Medical Commerce, Physician Entrepreneurialism, and Conflicts of Interest

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Is medical commerce a recent phenomenon? Does it distort the patient–physician relationship? Are investor-owned firms the main source of medical commercialism?[1] I contend that medicine has generally been commerce in the United States, that medical commerce is a problem when it creates or worsens physicians' conflicts of interest, and that these conflicts thrive in nonprofit organizations as well as in investor-owned firms. I provide a historical sketch to show that physician entrepreneurialism, rather than commerce generally, is the main source of physicians' conflicts of interest.

Physicians have a *conflict of interest* when they have an obligation to act in their patients' interest and have incentives to act in their own interest, also the interest of other parties or they perform roles that prompt them to act in the interest of third parties.[2] Conflicts of interest compromise physicians' loyalty to patients or their independent judgment in acting on behalf of their patients and thereby increase the risk that they may not fulfill their obligations. To reduce this risk, public policy and professional ethics sometimes restrict engaging in activities that create conflicts of interest or regulates them.

Self-employed physicians are entrepreneurs in that they earn profits and bear the risk of loss from their practice.[3] They sell medical services, tests, drugs, medical devices, and may own or invest in hospitals or other medical facilities. They have conflicts of interest arising from incentive to manage their practice and to advise, prescribe, refer, and make clinical choices that promote their income, even at the patient's expense.[4]

A Continuum of Entrepreneurial Opportunities in Private Medical Practice

The degree of entrepreneurial opportunities physicians have depends on how private practice is organized. Consider solo primary care practitioners, paid fee-for-service, who examine patients, diagnose problems, prescribe medicine, provide simple treatment, and refer patients to specialists. Such practitioners can increase their income by raising fees or providing more services, either by treating more patients or by performing more services for existing patients. If solo practitioners have more time than patients, pursuit of income might lead them to perform unnecessary services.

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By marketing their services, solo practitioners expand opportunities to generate income. They can solicit patients through advertisements or offer free or discounted services to develop patient relationships. They can also pay medical providers or laymen to refer patients. Two physicians in different specialties can generate fees if each one refers all their patients needing certain services to the other colleague.

Physicians create additional sources of income when they expand the range of services they provide. They can train to perform additional kinds of medical procedures or learn medical specialties. They can also perform related services sometimes provided by others, such as laboratory or diagnostic tests, or dispense medicine. Self-employed physicians can further increase their income by employing allied health professionals or other physicians. Nurses or assistants can increase physician productivity and the number of patients treated. Personnel can also perform ancillary services, such as diagnostic and laboratory tests. Physician employers profit when the fees that their employees generate exceed their compensation.

Physicians in group practices increase income by referring patients within, rather than outside their practice. Group practices facilitate the supply of ancillary service by sharing the cost of equipment and personnel. As the volume and scope of services increase, so do opportunities to generate income through prescriptions and referrals. Group medical practices can provide many traditional hospital services. Physicians can also tap income from such services by owning or investing in free-standing facilities.[5]

Three Phases of Commerce and Entrepreneurialism

The evolution of medical commerce tracks the rise and subsequent decline of organized medicine—principally the American Medical Association (AMA)—as a force shaping the organization of the medical economy, often to promote the financial interest of physicians. It also reflects the development of medicine and the national economy.

It is helpful to distinguish between three periods of medical commerce.[6] In the first phase, from the colonial period until the last decades of the 19th century, doctors had an entrepreneurial role in that they sold their services and medicine. However, an undeveloped market restricted entrepreneurial opportunities and income. Physicians had few services and products to sell, they competed with alternative healers, and most people had little income to pay for medicine.

During the second phase, roughly from 1890 through the mid-20th century, physician entrepreneurship became profitable. The value of physician services increased due to developments of knowledge and improvements in technology. Organized medicine promoted a protected market that sheltered physicians from competition, oversight, and countervailing power, while restricting some forms of physician entrepreneurialism. Private health insurance was created and this ensured physicians of payment. Hospitals subsidized private medical practice. Physicians became intermediaries between patients and drug firms and in other ways also developed a privileged position in the medical economy.

