INTRODUCTION

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

Yet, in recent years, a chorus of critics has emerged to highlight the toll that a creeping commercialization has taken on those historic, underlying ethical foundations of medical practice in the United States. ² In the wake of health care's emergence as one of the United States' dominant industries ³ and the concomitant deterioration of the profession's commitment to self-regulation, ⁴ I argue that a physician's business of treating patients should similarly be understood as an enterprise with ethical boundaries that requires monitoring by legislators, policy makers, and government regulators. ⁵

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

I. ETHICS AND THE BUSINESS OF MEDICINE

As famously noted by Kenneth Arrow, the Nobel laureate economist, the relational dynamics between a physician and her patient make it impossible for patients to be the same rational and savvy consumers they might otherwise be in most other marketplace settings. In short, the engagement between physician and patient is frequently infused--for both parties--with trust, intimacy, and vulnerability, as well as fear and uncertainty regarding the potential life and death consequences of decisions made and actions taken. The complex relationship between a patient-consumer and a physician-provider creates a unique transaction experience with few analogues. Moreover, the health care delivery business is, in essence, a business where the primary commodities are treatment and advice--that is, service. Literally, care for another individual's health is what is being bought and sold. The dynamics of this transaction between doctor and patient have at least three distinctive and interrelated qualities: the centrality of a relationship predicated upon trust between a professional health care provider and a patient, the unique potential for vulnerability and compromised judgment on the part of both the patient and the provider, and the myriad systematic issues of cost and access that inevitably impact upon one's encounter--or even access to an encounter--with his health care provider. This third dynamic of the health care business reverberates throughout society, as the general health of a population is a requisite condition for sustained economic well-being. In other words, in addition to moral concerns and conceptions of the good society, it is in everyone's best interest, financial and otherwise, for there to be broad and comprehensive access to health care providers.

These variables, particularly the relational components, are infused with ethical concerns and serve to fundamentally differentiate the business of delivering clinical health care services from other market transactions. First, physicians and nurses are professionals who have historically enjoyed a measure of public respect and deference concomitant with an expectation that their medical judgments would be guided first and foremost by what is in their particular patients' best interest. Regardless of her socioeconomic status or level of education and notwithstanding the past forty years of bioethicists emphasizing the necessity for patient autonomy and choice, a patient must ultimately rely upon the advice and direction of her health care professionals for her well-being. Even as the savvier health care consumer seeks multiple opinions and consults virtual libraries of data on the Internet, the motivation to self-educate and question one's physician is not born of caveat emptor. Rather, one seeks a second opinion because it is understood that medicine is as much art as science. Healing is an interpretive exercise, and a patient's decision to seek alternative interpretations should be animated by a rational and prudent awareness of medicine's subjectivity, not fear or mistrust regarding a physician's potential ulterior motivations or incentives. Patients, particularly those who are, for whatever reason, especially vulnerable, should not have to beware of what self-interested profit motivations might be lurking in the shadows and influencing their doctors' medical judgment. Of course, even the most altruistic caregiver rightly expects to receive some measure of compensation. However, if a patient's confidence in her health care provider to put the patient's best interests ahead of the physician's own pecuniary interest is too badly shaken, how soon will it be before patients no longer submit to invasive and painful procedures or even routine and regular preventive examinations? What are the public health consequences if what Arrow terms the patient's perception of her physician's “moral authority” is replaced with the perception that her physician is motivated only, or primarily, by profits?

The delivery of health care is, “at its roots, a helping enterprise”--a business permeated with the concept of care--that has historically been characterized by individual and corporate commitments to serving the best interests of others, not a reductionist pursuit of profit maximization driven by advertising campaigns, efforts to increase sales, and strategies for capturing market
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involving one's young child. Imagine a three-year-old, walking up a set of wooden deck stairs with his hands in his pockets. Tripping, as exuberant toddlers are apt to do, and with his hands buried deep inside his pockets, he lands face first on the edge of the wooden deck. Although difficult to recognize at first due to the blood and screaming, his parents soon discover that he has bitten through approximately two-thirds of his tongue. Only large, fleshy parts are left dangling.

In an instant the boy's parents are in the car with their son, racing to the nearest emergency room. Upon arrival this boy needs a trained health professional who can stitch together a three-year-old's tongue, relieve his pain, and calm down his mom and dad. After all, the minds of mom and dad are racing with stress and anxiety. They may or may not be native English speakers or well-educated, but regardless, in this moment they do not have the ability to read carefully or understand all the fine print on the admittance and consent forms that the intake nurse will put in front of them. These parents could agree to surrender the deed to their house as payment. They could grant the facility permission to videotape the entire experience for a network reality television show. They are unlikely to know precisely what they are signing. In the midst of this health care encounter, the hospital is holding all the cards. These parents will not be comparison-shopping for the next-nearest emergency department with a better deal on pediatric tongue sutures. Questions about cost, although perhaps in the back of their minds, will not be articulated until--at the earliest--their son's emergent condition is stabilized. In this moment, all these parents know is that they want their son to be treated as quickly and competently as possible.

Beyond the dramas of young children and parenthood, thousands of adult children every day must confront a different set of gut-wrenching dynamics as elderly parents waver between life and death. As one's mom or dad, beloved friend, or life partner is in the process of dying, those who sit vigil at the bedside are in no mental or emotional condition to haggle over the price of palliative medications or second-guess the necessity of additional MRIs and CT scans. Or consider a less bloody or macabre setting, yet no less traumatic: a young woman or man, with a history of being sexually abused by trusted figures wielding authority, is sitting naked in an examination room, being asked intimate questions about his or her body, diet, and lifestyle. It takes an enormous amount of courage and trust for someone to be that vulnerable. Yet, these dynamics--infused with ethical issues--are the hallmarks of the doctor-patient relationship, and they inform a patient's relationship with her health care providers.

These scenarios reveal the constitutive elements of what makes encounters with the health care system unique from one's daily engagement with other actors and institutions in the marketplace. Typically, the health care transaction is characterized by a relatively fragile and unequal relationship that best results in the patient's long-term well-being when the relationship with his physician is characterized by mutual trust and confidence. Even in the context of an elective procedure or formulation of a long-term treatment strategy--moments when “shopping around” for second and third opinions may be a viable option--the asymmetries in knowledge and power make it virtually impossible to negotiate or otherwise bargain for the best deal. Ultimately, a patient must trust that her physician or surgeon is making recommendations for treatments or procedures with as few unnecessary conflicting distractions as possible.

Beyond these individual patient-provider concerns, an unregulated market approach in health care fails to resolve social inequalities and injustice that arise when unfettered health care markets fail to provide access to uninsured or under-insured patients. Moreover, in a broader social context, vast sums of government money subsidize medical training, research, and treatment, so taxpayer money subsidizes much health care delivery. Yet, if the health care market were left to operate solely pursuant to principles of profit maximization, many of these same physicians, trained at government expense and subsidized by government Medicare or Medicaid programs, would have little incentive--beyond a commitment to professional or moral duty--to treat those who are often the sickest and without private payment sources. As Brennan observed, “the pure procedural justice of the market is admirable,” but “the consequence of an unregulated market, especially the unequal access to health care for those unable to pay, undermine ethical health care ... [and] outweigh the market's other attributes.” Thus, some
measure of government regulation becomes essential, and such governmental interference in the business of medicine should be informed by ethical principles.

Another way of thinking about the deep ethical connections between medicine as a business and medicine as a policy or regulatory concern is to consider the concept of autonomy. The notion that the patient ought to be deeply engaged in making decisions about her health care is foundational to contemporary medical practice, as well as health law and policy developments. Yet, if a patient does not even have access to health care services, ethical concerns over informed and shared decision making with one's physician become moot.

So what might future health care reforms and regulations guided by a robust concern for Brennan's ethical guideposts produce? The remainder of this article addresses that question by exploring the specific case of physician-owned specialty hospitals. Part II offers some background on these particular health care providers and the specific ethical issues these businesses present. Heralded by Professor Herzlinger as “the best hope for a higher-quality and higher-productivity healthcare system,” these physician-owned facilities were targeted by the PPACA in ways that will sharply curtail their future growth and expansion. Part III applies Brennan's guidelines to physician-owned specialty hospitals and considers whether the PPACA goes far enough in “doing no harm” to the patient's best interest, eliminating or reducing unnecessary conflicts of interest between patients and providers, and justly allocating resources in ways that recognize the interconnected and collective impact of health care decisions and how they reverberate throughout society.

II. PHYSICIAN-OWNED SPECIALTY HOSPITALS

Physician-owned specialty hospitals are health care delivery businesses that are either partially or fully owned by physician-investors who limit the services provided to three primary specialties: cardiac, orthopedic, or other surgical procedures. Limiting their practice to these high-profit-margin services has resulted in health care delivery centers that constitute many successful businesses providing tens of thousands of jobs, millions of dollars in state and federal tax revenues—which nonprofit general hospitals do not pay—and hundreds of millions of dollars in cumulative payroll. However, these specialty hospitals treat a lower percentage of severely ill patients than do their general hospital competitors, suggesting that these physician-owned specialty hospitals either intentionally skim the cream off the top of the patient population or intentionally limit their technological and personnel capacity so they are equipped to treat only the healthiest and least costly sector of cardiac, orthopedic, or surgical patients. Moreover, due to differences in staffing levels, employee compensation, and the use of single-occupancy rooms, physician-owned facilities have higher costs than do general hospitals and result in higher utilization rates and greater requests for Medicare reimbursement. Nonetheless, for their physician-owners, who have seen personal incomes decline over the last decade, these investments offer a practice environment where MDs—not MBAs—control administrative decisions that impact patient care and produce increased earning opportunities.

