark that would regulate physician self-referral, the report proposed committees to oversee the ethics of joint ventures between physicians and hospitals, ventures in which physicians self-refer. The report states, "The Board of Trustees believes that increased promotion of ethical guidelines by the profession will discourage unethical conduct . . . and obviate the pressures for federal intervention" (AMA Proceedings: June 1989).

In any event, the anti-self-referral ethical guideline is on weak footing and may be short lived. State medical societies have actively op-

⁸ *Inspector General v. Hanlester Network et al.* September 18, 1991. Final Decision on Review of Administrative Law Judge.

posed the guideline, which suggests that enforcement will be minimal (McCormick 1992a). Moreover, powerful groups within the AMA oppose the guideline and proclaim a different policy. In June 1992 the AMA House of Delegates passed a resolution that declared physician self-referral appropriate so long as patients were told of the ownership and the existence of alternative facilities, a position that had been rejected by the Council on Ethical and Judicial Affairs the previous December (AMA Proceedings: June 1992; McCormick 1992b). Thus the House of Delegates and the Council on Ethical Judicial Affairs have split and the AMA now has no clear policy on self-referral.

Medical subspecialty groups also have codes of ethics, but, like the AMA, they cannot ensure compliance. Even the ACS, which championed the fight against fee splitting, is ambivalent on other conflicts of interest. Their principles declare that "professional income should come from professional services, and not from the sale of drugs, appliances, spectacles, etc." Yet it allows physicians to sell such products to patients "when it is in the best interest of the patient, and there is no exploitation of the patient" (American College of Surgeons 1985). The ACS policy makes individual doctors the arbiter of whether they meet these amorphous criteria.

Conclusion

This history has shown that physicians' financial conflicts of interest arising from fee splitting, self-referral, entrepreneurship, and other commercial practices are not new. The organized medical profession faced these issues, although only indirectly and partially, for over a century. Contrary to popular belief, the AMA's stance on these matters became weaker after the 1950s as conflicts of interest became more complex and increased spending on medical care raised the financial stakes. When the AMA ethical code announced a strict official position against fee splitting and various commercial practices early in the century, it was unable to hold physicians accountable. Later the AMA weakened its code to placate its members. Despite the AMA's contention that its code and principles of ethics promote the interest of patients, both were amended to reflect the economic interests of physicians.

Policy makers concerned over physician self-referral today may draw some inferences from the organized medical profession's experience with

fee splitting. Although existing evidence does not indicate whether fee splitting decreased or increased, it certainly has persisted despite professional self-regulation, and new variations arose that posed similar conflicts. Moreover, from the mid-1950s on, the organized medical profession tolerated, sometimes even encouraged, substitutes for fee splitting that are at the heart of today's debate about physician self-referral and conflicts of interest. Policy makers concerned about kickbacks and conflicts of interest would do well to address these issues broadly rather than focus on specific abuses. As in the past, narrowly tailored regulations are likely to spur the development of new practices with similar conflicts of interest designed to evade restrictions.

Unlike other professionals who are subject to extensive conflict-of-interest regulation—government employees, lawyers, and certain financial professionals working in business—physicians have addressed these issues largely on their own, and have been subject to minimal regulation by state and federal laws or even by professional codes. Professional self-regulation has not been particularly effective, however. The AMA addressed these issues primarily by relying on professional norms, individual discretion, and subjective standards. For many years the ACS explicitly condemned fee splitting. Both organizations lacked an effective means to hold physicians accountable.

What changes are likely in the future? The past offers some clues. Early in this century, critics of fee splitting and commissions charged that these practices led to unnecessary surgery and substandard care. Recent studies suggest that physician self-referral leads to higher utilization and costs and unnecessary services (Mitchell and Scott 1992a,b; Hillman et al. 1989, 1990; Hemenway et al. 1990; Kusserow 1989; Blue Cross and Blue Shield of Michigan 1984; U.S. Department of Health and Human Services 1983; Michigan Department of Social Services 1981; Childs and Hunter 1972). As researchers continue to document such connections, policy makers will become aware that many physicians' financial conflicts of interest can result in inappropriate medical care or increased spending. There will then be pressures for public intervention. Deference to physicians and lack of accountability—often the rule in the past—is unlikely to continue in a period when medicine has become not only big business, but also social business.

In the past, conflicts of interest arose mainly from medical practices and were left to be resolved largely by the medical profession. Today, however, physicians face new conflicts of interest—as well as the old—many of which are generated by policies and financial inducements of

third-party payers, governmental policies, and providers. In the future, powerful actors outside the medical profession, including insurers, providers, and governmental agencies, will shape the medical profession's and society's response.

Sooner or later policy makers will assess how their own policies encourage or discourage conflicts of interest. They might also consider trade-offs in addressing conflicts. Prophylactic measures that limit certain financial practices of physicians and providers may appear highly intrusive, and therefore undesirable. In the absence of such restrictions, however, government and third-party payers will have to spend resources on monitoring the conduct of physicians and providers to determine whether their clinical decisions are appropriate. Such monitoring is likely to be more costly for government and more intrusive for physicians.

Major innovations appear likely because of the stakes. In recent years other areas of medicine have been subject to protocols and standards. Third-party payers and governmental agencies are likely to push for similar oversight of physicians' financial practices, thereby transforming problems traditionally treated as the domain of professional and personal ethics into the realm of public policy. Such a transformation will not guarantee "solutions," but in light of the failure of professional self-regulation to come to terms with the problem, it is probably a necessary condition to conflicts of interest being effectively addressed.

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The American Medical Association's *Proceedings of the House of Delegates* are published each year and are available at major medical libraries. Summaries and excerpts of many of the proceedings cited are more easily found in several volumes of the American Medical Association's *Digest of Official Actions*. The AMA also periodically publishes *Principles of Medical Ethics* and *Judicial Council Opinions and Reports* (after 1985 renamed *Opinions of the Council on Ethical and Judicial Affairs*). Rather than adding these sources to the list, they are parenthetically noted in abbreviated form within the text as AMA Proceedings, AMA Principles, and AMA Ethical Opinions, respectively, followed by the appropriate dates.

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