In the third phase, from the mid-20th century until today, organized medicine relaxed its restraints on physician entrepreneurship. Then professional

control over medical markets ended through increased government regulation, market competition, and the third-party payers using their purchasing power to influence the medical economy.

Physicians today are not encumbered by organized medicine's earlier restrictions on entrepreneurship. However, they are subject to competition from lay-owned firms and subject to countervailing power and oversight from third-party payers and government. Nevertheless, physicians have opportunities to profit that others lack. Doctors control the use of medical services through their clinical choices, prescriptions, patient referrals, and the tests they order. They control patient admissions to hospitals and the timing of their discharge. Physicians have a personal relationship with patients who trust and rely on them. Physicians can exercise their clinical authority to promote their income. Many potential competitors and lay firms create joint ventures or other financial ties with physicians to encourage physicians to make clinical choices in ways that generate revenue or minimize resources expended.

Phase 1: From the Colonial Period through the 19th Century

In colonial and early America, a significant amount of medical care was provided by nonphysicians. Women took charge of healing as part of their household work without remuneration. Alternative healers and sects also provided healthcare. Furthermore, there were few obstacles to individuals engaging in medical practice. Most physicians had little training aside from apprenticeships. Physicians often supplemented their meager income from medical practice by engaging in other work.

Following the War of 1812, medical schools multiplied.[7] Most were physician owned or operated, for profit. There was no system of school accreditation, developed curriculum, or standards for admission or graduation. Medical schools flooded the market with poorly trained physicians.[8] A few states had medical licensing laws, a holdover from European medieval guilds, but most allowed all medical school graduates to practice. And between 1817 and 1850, nine states repealed their licensing statutes.[9]

Physicians in the 19th century had few tests to perform or supplies to sell and earned income mainly by selling their services. They sometimes sold medicine, but competed with pharmacists and laymen, who sold medicine without prescriptions. There was no insurance, so physicians could not collect more than their patients could pay and thus often discounted their fees, a practice economists call price-discrimination: maximizing revenue by charging whatever amount each purchaser can pay.

Almshouses aided the poor, orphans, elderly, and mentally ill and provided these groups medical care as well. In the late 19th century, many almshouses were transformed into hospitals for the poor. Public authorities and religious and secular charities also founded hospitals and dispensaries for the poor. Some physicians volunteered their services in charitable hospitals part-time to gain experience or train their students. However, most physicians worked in private practice without contact with hospitals.[10]

Most physicians did not join local or state medical societies because they conferred few benefits. In 1847, state medical societies formed the AMA, but it had few members, resources, or clout until the 20th century.[11] At its founding

meeting, the AMA adopted a code of ethics, which it used to bolster its authority over medical practice.[12]

The AMA code portrayed medicine as different from other commerce but assumed that physicians should be self-employed and sell their services. It held that physicians should not engage in certain practices including advertising, selling medical supplies and products, earning commissions from medical suppliers for using or recommending their products, or accepting kickbacks (typically known as fee splitting) for referring patients to doctors. Physicians were not to compete by reducing fees, stealing patients from other doctors, disparaging colleagues, or by bringing disrepute to the medical profession.[13] The code condemned secret nostrums, also called patent medicine (i.e., medicine with secret contents), which were typically sold by laymen and sometimes by physicians.

Phase Two: Medicine in the First Half of the 20th Century

The Transformation of Hospitals

Traditionally, hospitals served the poor, and physicians who worked in them were not permitted to charge patients fees. Thus in the 19th century most physicians never set foot in hospitals. This changed in the early 20th century as medicine developed new ways to perform surgery, clinical tests, and diagnosis. Hospitals were transformed from marginal institutions for the poor into centers of medical practice.[14]

Around 1890, not-for-profit and publicly owned hospitals began to seek middle-class patients and charge them fees, but physicians were still not allowed to bill patients.[15] Physicians began to view hospitals as competitors that siphoned away patients physicians might have treated in private practice. At the same time, access to hospitals became crucial for physicians to perform surgery, use X-ray and other diagnostic equipment, and maintain a relationship with their patients.