Ron Winslow’s investigation of the Heart Hospital of New Mexico, which opened in 1999, offers an illustration of conflicts created by physician-owned specialty hospitals. At its inception, local cardiologists owned forty-one percent of Heart Hospital, a stand-alone cardiac center, in partnership with MedCath Inc., a publicly traded nationwide operator of cardiovascular clinics. The doctors who invested in and planned to practice at Heart Hospital were enthusiastic about “restor[ing] their eroding control over medical decisions and ensur[ing] that, amid relentless cost-containment pressure, the best patient care [would be] delivered.” However, physicians and administrators at the ninety-one-year-old Presbyterian Hospital located across the highway from the Heart Hospital were not as excited about what they viewed as “a wasteful duplication that threaten...
[ed] to dilute quality of care ... [while serving as] a vehicle for doctors and their investing partners to cherry-pick the most profitable heart patients to enhance their returns." \(^{56}\)

Two primary reasons reportedly prompted the cardiac physician-investors to invest in the upstart hospital. First, during the preceding decade they had seen their income erode dramatically. From 1989 to 1999, the Medicare reimbursement fee for a common cardiac diagnostic procedure had been reduced by sixty-two percent, while the fee for triple-bypass surgery had been cut by thirty-nine percent. \(^{57}\) Meanwhile, hospitals during the same decade had begun retaining a greater percentage of what Medicare paid. For example, in 1989, hospitals kept approximately sixty percent of the Medicare reimbursement for bypass surgery, with the remainder passing through to the heart surgeon. In 1999, however, general hospitals were keeping as much as eighty-five percent, with the remainder being paid to the surgeon. \(^{58}\) The second motivating factor for those physicians who would invest in and practice at Heart Hospital was purported to be control. The emergence of managed care in the 1970s had, by the mid-1990s, left physicians and surgeons weary of having their judgment challenged by “cost-obsessed hospital and managed-care \(^*389\) bureaucrats.” \(^{59}\) It is reasonable to infer that when MedCath invited cardiologists to invest in and practice at Heart Hospital, the entrepreneurial opportunity presented a solution both to the problem of declining incomes and to the cardiologists' administrative frustration over bureaucratic second-guessing and other real or perceived practice inefficiencies.

One could conclude that the emergence of physician-owned specialty hospitals is directly linked to disagreements among health care providers, administrators, and government bureaucrats, all of whom have failed to recognize the necessity of an interconnected health care community. As noted above, in addition to the profit motivations fueled by decreasing physician salaries, expansion of the physician-owned specialty hospital movement was propelled to some extent by community hospital administrators and corporate hospital conglomerates that frustrated physicians’ efforts to exercise reasonable and legitimate controls over their clinical practices. The reaction from these disgruntled cardiac and orthopedic surgeons, however, could be seen as disproportionate, as many promptly created their own treatment facility across town and then actively pursued the most lucrative patient population in a grab for high-profit-margin market share. Neither the climate that fueled the frustration nor the response of physician-investors was consistent with the hallmarks of ethical health policy Brennan seems to have in mind when he describes “providers [who are] actively cognizant of the nature of their activities (as part of a group process) and the collective impact of their individual actions.” \(^{60}\) Deeper analysis of the physician-owned specialty hospital industry reveals costs to both the system of health care delivery and the individual patient.

\*390  A. Systematic Costs

As noted in the previously discussed investigation in New Mexico, the opportunity for the physician-investors to maintain privileges at both Heart Hospital and Presbyterian Hospital was viewed as a destabilizing threat by those administrators and physicians who remained affiliated solely with Presbyterian. After all, the physician-investors at Heart Hospital would have a financial incentive to refer their least costly and healthiest cardiac patients to the facility in which they have an ownership interest, while choosing to operate on their sicker and more complex cases in the general hospital, where the costs of lengthy recuperation could be passed on and an emergency room would stand ready in the event of an emergency. The concerns voiced by administrators at Presbyterian Hospital about the potential impact of shifting patient referral patterns had merit, as they simply forecast later rational decision making on the part of the physician-investors at another physician-owned specialty hospital, Albuquerque's Heart Hospital. \(^{61}\)

Additional examples illustrate the threat to financial viability facing general hospitals. \(^{62}\) In 2001, the Galichia Heart Hospital opened in Wichita, Kansas. Within two years, the full-service Wesley Medical Center in Wichita saw the net revenues from its cardiovascular program drop from approximately $18 million to roughly $2 million. \(^{63}\) When the Kansas Spine Hospital opened
in 2003, it took only a year for Wesley’s neurosurgery revenues to decline from $8.8 million to approximately $1 million. To the south, the Oklahoma Heart Hospital opened in 2002 in Oklahoma City, Oklahoma, and immediately began competing with the Oklahoma University Medical Center (OUMC). Within two years, the number of inpatients admitted for cardiac care at OUMC dropped dramatically, as sixteen surgeons and cardiologists on OUMC's clinical faculty immediately began referring the majority of their patients to the specialty hospital in which they owned an interest. The reduced patient population, which was directly attributable to a shift in referrals from OUMC to Oklahoma Heart Hospital, resulted in losses of $11.6 million in the full service hospital's “cardiology operating income” between 2002 and 2004. Similarly, in Ruston, Louisiana, the Lincoln General Hospital saw its total number of surgeries cut in half, resulting in an $8 million deficit, after forty surgeons opened the Green Clinic Surgical Hospital across the street.

A 2005 MedPAC report concluded that physician-owned specialty hospitals obtain most of their patients by taking market share away from community hospitals. Moreover, the report revealed that physician-owned specialty hospitals treat a higher percentage of patients who are less sick, and therefore less costly and more profitable, than patients receiving similar treatments at general hospitals. Coupled with the finding that most specialty hospitals treat few, if any, Medicaid patients, the MedPAC report speculated that if the specialty hospital industry were to continue to grow without additional regulation, community hospitals attempting to compete with specialty hospitals could find their profits adversely impacted, which could have a negative ripple effect on their ability to provide charity care and other less financially rewarding medical services. MedPAC's data analysis also disputed the specialty hospitals' claim that, through specialization, they were able to have lower overall costs than full-service community hospitals. Likewise, a 2005 report issued by Michael Leavitt, Secretary of the Department of Health and Human Services (HHS), also found that specialty hospitals generally treat a less-sick patient population with “lower severity levels.”

In late 2005, Georgetown's Jean Mitchell published additional data comparing the practice patterns of physician-owners of specialty cardiac hospitals to the practice patterns of physician-nonowners treating cardiac patients at competing full-service community hospitals. Her study of Arizona providers conclusively confirmed that physician-owners treated nearly twice as many cardiac cases as physician-nonowners. Moreover, the majority of the patients treated at the physician-owned facility were less ill and better insured, either through Medicare or a private insurer.

At the request of Congress, MedPAC released another report in 2006. Analyzing a more robust set of data, the 2006 MedPAC report confirmed several findings from earlier studies. First, MedPAC again found that physician-owned facilities treat fewer Medicaid patients. Second, the 2006 report reconfirmed patients stay a shorter time on average in physician-owned facilities than in community hospitals, yet the overall cost of patient care at physician-owned facilities is not comparatively less.

Furthermore, the 2006 MedPAC report found that when a physician-owned specialty hospital enters a market, the utilization rates and requests for Medicare reimbursements increase. These findings are consistent with what Jean Mitchell found in her analysis of Arizona's health care landscape. Professor Mitchell's subsequent comparison of the practice patterns of physician-owners of specialty hospitals in Oklahoma, both before and after they acquired their ownership interest, to the practice patterns of physician-nonowners treating similar cases during the same time frame further highlights the issue. This research again confirmed that after physicians became owners in their specialty orthopedic hospital, the utilization rates for surgical, diagnostic, and ancillary services used to treat back and spine ailments “increased significantly.” Mitchell found that during the same time period in the same market, dramatic increases in utilization were not seen in the practices of nonowner
While recognizing the possible limitations of her study, given the fact that it relied only on data from one area of the country, Mitchell concluded that substantial increases in utilization rates can be linked to physician ownership and that treatment costs are likely to be “significantly higher in comparison to those who obtain care from non-self-referral providers.”

**394 B. Patient Costs**

[When the doctors own the hospital and operate it to their benefit, when the almighty dollar rather than quality patient care is the bottom line, when physicians can pick and choose who they will treat, and when the hospital has no one holding everyone's feet to the fire, then patients will not be well-served.]

In the summer of 2005, Helen Wilson, an eighty-eight-year-old woman who enjoyed an active, independent life in Vancouver, Washington, began experiencing a nagging pain in her legs and opted for elective lumbar surgery on her lower spine to decompress nerves leading to her legs. On July 27, she was admitted to Physicians' Hospital, a thirty-nine-bed, physician-owned facility in Portland, Oregon, focusing on the dual specialties of orthopedic surgery and neurosurgery. Despite the dangers of anesthesia and pain medication in a patient over the age of eighty-five, Wilson's specific history of high blood pressure, and her prior open-heart surgery, her surgeon, Dr. Mark Metzger, elected to operate on her at Physicians' Hospital rather than Portland Adventist Hospital, a full-service hospital with an emergency department, at which Dr. Metzger also had operating privileges. Dr. Metzger would not respond to local media inquiries seeking clarification about his motivations, but as one of the thirty-two doctors who co-owned Physicians' Hospital, he would have had an additional financial incentive to treat Wilson there.

Following what was believed to be a routine and successful two-hour surgery, Wilson suddenly began experiencing respiratory distress and cardiac arrest. With Wilson's husband and son watching in disbelief, several nurses frantically attempted to resuscitate Ms. Wilson. Dr. Metzger was nowhere to be found, and the receptionist for Physicians' Hospital ultimately resorted to dialing 9-1-1 to request paramedics be sent to the hospital. With her brain deprived of oxygen for many minutes, Ms. Wilson never regained consciousness; she passed away five days later.

A few tragic and unnecessary deaths suggest a possible proliferation of grave patient safety issues throughout the physician-owned specialty hospital industry. Absent additional data, however, it is unclear to government officials how extensive these threats to patient well-being might be. Moreover, with many of these facilities designed to have the “look and feel of a Four Seasons Hotel,” Consumer Reports magazine promoted them as the “Number One Hospital” in two-thirds of the markets in which they were operating.

In January 2008, HHS's Office of Inspector General (OIG) issued a report on physician-owned specialty hospitals and their ability to manage medical emergencies. Out of the 109 specialty hospitals the OIG reviewed, only fifty-five percent had an emergency department. Of those, more than half were equipped with only one emergency bed. Additionally, while ninety-three percent of the physician-owned specialty hospitals were found to have nurses on duty and physicians on call twenty-four hours a day, seven hospitals failed to meet the Conditions of Participation (CoP) promulgated by the CMS. Given that so many of the physician-owned specialty hospitals lack the capacity to offer complete, on-site emergency services or the availability of trained personnel, it is not surprising that the OIG report found that sixty-six percent of these facilities instruct their staff to dial 9-1-1 as an official component of their medical emergency response protocol.
The use of 9-1-1 “to obtain medical assistance to stabilize a patient” seemingly constitutes a violation of the CMS’s CoP, which state that a hospital receiving Medicare funds may not rely on 9-1-1 emergency services as a substitute for its own emergency services.\(^{102}\) Moreover, the OIG’s \(^{398}\) investigation revealed that twenty-two percent of all physician-owned specialty hospitals do not even have a policy or protocol in place that addresses patient emergencies, including appropriate use of response equipment, initial life-saving treatment, or transfer of patients to full-service hospitals.\(^{103}\) This too constitutes a violation of the CMS’s CoP.\(^{104}\)

The substantive impact of the OIG’s report was a series of four recommendations directing CMS to better monitor physician-owned specialty hospitals and to ensure their compliance with existing regulations regarding patient safety and emergency situations. But the real upshot was the additional fuel these data added to the fire of political criticism that the physician-owned specialty hospital industry had been regularly enduring for much of the preceding decade. Given the considerable magnitude and variety of criticism, the industry should not have been caught off guard when it was delivered a mortal wound in March 2010 when Congress and the Obama administration passed the most extensive legislative health care reforms since the creation of Medicare and Medicaid.

### III. A CASE STUDY FOR ETHICAL HEALTH CARE POLICY

Legislative efforts addressing the constellation of issues raised by physician-owned specialty hospitals can be traced to the Medicare antifraud and abuse legislation of the 1970s and early 1980s that attempted to eliminate perverse incentives that were contributing to overutilization of health care services and concomitant rising costs.\(^{105}\) In 1989 Congress directed the OIG of HHS to report to Congress on:

- physician ownership of, or compensation from, an entity providing items or services to which the physician makes referrals and for which payment may be made under the Medicare program;
- the range of such arrangements and the means by which they are marketed to physicians;
- the potential of such ownership or compensation to influence the decision of a physician regarding referrals and to lead to inappropriate utilization of such items and services; and
- the practical difficulties involved in enforcement actions against such ownership and compensation arrangements that violate current antikickback provisions.\(^{106}\)

The OIG’s report provided the data necessary to cement growing concerns over the practice of some physicians who were maintaining an ownership interest in health service centers to which they referred their Medicare and Medicaid patients. Congress soon passed the “Ethics in Patient Referrals Act,” which had been sponsored by U.S. Representative Fortney H. (Pete) Stark and primarily targeted self-referrals to facilities furnishing clinical laboratory services.\(^{107}\) The reforms were expanded in 1993 to cover self-referrals to facilities offering additional health services, including inpatient and outpatient hospital services.\(^{108}\)

Together, these efforts to prohibit physician self-referral would become more widely known as the Stark Laws.\(^{109}\) Originally intended to \(^{400}\) prevent physicians from making patient referrals to any institution in which the physician enjoyed any financial connection, legislative compromises resulted in the insertion of an exception that would permit physicians to own an
interest in a general facility if the “financial interest was in the entire hospital and not merely in a distinct part or department of the hospital.” Such compromise was possible because it was assumed by Congress that physicians with an ownership interest in a “whole hospital”—offering a diversity of services—would be less likely to have clouded judgment due to the dilution of potential economic gains in the context of a full-service, general hospital. This exception notwithstanding, the Stark Laws were clear in their prohibition against physicians with an ownership interest in a distinct hospital subdivision referring their Medicare patients to that subdivision.

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

On March 23, 2010, President Barack Obama signed into law the PPACA, which includes section 6001, “Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals.” “[F]erociously complex,” the 2000-page systematic health care overhaul was heralded as “the most significant piece of domestic legislation to emerge from Washington in decades.” Although the details are described below, section 6001 essentially amends the Social Security Act to prohibit new or expanded physician-owned specialty hospitals from filing Medicare claims if a financial relationship exists between the referring physician and the hospital receiving the government reimbursement. For advocates of physician-owned specialty hospitals, however, the “illogical and unfortunate” legislation was predicted to “virtually destroy over 60 hospitals” that were currently under development and stifle any future growth of those facilities already in existence. Predictably, interested parties opposed to physician-owned specialty hospitals viewed section 6001 as “a good [law] that will stem the tide of an entrepreneurial approach to medicine that is potentially fatal.”

A. What Does Section 6001 Do?

Section 6001 of the PPACA amends section 1877 of the Social Security Act—that is, the Stark Laws—in ways that impact both physician-owned specialty hospitals already in existence, as well as those under development. For those physician-owned specialty hospitals currently operating with Medicare certification, the new law prohibits increases to the number of operating rooms, procedure rooms, and beds for which the hospital is licensed, unless narrow exceptions can be met.
Moreover, the legislation addresses conflict-of-interest concerns by requiring disclosures to make the operation of these facilities more transparent.\textsuperscript{127}

In this same spirit of transparency, the new law also requires physician-owned specialty hospitals to make available to HHS a detailed annual report on the identity of investors and the nature and extent of all investment terms.\textsuperscript{128} Additionally, these facilities will have to disclose all ownership and investment interests to specific patients, as well as post general disclosure notices on websites and public advertising alerting the public to the hospital's status as physician-owned.\textsuperscript{129}

Finally, the reforms address concerns related to the legitimacy of a physician's investment and patient safety. In a subsection entitled “Ensuring bona fide investment,” the legislation curbs the ability of these facilities to expand the pool of physician-investors, while also explicitly forbidding an array of fraudulent investment terms and conditions.\textsuperscript{130} The law *404 addresses safety by requiring all physician-owned specialty hospitals without twenty-four-hour onsite physicians to secure signed consent from patients.\textsuperscript{131} Moreover, physician-owned specialty hospitals relying on dialing 9-1-1 emergency services supplied by other, full-service area hospitals will have to provide baseline stabilization treatments and have the capacity to transfer patients to full-service hospitals without reliance upon 9-1-1 emergency transfer services.\textsuperscript{132}

\textbf{B. Can Section 6001 Survive a Legal Challenge?}

On June 3, 2010, Physician Hospitals of America (PHA) and Texas Spine & Joint Hospital (Texas Hospital) initiated litigation to enjoin the Secretary of HHS from implementing and enforcing section 6001 on the grounds that the legislation was unconstitutional.\textsuperscript{133} PHA is the trade association representing the interests of 166 physician-owned specialty hospitals in thirty-four states.\textsuperscript{134} The Texas Hospital is a twenty-bed facility that specializes in joint replacement, spine surgery, total knee replacement, and back and neck surgery.\textsuperscript{135} At the time of section 6001's passage, Texas Hospital had spent nearly $3 million on an expansion project to increase facility capacity.\textsuperscript{136} The total expansion project was forecast to exceed $30 million, with financing “anchored in expected Medicare reimbursements.”\textsuperscript{137} The plaintiffs' suit requested declaratory and injunctive relief and advanced a theory that section 6001 is not rationally related to a legitimate purpose nor is it justified by a factual basis, thereby violating their due process and equal protection rights under the Fifth Amendment.\textsuperscript{ *405 138} In addition to the plaintiffs' contention that no factual basis exists to support section 6001, they further argued that section 6001 was enacted merely to provide a competitive business advantage to general and full-service hospitals.\textsuperscript{139}

In defense of section 6001, HHS set forth four justifications: “(1) physician ownership leads to overutilization of services; (2) physician ownership results in greater healthcare expenditures; (3) referral patterns undermine public and community hospitals, which provide uncompensated care and other services not usually offered by [physician-owned specialty hospitals]; and (4) [physician-owned specialty hospitals] provide inadequate emergency care.”\textsuperscript{140} Although the plaintiffs challenged the evidence relied upon by Congress when reaching its conclusions and advanced their theory that section 6001 was only passed as “the product of a backroom deal brokered for the benefit of the American Hospital Association,” the Federal District Court for the Eastern District of Texas noted that it “is not in the business of passing judgment on the wisdom or appropriateness of legislative action.”\textsuperscript{141} Moreover, the court noted that precedent only permitted overturning a statute under the rational basis standard when “the legislative facts on which the classification is apparently based could not reasonably be conceived to be true by the government decision makers.”\textsuperscript{142} In reviewing section 6001 and its legislative history, the court concluded that concerns over physician ownership and evidence that such arrangements create incentives for unnecessary referrals constitute a rational basis for the law.\textsuperscript{143}
The plaintiffs also alleged that section 6001 constitutes a regulatory taking of their real property and capital investment, as well as their ability to bill Medicare for additional patients they would treat in new or expanded hospitals. The court noted the fact that physician-owned specialty hospitals are not economically viable without the ability to bill Medicare for self-referrals, yet concluded that the loss of the ability to bill Medicare for self-referred patients does not constitute an impermissible taking. Section 6001, as the court highlighted, does not prohibit physician-owners from building or expanding a hospital or from seeking Medicare reimbursements for health services that do not result from a physician-owner referral. Moreover, physician-owned specialty hospitals are not forbidden by section 6001 from continuing to self-refer when patients or their private insurers are paying the bill. Thus, the court concluded that because section 6001 does not proscribe, limit, or otherwise interfere with the plaintiffs' use of their real property, the legislation does not result in a regulatory taking of real property.

Additionally, the plaintiffs argued that section 6001 would create enormous financial hardship because Texas Hospital would have to forfeit its $3 million investment and other PHA-affiliated hospitals would lose “over $5 billion of investments” made toward new construction and expansion projects, all predicated upon their ability to bill Medicare for self-referred patients. Yet the court found that the plaintiffs could have “no reasonable expectation that the Medicare program would remain unchanged.” Rather, the history of Medicare—a “voluntary program which the government may alter at any time”—is marked by numerous changes in benefit policies, and, furthermore, the specific changes contained in section 6001 had been considered and “almost enacted” by Congress in 2007 and 2008. Physician-owned specialty hospitals were clearly on notice that reform efforts to close the “whole hospital exception” loophole were afoot, and any financial decisions taken in the direction of expansion or further investment was a calculated risk on the part of physician-investors.