Hospitals depended on physicians to care for patients and also to refer patients who could pay fees. Yet, physicians were potential competitors. Some physicians—particularly those not located near hospitals or not allowed to practice in community hospitals—opened private hospitals for patients who could pay fees, and this reduced physician referrals of patients to independent hospitals. By 1925, 32% of hospitals, with 7.5% of all hospital beds, were physician owned.[16] In addition, according to the AMA in 1933 there were 1165 hospitals with closed medical staffs.[17]

Tensions between physicians and hospitals were eventually reconciled by creating a unique American hospital system. Hospitals used an open medical staff that allowed all qualified physicians to apply for privileges to admit patients or practice in the hospital. Physicians remained self-employed and billed patients for medical care they performed in the hospital.[18] Nonprofit hospitals, funded by charity and government subsidies, exempt from taxes and other requirements, dominated the hospital sector. Physicians did not earn income directly from hospital services. However, doctors used hospital resources—their equipment, laboratories, and the work of nurses and interns—without cost, to provide their own services through which they earned their living. Nonprofit hospitals became a subsidized workshop for physicians in private medical practice.

Medical Licensing and the Demise of Physician-Owned Medical Schools

States began enacting medical licensing statutes again in the 1870s. By 1898, every state had a licensing statute that set forth qualifications and empowered state boards to screen candidates. Typically, boards were composed of physicians nominated by the state medical society. By 1905 all but three states required physicians to pass state medical exams and to have graduated from approved schools in order to practice. State licensing, in conjunction with medical education reform, led to the demise of physician-owned for-profit medical schools and their replacement by not-for-profit and state-owned institutions. As state laws limited entry into practice, physicians with licenses were insulated from competitors and medical licenses gained economic value.[19]

The Growth of Organized Medicine and the Drug Commerce

In 1901 the AMA reorganized. Under the new system the AMA represented local and state medical societies and membership grew from 8000 in 1900 to 70,000 in 1910. By 1920, 60% of physicians were AMA members.[20] Increased membership generated revenue for the AMA and state medical societies and allowed them to become a significant political force in medical affairs.

The AMA had condemned patent medicine since 1847, but its medical journal depended on their advertising revenue. By 1905 the AMA had boosted membership dues enough to end its dependence on patent drug advertising. The AMA created a Council on Pharmacy and Chemistry to test and approve drugs. Firms seeking to have their drugs approved had to label drug contents, not advertise to the lay public, and not provide information for patient self-medication. The AMA journal only advertised approved drugs.

The AMA policy created two distinct systems for drug marketing: Either firms marketed drugs to doctors through medical journals or they marketed drugs to the public. Most drug firms shifted their marketing to physicians through medical journals, generating revenue for the AMA and state medical societies. Medical journals became dependent on drug advertisements. Physicians became intermediaries between drug companies and patients. However, until the 1938 Federal Food, Drug and Cosmetic Act, except for narcotics, drugs could be sold without a prescription, so the physician's control over drug use was not yet complete.[21]

Organized Medicine, Private Medical Practice, and Health Insurance

In the early 20th century, the AMA and state medical societies championed a system in which physicians practiced medicine with little competition or oversight from corporations, government, and laymen.[22] Medical societies had authority over physicians because membership was necessary to obtain hospital privileges, referrals from colleagues, and malpractice insurance. Medical societies often used the AMA code to control the organization and financing of medicine. For example, they often expelled and boycotted physicians who did not follow their fee schedule or worked for prepaid group practices, which were viewed as a threat to traditional physician-owned private practice.[23] Medical societies engaged in such practices with impunity because the Supreme Court

held that medicine was a "learned profession" rather than "a trade or commerce" and thus exempt from antitrust prohibitions on the restraint of trade.

Some industrial employers had hired doctors to provide medical care for their employees starting in the 1870s. This practice continued in the 1920s, and benevolent societies also engaged physicians at fixed fees to treat their members. Organized medicine called such *contract practice* unethical. It also condemned lay-owned firms that employed physicians to provide medical services to the public, a practice it called "*the corporate practice of medicine*."[24] Later, courts and legislatures in several states prohibited the corporate practice of medicine.