On March 31, 2011, the court granted the defendant's motion for summary judgment and dismissed all of the plaintiffs' claims. The plaintiffs appealed the court's ruling to the Fifth Circuit Court of Appeals, and legislation that would repeal section 6001 has been introduced in the U.S. House of Representatives.

C. In What Ways Does the Reform Legislation Reflect Ethical Health Care Policy?

As Brennan argued in 1993, reforms to health care should be evaluated in social and moral terms, because the health of a nation is “as much a matter of social commitment as it is an industry.” In the discussion that follows, I argue that the PPACA's reforms of the physician-owned specialty hospital industry addressed ethical concerns over harm, conflicts of interest, and transparency. Indeed, such concerns justify the reforms that were signed into law and, I believe, would have justified even bolder action.

1. Nonmaleficence

Considered narrowly, the medical ethics mandate to “do no harm” applies to the treatment an individual physician provides for an individual patient at the bedside. Yet, more broadly applied, the principle can be used to interrogate the systems and institutions that constitute the health care delivery mechanisms throughout society and to determine whether a systematic harm is being perpetrated. Phrased more positively, a concern for beneficence would argue for a more concerted effort by policy makers to promote Brennan's conception of the traditional altruistic commitment between a physician and her patient both in light of individual patients and the broader good of all potential patients. In the context of physician-owned specialty hospitals—or any component of the health care system--two questions are operative. First, are individual patients being harmed?
Second, are broader, perhaps less immediately recognizable, harms being done to the health care system and the professionals who inhabit it? 158

The question of harm that may be done to individual patients is not easily answered. As Helen Wilson's tragedy illustrates, mistakes can happen in these physician-owned facilities. Without the adequate emergency facilities or appropriately trained personnel available, routine complications can result in unnecessary patient deaths. 159 Clearly, some physician-owned specialty hospitals recklessly instituted cost-saving measures, and some patients paid the ultimate price. Yet, proponents of the industry argue that three individual patient deaths are outliers, and the vast majority of patients receive quality care and enjoy an above-average hospital experience. Indeed, popular media and government reports support the view that patient satisfaction at physician-owned specialty hospitals is generally high—ind some instances higher than it is in competitor full-service, community hospitals. 160 Moreover, provisions of section *409 6001 are clearly intended to compel more rigorous oversight of patient issues by the CMS.

Yet, the nonmaleficence analysis is incomplete if it concludes with the individual experience of those patients equipped with private insurance or Medicare who are fortunate enough to experience one of these five-star facilities. The individual customer may always be right in most areas of commerce, but in the health care domain, broader social commitments must not be ignored. Considered in a broader social context and recalling Brennan's modified Rawlsian thought experiment, physician-owned facilities appear to perpetrate systematic harms that necessitate regulations consistent with ethical health care policy. 161

Take, for instance, the patterns of care at physician-owned specialty hospitals relative to Medicaid patients. MedPAC reports provide empirical evidence that physician-owned specialty hospitals are “less likely to treat Medicaid patients than community hospitals in the same areas and that physician-owned specialty hospitals tended to treat healthier patients.” 162 In fact, according to the 2006 MedPAC data, Medicaid patients represented only three percent of the discharges at physician-owned heart hospitals and only two percent of the discharges at physician-owned orthopedic and surgical hospitals. 163 At non-physician-owned heart hospitals, the share of Medicaid patients was seven percent, while non-physician-owned orthopedic and surgical hospitals averaged a patient population consisting of three percent Medicaid eligible. 164 These findings were consistent with a GAO report finding that community hospitals treated twice as many Medicaid patients as did physician-owned specialty hospitals. 165 These statistics and the investigations that yielded them led MedPAC to conclude that “[o]ther specialty hospital decisions such as location, mission, emergency room capability, and physician financial incentives to avoid *410 Medicaid patients may have contributed to the lower Medicaid shares at physician-owned hospitals.” 166

Section 6001 includes specific provisions addressing the discrepancy between physician-owned specialty hospitals and non-physician-owned facilities in treatment patterns relative to Medicaid patients. Going forward, any physician-owned specialty hospital seeking to expand its capacity will have to match or outpace the percentages of Medicaid patients being treated at non-physician-owned facilities. 167 This legislative solution seems consistent with the priorities of an ethical health policy designed to address systematic harms, because it seeks to eliminate the temptation to avoid treating patients who are potentially both sicker and less likely to result in high profit margins. Specifically, these provisions of the new law attempt to fix the competitive harm created by an unfair playing field where physician-owned specialty hospitals can exploit the “whole hospital exception” and operate with little concern for treating Medicaid patients, while this less-profitable care is relegated to the full-service hospital across the street. At a minimum, this provision of the new law addresses concerns that physician-owned specialty hospitals foster a two-tiered health care system—one for the wealthy and well-insured and one for those of lower socioeconomic status. To the extent that physician-owned specialty hospitals were incentivized to pursue treatment opportunities with patients that would yield higher profits, while relegating others to a second-class network of treatment facilities, such incentives were eliminated as of March 23, 2010.
Yet, one wonders whether a more robust appreciation for ethical concerns might have prompted reformers to go a step further. The mandate to treat a higher percentage of Medicaid patients is triggered only in the event the physician-owned specialty hospital seeks to expand capacity. Arguably, Congress missed an opportunity to even the playing field in those communities where physician-owned specialty hospitals have skimmed the more lucrative patients away from full-service facilities that are also engaged in charity care. Given that public money in the form of Medicare reimbursements provides the operating capital for these for-profit enterprises, it would perhaps be even fairer and more reasonable to require existing physician-owned specialty hospitals to increase their percentage of care to underserved populations as a retroactive condition for continued participation in the Medicare program.

2. Conflicts of Interest

In addition to the ethical concerns over unnecessary harms that threaten individual patients, an entire class of non-Medicare-eligible patients, and full-service hospitals, another fundamental ethical concern addressed by the new legislation is the issue that Brennan frames as systematic resource limitations in the allocation of services, which manifests in this context as a physician's conflicting pecuniary interests. This conflict of interest, which is to a certain extent unavoidable, has been at the heart of medical ethics and professionalism norms throughout the history of health care, especially in the United States, where the entrepreneurial, money-making potential of health care delivery has been well-documented. At some level, a conflict will always exist between a physician's need for personal income and the patient's need for medical treatment. Thus, the question may simply boil down to whether physician-owned specialty hospitals exacerbate or reduce this inherent challenge to the “altruism of healing.” On May 17, 2006, in a Senate Finance Committee hearing considering the issue of physician-owned specialty hospitals, Senator Charles Grassley pondered the fundamental questions of “whether [physician-owned specialty hospitals] serve the best interest of the patients being treated at them, or if they are serving the best interests of the physicians who own and operate them.”

Appropriating an ethical health care policy framework might reformulate the question to ask specifically, do institutions promote a patient-centered commitment that reinforces the physician's ethical duty? Or do these facilities only further confuse the physician's judgment when the physician is making determinations about treatments and tests that may or may not be necessary?

Given the abundance of evidence demonstrating repeated patterns of overutilization when physicians have an economic self-interest, physician-owned facilities necessitate a high level of regulatory scrutiny. Thus, the provisions of section 6001 that require annual reporting to federal regulators specifying the identity of all physician-owners or-investors and the nature and extent of their ownership interests are reasonable measures in the right direction. Providing information to the government that will facilitate the monitoring of physician practice patterns is a reasonable requirement for participation in a federal reimbursement program, and it should aid efforts to monitor physician-owned specialty hospitals. Moreover, additional requirements included in the legislation that mandate full disclosure to specific patients and explicit public notice on all websites and advertising are likewise reasonable regulations that theoretically serve both to intensify the public oversight of the industry and also to inform individual patients and the public consistent with the ethical and common law duty to ensure that medical treatment commence only after informed consent has been secured.

Yet, critics have argued for decades that legal regulations requiring informed consent do not necessarily result in better-informed patients. Nothing in the PPACA reforms can guarantee that patients, many of whom may have compromised capacity, will appreciate the conflict created by physician-investor self-referral schemes. Additionally, one is left to wonder...
how such a disclosure might undermine a patient's or a community's general sense of trust in the medical profession. Could a more widespread public knowledge of physician ownership actually intensify cynicism and undermine efforts to encourage the public to develop long-term, trusting relationships with health care providers? Given the dual uncertainties over whether disclosure will actually adequately inform and empower patients, as well as the concern over public backlash if physicians are broadly viewed to be driven by pecuniary interests, one wonders if an outright, retroactive ban would be the most ethical policy reform in this area.

After all, some measure of conflicting financial interest is unavoidable. Physicians must eat. Staff must be paid. Medical school loans are a reality. Yet, physician-owned specialty hospitals unnecessarily create an additional layer of pecuniary conflict that policy makers, guided by the ethical concerns raised in this article, could reasonably decide to ban retroactively and completely, consistent with the Stark legislation's original intent, which was to prevent physicians from referring Medicare patients to any institutions in which they had a financial connection. 177

3. Bona Fide, Transparent Ownership

Proponents of physician-owned specialty hospitals are tireless in claiming that their entrepreneurial efforts are consistent with the best ideals of a competitive, free-market environment that rewards efficiency and innovation. 178 Additionally, their insistence that a motivation beyond profit taking can be found in a good-faith desire for both greater physician autonomy *414 and freedom from large hospital and conglomerate bureaucracies is compelling. Indeed, it is completely reasonable for physicians to desire professional freedom from the frustrations of administrative hassles and clinical empowerment to exercise control and develop specific competencies over those practice dynamics that will result in the highest levels of patient care. The desire to “own” their own practice, in the sense of controlling it, seems both reasonable and consistent with enduring ethical concerns over individual autonomy and self-determination on the part of professional health care providers. And yet, such individual interests are in tension with Brennan's vision of a “healing community” that recognizes the interconnected and collective impact of medical practice. 179

Indeed, American medicine's history of kickback deals and fiscally reckless self-referral practices renders it difficult to see only this silver lining of hospital ownership that proponents proffer. 180 Copious amounts of data confirm that financial interests influence medical decision making. 181 Hence, those provisions of section 6001 designed to monitor whether physician-ownership deals will indeed be “bona fide investments” appear to be justified by the concerns of a health care policy guided by ethical considerations. Indeed, abuse of patients by ordering extraneous tests or procedures and abuse to the system by increasing Medicare costs and waste of finite resources each are more likely if a physician feels *415 obligated to co-investors in the hospital who have done any of the following: offered investment terms to the physician more favorable than those offered to nonphysician owners, provided a loan to entice the physician to invest, guaranteed or subsidized a loan related to the physician's acquisition of an ownership interest, distributed a dividend or other return on any basis other than one directly proportional to the physician's investment share, or provided an opportunity for a physician to purchase or lease property under the control of the hospital on terms more favorable than those offered to an individual who is not a physician-owner.