The AMA opposed enactment of governmental health insurance programs from the progressive era on, except for a short period between 1917 and 1919.[25] In 1934, it published principles of insurance.[26] These held that private insurers should not be intermediaries between physicians and patients or restrict physicians from setting fees, prescribing, or practicing medicine. The AMA opposed private health insurance that did not conform to these principles. The insistence on free choice of physicians limited patient's free choice of alternative insurance arrangements such as prepaid group practice and competing provider networks. It promoted a protected medical market that limited competition among physicians.[27] Drawing on its principles and its guidelines on contract practice and the corporate practice of medicine, the AMA and local medical societies opposed the growth of prepaid group practice, an early form of HMO, stifling their growth. Medical societies in Oregon, Washington, Washington, D.C., California, and elsewhere boycotted physicians who worked for prepaid group practices or medical co-ops.

In the 1930s, hospitals and community groups formed not-for-profit Blue Cross plans to offer hospital insurance in line with AMA insurance principles.[28] The success of Blue Cross led commercial insurers to offer competing policies. Later, not-for-profit insurers called Blue Shield, controlled by physician groups, sold insurance for physician services, although the AMA had opposed such plans. Soon commercial insurers offered competing policies as well. By the mid-1950s, insurance covered half the working population and transformed the economics of medicine. Physicians no longer needed to lower their fees when insured patients had low income. They were free to set fees and perform whatever services they prescribed without financial constraints. And physicians continued to operate as small entrepreneurs.

Phase Three: Medicine in the Second Half of the 20th Century

The Expansion of Physician Entrepreneurialism in a Protected Market

The AMA revised its ethical code in the 1950s while the medical market expanded due to federal funding of hospital construction and the growth of insurance.

First, the AMA limited enforcement of rules against fee splitting and allowed practices with incentives similar to fee splitting. For example, the AMA allowed surgeons to hire as assistant surgeons doctors who referred patients, a subterfuge for fee splitting. Then the AMA replaced clear prohibitions with standards that allowed entrepreneurial activities previously prohibited, so long as physicians did not "exploit patients." Physicians were permitted to provide ancillary

services, dispense medicine, sell medical products, employ healthcare providers, and own pharmacies. The AMA embraced physician entrepreneurship just as opportunities to profit from it increased.[29]

The AMA journal sought to boost advertising revenue in the mid-1950s. Based on their marketing consultants' advice, the AMA ceased its policy of advertising only drugs it had evaluated and approved, and pharmaceutical advertising increased.[30] In the second half of the 20th century, pharmaceutical firms also funded research and continuing medical education. To boost prescriptions, they showered physicians with gifts.[31]

In the late 1950s and early 1960s, there were numerous bills introduced in Congress to create a governmental insurance program for the poor and/or elderly. These bills were the basis of the Medicare and Medicaid programs that Congress enacted in 1965. In an effort to garner support of the AMA and physicians, the legislation allowed physicians to set their fees and decide which services to provide. Patients could freely choose their physicians, and physician participation in the program was voluntary. Just as with private insurance, Medicare and Medicaid were developed to accommodate the AMA's 1934 principles. Still, Medicare and Medicaid were enacted despite the AMA's vigorous opposition.

The AMA and physicians soon learned to use Medicare and Medicaid to their benefit. In the past, physicians needed to reduce their fees to obtain payment from low-income individuals. This promoted a medical ethos that physicians should provide some charity care or at least adjust fees downward for some patients. With Medicare and Medicaid paying the bills, it was no longer necessary for physicians to lower fees. The charitable medical ethos eroded. Physician fees increased as did the number of services that they provided. Physician and hospital income rose as did national spending on medical care. The favorable climate lured investor-owned firms into medical markets to operate hospitals, ancillary medical facilities, and kidney dialysis centers.[32]

The Demise of Professional Control over Medical Commerce

As governmental healthcare spending rose, federal and state governments sought to rein in expenditures and rationalize healthcare organization. They enacted health planning legislation which required hospitals to obtain a certificate of need from the state Health Systems Agency prior to hospital construction or expansion. Health systems agencies challenged the authority of physicians over medical care.[33] Many states also created hospital rate-setting commissions that regulated hospital charges. Insurers started to review whether services were medically necessary before reimbursing them.[34] As the power of other actors grew, the authority of organized medicine decreased.

In 1971, the Supreme Court ended the antitrust exemption for learned professions.[35] Change was swift. In 1975 the Federal Trade Commission sued the AMA and local medical societies for using their ethical codes to restrict trade. The court found the AMA liable and issued a decree that enjoined the AMA from using its ethical code to restrict physicians from advertising, selling eyeglasses, and other competitive activities.[36] Other antitrust lawsuits prohibited medical societies from setting fee schedules and other anticompetitive activities.[37] The influence of organized medicine over physicians and insurance diminished. In 1973 federal legislation promoted HMOs as an alternative to

indemnity insurance and private practice.[38] These changes destabilized the protected medical markets organized medicine favored.

New Opportunities for Physician Entrepreneurialism in Contemporary Medical Markets

In the 1980s the federal government ended health planning, which had limited hospital construction, and promoted market competition. States abandoned hospital rate setting.[39] Changes in technology increased the range of surgery that could be performed in ambulatory settings and the laboratory and diagnostic tests that could be performed outside of hospitals.[40] Physicians were able to provide more services in their private practice or refer patients to facilities they owned or invested in, thereby competing with hospitals.

Group practices enable physicians to earn income through ancillary services and cross referrals. They have expanded since 1980, and by 2001, 61% of self-employed physicians were in group practice.[41] Many group practices selectively provided profitable services, leaving community hospitals to provide services that generate low profits or that lose money, as well as the burden of uncompensated care. Some large group practices negotiated contracts with managed care organizations under which they assumed part or all of the resource management and insurance risk for their patients; they thus had incentives to limit costs by restricting the services they provided.[42] Other group practices formed captive insurance companies that steered insured patients to them.

Some not-for-profit and for-profit hospitals formed joint ventures with group practices and individual physicians to operate facilities that provided ancillary services. They sought to stem the flow of income that resulted when physicians provided these services outside of hospitals in their own practices. Hospitals also hoped that joint ventures would bond physicians to the hospital and promote patient referrals.

Investor-owned firms also created joint ventures with physicians to own clinical laboratories, imaging centers, specialty hospitals, and other facilities. Physician investors earned a share of the facility's profit and thus had an incentive to refer patients; however, they did not assume any managerial or financial responsibility and typically invested very little money. The firms promoting these ventures usually could have obtained the capital that physicians invested at much lower cost through bank loans, bonds, or corporation stock, but they solicited physician investors as a way to generate patient referrals.[43]

Congress moved to restrict physician referral to free-standing facilities in which they invested when studies suggested that many such arrangements were created as an alternative means of compensating physicians for referrals while avoiding prosecution under the Medicare antikickback law. Evidence also showed that when physicians invested in ancillary services they used such services much more than other physicians. This suggested to many observers that their judgment was compromised by their financial interest. In a move to stave off federal legislation that restricted physician self-referral, the AMA developed ethical guidelines that discouraged but did not prohibit such referrals and let each physician decide what was appropriate. Today, the Medicare and Medicaid programs and some states restrict certain physician referrals to facilities in which they invest and prohibit certain other economic transactions.[44] These laws, however, set boundaries on entrepreneurial practice

selectively, rather than severely limit it. American physicians still have an enormous range of lucrative entrepreneurial opportunities.

Concluding Observations

For-profit firms and other third parties can create conflicts of interest for physicians and thereby compromise their loyalty to patients. However, third parties do so by providing physicians incentives to work for their gain. In short, they call forth physician self-interest and their entrepreneurial spirit. Indeed, investor-owned firms often create joint ventures that give physicians a share of profits. However, even in the absence of for-profit firms, physicians encounter such conflicts of interest when they engage in private practice because they perform entrepreneurial roles. They bear the risk, earn the profit, and decide how to organize their practice.

In early America, physician entrepreneurs did not earn much money because market conditions were not ripe. They had little to sell, patients lacked resources to buy much, and physicians faced competition. These conditions changed as medicine developed valuable service and insurance provided means to finance the purchase of medical care. In addition, organized medicine created a sheltered medical market in which physicians practiced with limited competition or oversight, while they exercised control over their fees and the services they provided with some professional limits on their entrepreneurial activities. Over time, organized medicine relaxed its restrictions on physician entrepreneurship and physician income rose as they expanded their professional activities. The lure of profits drew lay-owned firms into markets, and, as spending rose, the government began to regulate medical markets and then removed the rules that protected physicians from competition.