Each of these potential deal points, arguably completely ethical in the context of negotiations and transactions in most other industries, is forbidden by section 6001. 182 However, such regulations, viewed through the lens of ethical health care policy concerns, are easily justified on the basis that in their absence it would be too easy for investment-related concerns and motivations to cloud the physician's judgment and result in adverse consequences to an array of stakeholders, including the individual patient and the broader population that rightly expects prudent financial decisions with regard to finite public resources. As noted throughout this article, people who become patients are frequently in uniquely vulnerable conditions, and
the care they expect and deserve to receive should not be influenced by some lingering sense of payback or obligation felt by the physician toward his investment partners in a jointly owned hospital facility.

Section 6001 will have reformed this industry in ways that highlight ethical priorities for future reform efforts, assuming that (1) these investment restrictions can adequately safeguard the legitimacy of physician ownership in these facilities, (2) sufficient transparency protocols can be put in place that allow for regulatory oversight of potential overutilization and assure appropriate patient consent that permits informed decision making, (3) fair competition can be promoted with regard to the socioeconomic demographics and illness severities of the patient population, and (4) corners are not cut with regard to emergency services and patient safety. Yet, these are not trivial assumptions, and one is left to wonder whether the plethora of negative attributes associated with physician-owned specialty hospitals simply outweighs their potential for positive contributions to the health care system. If one accepts the more robust ethical considerations highlighted in this article, perhaps a complete ban of these facilities is justified. Indeed, a more robust and aggressive attempt at health care reform driven by ethical considerations suggests that a complete closure of the “whole hospital exception” loophole and retroactive removal of Medicare certification from those facilities currently operating may have been the more prudent course.

CONCLUSION

“Ethics in its broadest sense,” Professor Larry Churchill observes, “concerns how we live and the choices we make.” Brought to bear in the context of practical policy deliberations, such normative reflections facilitate review of the array of values in play and the commitments of the various participants. Contemplation of ethical concerns, ultimately, makes it possible to understand more fully the operative principles underlying stakeholders' positions, as well as their implications and likely consequences if adopted.

This article has argued that ethics deserves a seat at the table when arguments are considered for reform to health care policies. Unique among economic enterprises, health care is marked by a delicate relationship of trust between physician and patient, potential patient vulnerabilities, and systematic complexities relating to cost, quality, and access to services. In the face of these vexing dynamics involving competing goods, duties, and responsibilities, the medical profession has historically been self-regulated by codes of ethics and commitments to professionalism. Rising tides of commercialization, however, have eroded much of those internal constraints and, at least in the context of physician-owned specialty hospitals, resulted in exploitation of a legislative loophole, the original intent of which was to mitigate conflicting interests between entrepreneurial, profit-taking opportunities and the patient's best interest.

To the extent health policy decisions must negotiate inherent conflicts of interest, the prioritization of these competing goods, and the distribution of benefits and burdens among those who are vulnerable and have disparate bargaining power, I have argued that the explicit guidance of ethical considerations—consistent with the bedside concerns historically addressed by medical ethics—should be more robustly adopted by those charged with the oversight, governance, and continuing reform of our health care system. Perhaps the recent reforms of the physician-owned specialty hospital industry may spur future legislative and regulatory efforts that recognize and take seriously the ethical consequences that flow when the health care business becomes more about business and less about the care of our health.

Footnotes

a1 Assistant Professor of Business Law and Ethics and Life Sciences Research Fellow, Kelley School of Business, Indiana University-Bloomington. I am grateful for the contributions of a variety of people. First, I owe a hearty thanks to Daniel Cahoy, Joan Gabel, Stephanie Greene, Ann Morales Olazábal, Robert Thomas, David Orozco, Norman Bishara, and Amy Sepinwall for helpful comments.
on a very early draft presented at the American Business Law Journal Invited Scholars Colloquium held at the 2010 Academy of Legal Studies in Business national conference in Richmond, Virginia. Additionally, I am grateful to my colleagues in the Kelley School’s Department of Business Law and Ethics, who offered detailed, thoughtful feedback on a more evolved draft in the context of our department’s faculty research workshop. Finally, the paper was improved in a variety of ways by the nimble editorial efforts of Robert Sprague. I am indebted to these generous and constructive scholars.

The substantive basis of the first American Medical Association code of medical ethics was THOMAS PERCIVAL, MEDICAL ETHICS; OR, A CODE OF INSTITUTES AND PRECEPTS, ADAPTED TO THE PROFESSIONAL CONDUCT OF PHYSICIANS AND SURGEONS (1803). See generally DONALD E. KONOLD, A HISTORY OF AMERICAN MEDICAL ETHICS 1847-1912 (1962) (describing the mid- and late- nineteenth-century developments of medical practice in the United States).

See, e.g., CARL ELLIOTT, WHITE COAT BLACK HAT: ADVENTURES ON THE DARK SIDE OF MEDICINE xi (2010) (“A series of social and legislative changes have transformed medicine into a business, yet because of medicine’s history as a self-regulating profession, no one is really policing it.”); Joseph J. Fins, Commercialism in the Clinic: Finding Balance in Medical Professionalism, 16 CAMBRIDGE Q. HEALTHCARE ETHICS 425, 425 (2007) (“There is a palpable malaise in American medicine as clinical practice veers off its moorings, swept along by a new commercialism that is displacing medical professionalism and its attendant moral obligations.”); John H. McArthur & Francis D. Moore, The Two Cultures and the Health Care Revolution, 277 JAMA 985, 985 (1997) (arguing that, while traditions of commercialism and professionalism both share a central role in the evolution of social institutions in the United States, “threats” exist to the “quality and scope of medical care” when “the tradition of medical professionalism is overtaken by the commercial ethic and by corporations seeking profit for investors from clinical care of the sick”); Jacob Needleman, A Philosopher’s Reflection on Commercialism in Medicine, 16 CAMBRIDGE Q. HEALTHCARE ETHICS 433, 437 (2007) (advocating for reflection among physicians as to “[h]ow ... the money factor ... impact[s] the human values often assumed to define the art of medicine, understood as the work of always and in everything giving first priority to the health and well-being of the individual patient”); Arnold S. Relman, The Problem of Commercialism in Medicine, 16 CAMBRIDGE Q. HEALTHCARE ETHICS 375, 376 (2007) [hereinafter Relman, Commercialism] (“We have a dysfunctional healthcare system, dominated by investor-owned businesses and by market competition that has created a new commercialized environment. It is a system incompatible with the needs of community and personal medical care and with the values of medical professionalism that have traditionally shaped the behavior of our physicians. But we also have a new generation of physicians too ready to accept the replacement of professional values by market dogma--too willing to believe that medical care is just another economic commodity, of which they are simply ‘providers.’ All in all, this bodes ill for the future of U.S. healthcare, which is becoming intolerably expensive, inequitable, and insensitive to the needs of our society.”); Bernard Lown, The Commodification of Health Care, PNHP NEWSL. (Physicians for a Nat’l Health Program, Chi., Ill.), 2007, at 40, available at http://www.pnhp.org/publications/the-commodification-of-health-care (“Health care in America ... has been transformed into a for-profit enterprise in which physicians are ‘health care providers,’ patients are consumers, and both subserve corporate interests. The effect has been to convert medicine into a business, depersonalize doctors and far worse, depersonalize patients.”). See generally, JEROME P. KASSIRER, ON THE TAKE: HOW MEDICINE’S COMPLICITY WITH BIG BUSINESS CAN ENDANGER YOUR HEALTH (2005) (describing the widespread and pernicious impact of money on the practice of medicine); MAGGIE MAHAR, MONEY-DRIVEN MEDICINE: THE REAL REASON HEALTH CARE COSTS SO MUCH (2006) (noting that medicine involves a transaction based on trust and documenting the tensions between free markets and the delivery of health care services); William S. Andererick, Commodified Care, 16 CAMBRIDGE Q. HEALTHCARE ETHICS 398 (2007) (examining the characteristics of health care commodification in the context of medical care and exploring its effects on the doctor-patient relationship); Larry R. Churchill, The Hegemony of Money: Commercialism and Professionalism in American Medicine, 16 CAMBRIDGE Q. HEALTHCARE ETHICS 407 (2007) (exploring the cultural meaning attached to money and its pervasive force throughout medical research, education, and the delivery of health services); Arnold S. Relman, Medical Professionalism in a Commercialized Health Care Market, 298 JAMA 2668 (2007) (arguing that commercialization, led by many physicians who see themselves as primarily businesspeople, has endangered the ethical foundations of medicine); Marc A. Rodwin, Medical Commerce, Physician Entrepreneurialism, and Conflicts of Interest, 16 CAMBRIDGE Q. HEALTHCARE ETHICS 387 (2007) (tracing the historical development of medical commerce in the United States from the late eighteenth century through the early twenty-first century and arguing that the primary problem of commercialism in medicine today is the conflict of interest that arises when loyalty to patients and the exercise of independent professional judgment is compromised by physician entrepreneurship).
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With federal and state government spending included, total health-related expenditures are currently in the neighborhood of $2.5 trillion per year, accounting for greater than one-sixth of the U.S. economy. Timothy Stoltzfus Jost, Global Health Care Financing Law: A Useful Concept?, 96 GEO. L.J. 413, 414 (2008) (“The United States spent almost one sixth of its Gross Domestic Product (GDP) on health care in 2003; this was more than it spent on food, transportation, housing, or any other expenditure.” (citing Gerard F. Anderson et al., Health Care Spending and Use of Information Technology in OECD Countries, 25 HEALTH AFF. 819, 819, 820 exhibit 1 (2006); U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES, 2007, at 435 tbl.656 (126th ed. 2006))).