Today, physicians practice in a complex market with few professional restrictions on their activities but subject to market competition, countervailing power of third party pay and other groups, and some government regulation. Medicine is much more commercial today than in the past. It accounts for one-seventh of the gross domestic product. It relies on large firms to provide funding, operate healthcare institutions, and develop critical drugs, medical equipment and supplies, and ancillary services. However, the central problem of commercialism in medicine today, as in the past, is physician entrepreneurship. It creates conflicts of interest that compromise the loyalty of physicians to their patients and their exercise of independent judgment on behalf of patients. The challenge today is to find ways to cope with conflicts of interest in medicine while preserving those aspects of markets and commerce that produce value.

Notes

1. Some writers argue that for-profit firms, particularly investor-owned firms, are the main source of problems for medical practice and that ownership of medical facilities should be limited to nonprofit organizations or government. Dr. Arnold Relman is often associated with this view. See Relman AS, Reinhardt UE. An exchange on for-profit health care. In: Gray BH, ed. *For-Profit Enterprise in Health Care*. Washington, DC: National Academy Press; 1986:209–23. However, Dr. Relman's views are more complex than this statement suggests. His writings are a major contribution in exploring physicians' conflicts of interest and focusing policy attention on them. Among his numerous writings that discuss this subject are the following: Relman AS. The new

medical–industrial complex. *The New England Journal of Medicine* 1980;303(17):963–70; Relman AS. Dealing with conflicts of interest. *New England Journal of Medicine* 1984;310(18):1182–3; Relman AS. Medicine as a profession and a business. In: McMurrin SM, ed. *The Tanner Lectures on Human Values*. Salt Lake City: University of Utah Press; 1986:283–313; Relman AS. Salaried physicians and economic incentives. *The New England Journal of Medicine* 1988;319(12):784.

2. Rodwin MA. *Medicine, Money and Morals: Physicians' Conflicts of Interes*t. New York: Oxford University Press; 1993. For definitions of conflicts of interest see pp. 8–11 and Appendix A.
3. The dictionary defines entrepreneur as "A person who organizes, operates, and assumes the risk for a business venture"; *The American Heritage Dictionary of the English Language*, 3rd ed. Boston: Houghton Mifflin; 1992.
4. There are four sources of physicians' conflicts of interest: (1) physician entrepreneurship; (2) physician incentives, arising from the way they are paid; (3) physician financial ties to third parties; and (4) physician employment by third parties.
5. For a review of the literature on for-profit healthcare, see Gray BH. *The New Health Care For Profit: Doctors and Hospitals in a Competitive Environment*. Washington, DC: National Academy Press; 1983; Gray BH. *For-Profit Enterprise in Health Care*. Washington, DC: National Academy Press; 1986.
6. This history does not discuss in detail distinctions between kinds of medical markets and the role of professions in them. For an in-depth analysis, see Fligstein N. *The Transformation of Corporate Control*. Cambridge, Mass.: Harvard University Press; 1990; Fligstein N. *The Architecture of Markets*. Princeton: Princeton University Press; 2001. For an alternative short history, see Light DW. Ironies of Success: A New History of the American Health Care "System." *Journal of Health and Social Behavior* 2004;45(Extra Issue):1–24.
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18. See note 14, Rosenberg 1987, Stevens 1971.
19. See note 7, Starr 1982:105–20.
20. See note 7, Starr 1982:110; Burrows JG. *Organized Medicine in the Progressive Era: The Move Toward Monopoly*. Baltimore: Johns Hopkins University Press; 1977:49–51.
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23. See, for example, Group Health Cooperative of Puget Sound v. King County Medical Society, 29 Wash. 2d. 586, 237 P. 2nd 727 (1951); *American Medical Association v. United States*, 130 F. 2d 233 (D.C. Cir. 1942), affirmed 317 U.S. 519, (1943).
24. See note 20, Burrows 1977:119–132; Chase-Lubitz JF. 1987. The corporate practice of medicine doctrine: An anachronism in the modern health care industry. *Vanderbilt Law Review* 1977;40:445–88; Laufer J. Ethical and legal restrictions on contract and corporate practice of medicine. *Law and Contemporary Problems* 1939;516–27.

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