The diminished influence of professional societies and the decline in their systematic self-regulation can be traced to the U.S. Supreme Court's decision in Goldfarb v. Virginia State Bar, 421 U.S. 773, 787 (1975), and the ensuing series of antitrust lawsuits and Federal Trade Commission decisions. See Rodwin, supra note 2, at 393 (citing Wilk v. Am. Med. Ass'n, 895 F.2d 352 (7th Cir. 1990); In re Am. Acad. of Ophthalmologists, 108 F.T.C. 25 (1986); In re Mich. Optometric Ass'n, 94 F.T.C. 342 (1985); In re Am. Med. Ass'n, 94 F.T.C. 701, 801 (1979)).

Mattia Gilmartin and Edward Freeman acknowledge that many think “health care is not a business, never has been a business, and should not be operated as a business.” Mattia J. Gilmartin & R. Edward Freeman, Business Ethics and Health Care: A Stakeholder Perspective, 27 HEALTH CARE MGMT. REV. 52, 53-54 (2002). Citing health care's significant percentage of gross domestic product and the “corporatization of the American health care sector” that dominated the latter half of the twentieth century, Gilmartin and Freeman dismiss the notion that health care is not a business and make the assertion that this article assumes: “health care is solidly a business endeavor.” Id. (citing ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY (1989)); see also LEONARD J. WEBER, BUSINESS ETHICS IN HEALTHCARE: BEYOND COMPLIANCE 5 (2001) (“Healthcare is a business but it is not just like every other business.”); KENMAN L. WONG, MEDICINE AND THE MARKETPLACE: THE MORAL DIMENSIONS OF MANAGED CARE 66 (1998) (“Medicine has always been about someone's financial gain .... To some degree, medicine has always been a commodity.” (footnote omitted)); Sara L. Beckman & Michael L. Katz, The Business of Health Care Concerns Us All: An Introduction, CAL. MGMT. REV., Fall 2000, at 9, 11 (“Whether there is a strong backlash or not against reliance on market forces in health care, the business of health care is going to remain a business, and a complicated one.”); Mary Rorty et al., The Third Face of Medicine: Ethics, Business and Challenges to Professionalism, in ETHICS AND THE BUSINESS OF BIOMEDICINE 198, 215 (Denis G. Arnold ed., 2009) (“But the consensus at the beginning of this century is that indeed, if not merely a business, medicine is also a business.”). Moreover, to paraphrase the U.S. Supreme Court's discussion of professionalism and the practice of law, it simply cannot be denied that in the modern world the activities of physicians play an important part in commercial intercourse, notwithstanding the profession's historic claim that profit is not the goal. See Goldfarb, 421 U.S. at 787.

For a brief history of how entrepreneurial, market influences have contributed to the evolution of health care delivery in the United States, see Joshua E. Perry, An Obituary for Physician-Owned Specialty Hospitals, HEALTH LAW., Dec. 2010, at 24, 24-25. As early as 1914, “the commercial character of the practice of medicine” was causing concern in the medical community. James P. Warbasse, The Socialization of Medicine, 63 JAMA 264, 264 (1914). An American Medical Association survey of 6000 physicians conducted in the early twentieth century revealed that entrepreneurial, market-oriented approaches to medical practice in the form of kickbacks and commissions were not uncommon. MARC A. RODWIN, MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTERESTS 24-26 (1993). At the outset of the twenty-first century, a motley mix of free market forces, government bureaucracies, and legal rules and regulations drive most policies and procedures in the broad and complex health care sector of the nation's economy. Of course, this triumvirate dominates most commercial sectors of U.S. business activity, from trading floors in New York to automobile production in Michigan to industrial agriculture in California. Yet health care's deep connection with ethical traditions and concern over the best interests of the patient set it apart from most other industries. See Kenneth J. Arrow, Uncertainty and the Welfare Economics of Medical Care, 53 AM. ECON. REV. 941, 948-54 (1963) (discussing the unique challenges of applying normative economics to the practice of medicine).

For an additional example of entrepreneurial advances in health care delivery that raises similar concerns about misaligned interests between taking profits and treating patients in the specific context of end-of-life care, see Joshua E. Perry & Robert C. Stone, In the Business of Dying: Questioning the Commercialization of Hospice, 39 J. L. MED. & ETHICS 224 (2011).
The attorney-client relationship offers a notable analogue. Arrow notes the existence of “strong institutional similarities between the legal and medical-care markets.” Arrow, supra note 6, at 948-49. But beyond the particular relationship that might exist between certain types of attorneys and clients (e.g., criminal defendants, parties to divorce, and individuals involved in child custody proceedings), the health care transaction between doctor and patient is unique in terms of demand frequency, product uncertainty, supply conditions, and pricing. See Joshua E. Perry, The Ethical Costs of Commercializing the Professions: First-Person Narratives from the Legal and Medical Trenches, 13 U. P.A. J.L. & SOC. CHANGE 169, 197-201 (2009-2010) (presenting empirical qualitative evidence arguing that attorneys and physicians—both of which have constitutive commitments to put the interests of others ahead of their own—share similar moral distress around issues related to commercialization of their professions).

The discussion in this article is limited to the “transaction” between a patient-consumer and the physician-provider. A comprehensive application of this article's thesis to the sweeping landscape that constitutes the broader, systematic business of health care is beyond this article's scope. However, the vast array of treatment facilities (inpatient and outpatient), clinicians, insurance companies, marketing and advertising firms, information technology consultants, billing and collection agencies, the global pharmaceutical industry, and other producers of life science products and devices constitute a complex “healthcare business” that offers a variety of future explorations of the framework this article suggests is critical. See generally E. RICHARD BROWN, ROCKEFELLER MEDICINE MEN: MEDICINE AND CAPITALISM IN AMERICA 203 (1979) (noting it was the mid-1960s creation of Medicare and Medicaid that would feed “the market competition between hospitals and the avariciousness of hospital administrators, construction companies, banks, the medical supply industry, and others who could get their hands into the public till”). Dr. Arnold Relman, the Harvard Medical School professor and former editor of The New England Journal of Medicine, was among the earliest observers and critics of the health care business that mushroomed throughout the 1970s in the wake of the passage of Medicare and Medicaid in 1965. See Arnold S. Relman, The New Medical-Industrial Complex, 303 NEW ENG. J. MED. 963,963-65 (1980). Dr. Relman distinguishes between the “old” medical-industrial complex, primarily pharmaceutical and medical device corporations, and the new emerging “network of private corporations engaged in the business of supplying health-care services to patients for a profit.” Relman, supra, at 963. Writing in 1980, he was not concerned about the former. Id. Twenty-seven years later, he remains very concerned about “the future of U.S. healthcare, which [he argues] is becoming intolerably expensive, inequitable, and insensitive to the needs of our society.” Relman, Commercialism, supra note 2, at 376.


See Arrow, supra note 6, at 948-58; Marc J. Roberts & Michael R. Reich, Ethical Analysis in Public Health, 359 LANCET 1055, 1057 (2002) ("[H]ealth is generally viewed as special or different from most other things produced by the economy."). Building upon Rawls's theory of justice as fair equality of opportunity, Norman Daniels states that, “by keeping people close to normal functioning, health care preserves for people the ability to participate in the political, social, and economic life of their society. It sustains them as fully participating citizens—normal collaborators and competitors—in all spheres of social life.” Norman Daniels, Justice, Health, and Healthcare, AM. J. BIOETHICS, Spring 2001, at 2, 3. See generally NORMAN DANIELS, JUST HEALTH CARE (1985) (arguing that health care is special because of its impact on individual access to opportunity in a free society).

See Troyen A. Brennan, An Ethical Perspective on Health Care Insurance Reform, 19 AM. J.L. & MED. 37, 48 (1993) (“Indeed, traditional medical ethics insisted that physicians do everything possible for the individual patient, independent of political or
economic constraints.”); Perry, supranote 11, at 172-76 (discussing the service component and relational aspects at the heart of historic notions of medical professionalism).

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

17 See Arrow, supranote 6, at 949 (“[M]edical care belongs to the category of commodities for which the product and the activity of production are identical ... [and therefore] the customer cannot test the product before consuming it, ... [creating] an element of trust in the relation.”).

18 See Heather Elms et al., Ethics and Incentives: An Evaluation and Development of Stakeholder Theory in the Health Care Industry, 12 BUS. ETHICS Q. 413, 425 (2002) (concluding that economic incentives can encourage physicians to behave in ways inconsistent with the ethical norms of the profession).

19 See infra note 40 and accompanying text. This notion that being a patient is a unique ontological position is a key component to this article's claim that ethical considerations driven by concerns over the patient's best interest should inform health care law and policy reforms in the absence of industry self-regulation and overt exploitation of statutory loopholes.

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

21 Brennan, supranote 15, at 38; see also Wendy K. Mariner, Business vs. Medical Ethics: Conflicting Standards for Managed Care, 23 J.L. MED. & ETHICS 236, 238 (1995) (discussing the ethical tensions inherent in the health care industry).

22 Brennan, supranote 15, at 48 (arguing that “an ethics of health policy should share some common themes with traditional medical ethics”). Brennan, aiming his argument more specifically at the problems associated with access to health care by the uninsured, notes the difficulty of merging a traditional medical ethics that requires physicians to “do everything possible for the individual patient” with an ethics of health care policy that has as “its central paradigm the limits on medical care resources.” Id. at 48-49; see also Larry R. Churchill, What Ethics Can Contribute to Health Policy, in ETHICAL DIMENSIONS OF HEALTH POLICY 51,61 (Marion Danis et al. eds., 2002). However, Professor Churchill notes that in the current U.S. context of market-driven medicine, “health policy has no purpose beyond the separate purposes of the individual actors, and the only appropriate role of specific health policies, rules, and regulations is to make the bargaining process among providers and consumers at all levels devoid of fraud and abuse.” Id. Churchill's broader normative view is that health policy should be driven by the dual ends of two ethical concerns, security and solidarity. See generally CHURCHILL, supranote 13.

23 Brennan, supranote 15, at 50. As articulated in the seminal work on biomedical ethics, “[T]he principle of nonmaleficence asserts an obligation not to inflict harm on others.” TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 113 (5th ed. 2001). Beneficence refers to those actions of kindness, mercy, and charity that are performed for the benefit of others. Id. at 166.

24 Brennan, supranote 15, at 50.

25 Id. (citing JOHN RAWLS, A THEORY OF JUSTICE 118-50 (1971)). Another formulation of Rawls in this context is offered by Kenman L. Wong, who appropriates Rawls via Edward Freeman to suggest that a fairness-oriented stakeholder approach would guide physicians to make decisions for patients irrespective of the financial consequences at stake. See WONG, supranote 5, at 131 (citing R. Edward Freeman, A Stakeholder Theory of the Modern Corporation, in ETHICAL THEORY AND BUSINESS 66, 72 (Tom L. Beauchamp & Norman E. Bowie eds., 5th ed. 1997)).
See Brennan, supra note 15, at 50.

See infra Part III.C (applying and further developing these principles in the form of concerns over nonmaleficence, conflicts of interest, and bona fide, transparent ownership).

Brennan, supra note 15, at 51. Brennan highlights the hallmarks of trust, selflessness, and virtue that distinguish the physician-patient relationship from most other marketplace encounters. Moreover, he argues that ethical health policy must consider “the good” of this isolated relationship “in light of the good of all patients.” Id. This move from the individual physician-patient relationship to a concern for the broader good of all potential patients is controversial to the extent it threatens to dilute the physician’s duty of loyalty to her patient. Id.

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

Id. at 51-53. Here, Brennan challenges mere “non-interference” among physician practice groups and suggests that physicians will have to coordinate cooperative efforts to provide patient care in a system that will face economic constraints that will only increase over time. Id. at 52. Perhaps it is naïve to suggest, as Brennan does, that members of healing communities must be aware of the interconnectedness of their actions and that our health policy should reflect such a community orientation. Yet, such a view is constitutive of the approach to ethical health care policy that takes seriously the constellation of ethical and economic issues relating to the individual physician-patient relationship, as well as the broader concerns of access to all citizens and long-term systematic sustainability. Naïve or not, this notion of solidarity is an increasingly important value toward which policy makers must continue to strive, despite whatever difficulties might challenge its attainment. See, e.g., Atul Gawande, The Cost Conundrum, NEW YORKER, June 1, 2009, at 36 (describing how the health care community of Grand Junction, Colorado, for example, has operationalized ethical health policy premised upon a recognition that good public health and its financing are deeply interconnected and noting also that Grand Junction’s healing community has been successfully adopted by communities of health care providers in Pennsylvania, Wisconsin, Utah, California, and within the Mayo Clinic system in both Minnesota and Florida).

Brennan, supra note 15, at 53-54. Brennan also addresses the objections of those concerned that “the morality of the clinical relationship cannot be exported to the institutional level.” Id. at 53. He responds by asserting that his integration of medical ethics with liberal notions of justice is necessary for preservation of the physician-patient relationship and the unique identity of health care institutions. Id.


Amy Feldman, Are You Ready to Own Your Own Health Care? MONEY MAG., Nov. 2004, at 135.

Regina E. Herzlinger, Specialization and Its Discontents: The Pernicious Impact of Regulations Against Specialization and Physician Ownership on the US Healthcare System, 109 CIRCULATION 2376, 2376-78 (2004) (arguing also that these physician-owned specialty hospitals are exemplary models of efficiency and specialization that, if left unregulated, might serve as models for more widespread, market-based health care system reforms).

Id. at 2377. Even Maggie Mahar, a critic of Herzlinger and so-called “market-driven healthcare,” notes that it is “indisputable” that the reimbursement system is flawed. MAHAR, supra note 2, at 40. Indeed, the Medicare Payment Advisory Commission (MedPAC), an independent congressional agency, issued a report to Congress in March 2005 recommending that diagnosis-related groups payment
and reimbursement codes be adjusted for heart and orthopedic procedures. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS, PHYSICIAN-OWNED SPECIALTY HOSPITALS 40 (2005) [hereinafter PHYSICIAN-OWNED SPECIALTY HOSPITALS].

37 See HERZLINGER, MARKET-DRIVEN HEALTH CARE, supra note 33, at 167; Herzlinger, supra note 35, at 2378.

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

39 Mark A. Hall & Carl E. Schneider, Patients as Consumers: Courts, Contracts, and the New Medical Marketplace, 106 MICH. L. REV. 643, 650-51 (2008). Hall and Schneider explain:

Someone who is ill and seeking help--unlike someone who is purchasing a pair of socks or a pound of sausages--is often vulnerable, certainly worried, sometimes uncomfortable, and frequently frightened. [The term c]ustomer, like the other obvious choices--clients, consumers, and users--erases something that lies at the heart of medicine: compassion and a relationship of trust.

Id. at 651 (quoting Raymond Tillis, Commentary: Leave Well Alone, 318 BRIT. MED. J. 1756, 1757 (1999)). But see Marshall B. Kapp, The Ethical Foundations of Consumer-Driven Health Care, 12 J. HEALTH CARE L. & POL’Y 1, 6 (2009) (questioning whether health care is “so much more inherently and irreducibly complex and confusing” than other sorts of consumer goods and cautioning against the infantilization of patients).

40 These scenarios are extrapolations from my professional experiences in the health care field.


43 See infra notes 48-50 and accompanying text.

44 Brennan, supra note 15, at 54.


46 The ethical approach to health care regulation endorsed in this article favors health care policies that either increase access or guard against erosions in access to providers.

47 Herzlinger, supra note 35, at 2376.

Nationwide, eighty-three percent of these facilities can be found in states without “certificate of need” regulations, with the greatest concentration in seven states: Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota, and Texas. See FED. TRADE COMMMN & U.S. DEPT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 18 n.82 (2004) [hereinafter A DOSE OF COMPETITION]. Certificate of need (CON) laws arose in the 1960s in response to concerns regarding oversupply of medical services. The state-based laws basically require those entities wishing to build new medical facilities, or existing hospitals wishing to increase their number of beds, to demonstrate there is an unmet medical need within the geographic region to be served. Although Ronald Reagan's election in 1980 “ushered in a decade of emphasis on market solutions to health care,” which resulted in the repeal of many CON statutes, thirty-eight states still retain some measure of CON oversight. Sujit Choudhry et al., Specialty Versus Community Hospitals: What Role for the Law? HEALTH AFF. (WEB EXCLUSIVE), July-Dec. 2005, at W5-361, W5-366; see also Casalino et al., supra note 32, at 57; David N. Heard, Jr., The Specialty Hospital Debate: The Difficulty of Promoting Fair Competition Without Stifling Efficiency, 6 HOUS. J. HEALTH L. & POL’Y 215, 234-39 (2005); Lauretta Higgins Wolfson, State Regulation of Health Facility Planning: The Economic Theory and Political Realities of Certificates of Need, 4 DEPAUL J. HEALTH CARE L. 261, 262 (2001). According to the GAO, greater than ninety percent of the specialty hospitals that have opened in the United States since 1990 are for-profit operations. U.S. GEN. ACCOUNTING OFFICE, GAO-04-167, SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, SERVICES PROVIDED, AND FINANCIAL PERFORMANCE 8 (2003). By comparison, twenty percent of general hospitals are for-profit. Id.; see also John K. Iglehart, The Emergence of Physician-Owned Specialty Hospitals, 352 NEW ENG. J. MED. 78, 79 (2005). The specialty hospital genre with which this article is particularly concerned is marked by a focus on short-term, acute infirmities and a for-profit status, characterized by joint ownership among the physicians who practice in the facility. But see Louis Shapiro, The Specialty Myth: A Venerable Niche Hospital Is Model of Quality Care, MOD. HEALTHCARE, Aug. 25, 2008, at 54 (discussing New York's Hospital for Specialty Surgery, a nonprofit, academic musculoskeletal hospital founded in 1863 that provides orthopedic and rheumatologic services, research, and charity care, proving the point that “there really is no specialty hospital ‘industry’ and that among the models of niche facilities are many that contribute greatly to innovation in healthcare delivery and ensure the highest levels of quality and outcomes”).

Out of the twenty-five specialty hospitals surveyed by the GAO, twenty-one were found to have a less acute mix of patients than full-service hospitals. See SPECIALTY HOSPITALS: PATIENTS SERVED, supra note 48, at 4. For example, 3 percent of the patients in the 10 most common diagnosis categories at one Texas orthopedic hospital were classified as severely ill. A higher proportion—8 percent—of the patients in the same diagnosis categories were classified as severely ill at the 51 general hospitals in the same urban area. A cardiac hospital in Arizona provides a similar example. About 17 percent of the patients in that hospital's most common diagnosis categories were classified as severely ill. In contrast, 22 percent of the patients in the same diagnosis categories who were treated at the 26 general hospitals in the same urban area were classified as severely ill. Id. at 12; see also Allen Dobson & Randall Haught, The Rise of the Entrepreneurial Physician [sic], HEALTH AFF. (WEB EXCLUSIVE), July-Dec. 2005, at W5-494, W5-495 (acknowledging that it is well documented that “patients at specialty hospitals are less severely ill than patients at comparable nonspecialty community hospitals,” but suggesting that “[p]hysician referral patterns are complex, and plausible market reasons exist as to why specialty hospitals do not treat the sickest patients”).

MEDICARE PAYMENT ADVISORY COMMN, REPORT TO THE CONGRESS, PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED 8-10 (2006) [hereinafter PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED]. The MedPAC study found that at orthopedic/surgical specialty hospitals, “adjusted inpatient costs per discharge were 117% of the national average.” Id. at 9. Furthermore, the report found that, when a physician-owned specialty hospital enters a market, the utilization rates and requests for Medicare reimbursements increase. Id. at 20. “Whether the increase in surgeries stems from increased capacity, from the financial incentives for physicians to self-refer patients to facilities they own, or a combination of these factors, increased surgeries can lead to increased Medicare spending.” Id. at 21. These findings of greater costs to the Medicare system were bolstered by a follow-up academic study that compared the practice patterns of physician-owners of specialty hospitals in Oklahoma, both before and after they acquired their ownership interest, to the practice patterns of physician-nonowners treating similar cases during the same time frame. See Jean M. Mitchell, Do Financial Incentives Linked to Ownership of Specialty Hospitals Affect Physicians' Practice Patterns?, 46 MED. CARE 732, 736 (2008). Mitchell’s research confirms that, after physicians became owners in their specialty orthopedic hospital, the utilization rates for surgical, diagnostic, and ancillary services used to treat back and spine ailments
increased significantly. *Id.* at 736. During the same time period in the same market, dramatic increases in utilization were not seen in the practices of nonowner physicians. While recognizing the possible limitations of her study, given the fact that it relied only on data from one area of the country, Mitchell concluded that substantial increases in utilization rates can be linked to physician ownership and that treatment costs are likely to be “significantly higher in comparison to those who obtain care from non-self-referral providers.” *Id.* at 737; accord John M. Hollingsworth et al., *Physician-Ownership of Ambulatory Surgery Centers Linked to Higher Volume of Surgeries*, 29 HEALTH AFF. 683, 683 (2010) (analyzing five common surgical and diagnostic procedures and finding a significant association between physician ownership and higher surgical volume); Bruce Siegel et al., *Private Gain and Public Pain: Financing American Health Care*, 36 J.L. MED. & ETHICS 644, 649 (2008) (“Not surprisingly, the approximately 130 physician-owned specialty hospitals have been associated with much higher rates of costly elective surgery, such as spinal fusion, and with performing surgeries on relatively healthier patients.” (footnote omitted)); see also Brahmajee K. Nallamothu et al., *Opening of Specialty Cardiac Hospitals and Use of Coronary Revascularization in Medicare Beneficiaries*, 297 JAMA 962 (2007) (providing data showing a correlation between the opening of a specialty cardiac facility and significant increases in the market utilization rates of coronary revascularization services); Gawande, *supra* note 30 (investigating the extreme differences between Medicare reimbursement rates in two Texas markets—in one of which Medicare spent twice the national average per enrollee in 2006—and concluding the higher rates were directly attributable to patterns of overutilization driven by a “culture of money” where over time the “medical community came to treat patients the way subprime-mortgage lenders treated home buyers: as profit centers”).

Ron Winslow, *Coronary Bypass: Fed-Up Cardiologists Invest in Own Hospital Just for Heart Disease--They'll Regain Autonomy, but Critics See a Grab for Most-Profitable Care--A Showdown in Albuquerque,* WALL ST. J., June 22, 1999, at A1. Clearly, physician-owned specialty hospitals reflect rational and opportunistic business savvy on the part of those cardiac and orthopedic surgeons who have led the charge in their proliferation. These medical centers represent an entrepreneurial, market-based innovation in the delivery of specialized health care that offers a number of benefits to providers and individual patients. Yet, the services that physicians perform in relationship with potentially vulnerable individual patients, as well as the broader potential patient population, create unique variables in the marketplace that require ethical considerations. In the domain of health care delivery, public policies must look beyond customer satisfaction surveys and economic self-interests.


*Id.* note 52.

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

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

Brennan, *supra* note 15, at 52. Although a complete discussion is beyond this article's scope, the practice of “economic credentialing,” which was the retaliatory move made by some community hospitals to revoke admitting privileges in response to those entrepreneurial physicians who started competing hospitals, would certainly be an additional detour on the path toward the type of community orientation being described. See Robert Steinbuch, *Placing Profits Above Hippocrates: The Hypocrisy of General Service Hospitals*, 31 U. ARK. LITTLE ROCK L. REV. 505, 506-07 (2009).
Kelly J. Devers et al., Specialty Hospitals: Focused Factories or Cream Skimmers? ISSUE BRIEF (Ctr. for Studying Health Sys. Change, Washington, D.C.), Apr. 2003, at 2 (“The spate of specialty hospital construction is unnerving general hospitals, which worry that the new facilities will draw away profitable patients and undermine their ability to achieve the volume needed to provide high-quality, low-cost specialty services and to cross-subsidize other basic services .... [C]ardiology services ... can account for 25 percent of all hospital stays and 35 percent or more of community hospitals' revenue.”).

See A DOSE OF COMPETITION, supra note 48, at 15 (citing several testifying experts articulating concerns that specialty hospitals would “siphon off the most profitable procedures and patients, leaving general hospitals with less money to cross subsidize other socially valuable, but less profitable, care”). As one expert noted, “it is the profitable services they are taking away that jeopardizes a hospital's capability of providing unprofitable services.” Id. at 21.

Unmesh Kher et al., The Hospital Wars, TIME, Dec. 11, 2006, at 64.

Id.

Iglehart, supra note 48, at 81.

Id.

Id.

Id.

Kher et al., supra note 63.

PHYSICIAN-OWNED SPECIALTY HOSPITALS, supra note 36, at 23.

Id. at 33.

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

Id.

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


Id. at W5-484.

Id. at W5-485, W5-486.

PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED, supra note 51. MedPAC was following up on its 2005 report, which had been mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Id. at 3. While the 2005 report had analyzed data from 2002, the follow-up report examined an expanded set of physician-owned specialty hospitals from 2003 and 2004. Id. During that time period, the number of physician-owned specialty hospitals had almost doubled. Id. The 2006 report focused on twenty-five cardiac and sixteen orthopedic/surgical hospitals. Id. at 4.

Id. at 7.

Id. at 9-10 (finding that stays in physician-owned hospitals were over twenty percent shorter than stays in community hospitals). The MedPAC study found that at orthopedic/surgical specialty hospitals “adjusted inpatient costs per discharge were 117% of the national average.” Id. at 9. As noted supra note 51 and accompanying text, the 2006 report speculated that these increased costs at physician-
owned specialty hospitals were a result of different staffing levels, employee compensation, and the use of single-occupancy rooms equipped for intensive care. PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED, supra note 51, at 11.

80 PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED, supra note 51, at 20. “Whether the increase in surgeries stems from increased capacity, from the financial incentives for physicians to self-refer patients to facilities they own, or a combination of these factors, increased surgeries can lead to increased Medicare spending.” Id. at 21.

81 Mitchell, supra note 74, at W5-487.

82 Mitchell, supra note 51; see also Hollingsworth et al., supra note 51, at 683 (analyzing five common surgical and diagnostic procedures and finding “a significant association between physician-ownership and higher surgical volume”); Bruce Siegel et al., supra note 51, at 649 (“Not surprisingly, the approximately 130 physician-owned specialty hospitals have been associated with much higher rates of costly elective surgery, such as spinal fusion, and with performing surgeries on relatively healthier patients.”).

83 Mitchell, supra note 51, at 736; accord Nallamothu et al., supra note 51; Gawande, supra note 30.

84 Mitchell, supra note 51, at 736.

85 Id. at 737.


88 Id.

89 Id.

90 Id. Out of the $15,000 Medicare pays for a typical lumbar laminectomy, $10,000 goes directly to the hospital and $1800 is typically paid to the surgeon. The remainder is paid to the anesthesiologist and others assisting in the operation. Id.

91 See Wilson Testimony, supra note 86.

92 Jaquiss, supra note 87. Wilson's son, during his congressional testimony, described the scene as “the most egregious examples of negligence and incompetence” that he had ever witnessed or heard of. Wilson Testimony, supra note 86, at 4.

93 Jaquiss, supra note 87. Neither federal law nor Oregon statutes require a physician to be on the premises of a hospital at all times. Jessica Zigmond, CMS Probe Sought; Death Sparks Specialty Hospital Queries, MOD. HEALTHCARE, Feb. 20, 2006, at 7.

94 Jaquiss, supra note 87. Investigations by the Oregon Department of Human Services and its Health Care Licensure and Certification Program concluded that the governing body of Physicians' Hospital “failed to ensure that the medical staff was accountable for the quality of care provided to patients.” Id.; see also Joe Rojas-Burke, Potential Buyer Looks at Physician Hospital, OREGONIAN, Mar. 31, 2006, at B1. Less than a year after Wilson's death, government regulators stripped the hospital of its certification to receive Medicare payments, and the building was purchased by a private, out-of-state health care company that converted the hospital to a long-term acute-care facility. See Joe Rojas-Burke, Physicians' Hospital Suspends Procedures After Failed Inspection, OREGONIAN, May 13, 2006, at E1; Joe Rojas-Burke, Troubled Physicians' Hospital May Have Buyer, OREGONIAN, May 17, 2006, at E1. When Wilson's plight came to light in 2006, Senators Chuck Grassley, a Republican, and Max Baucus, a Democrat, immediately called for a federal investigation by HHS into whether the Centers for Medicare and Medicaid Services (CMS) was properly overseeing physician-owned specialty hospitals. See Laura B. Benko, Troubled Hospital on Notice; Oregon Facility Could Lose Certification from CMS, MOD. HEALTHCARE, May 22, 2006, at 8; Zigmond, supra note 93. At least two additional tragic stories in Colorado and Texas, similar to Wilson's, played out in the ensuing four years. See Karen Auge, Death Adds to Debate on Doc-Owned Hospitals, DENVER POST, Aug. 9, 2009, at A-01, available at http://www.denverpost.com/firstinthe/post/0ci_13023972 (reporting on the death of a patient at a physician-owned specialty hospital after a medication error that required
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Tragic and unavoidable deaths arising from physician error or hospital accidents are not limited to the environment of the physician-owned specialty facility. Indeed, since the Institute of Medicine published its report on medical errors over a decade ago, copious evidence has demonstrated that preventable deaths are not exceptional events in medical facilities, including full-service hospitals with emergency departments on site and trained emergency physicians on the premises around the clock. See, e.g., LINDA T. KOHN ET AL., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 26 (2000) (arguing that preventable adverse events in medical facilities are a leading cause of death in the United States); Lucian L. Leape & Donald M. Berwick, Five Years After To Err is Human: What Have We Learned? 293 JAMA 2384, 2385 (2005) (noting a proliferation of subsequent studies exploring widespread preventable medical injuries and hospital-acquired infections and suggesting that the report may have “substantially underestimated the magnitude of the problem”). Importantly, however, the three preventable deaths described above did not occur in traditional, full-service hospitals. These deaths took place in settings where the physicians and surgeons—entrusted with the ethical duty and professional mandate to put the patient's best interest in front of investor-provider profit margins—had a simultaneous economic self-interest in the profits generated by the facility in which they chose to operate on their patients.

Press Release, Physician Hosps. of Am. (PHA), Physician Owned and Operated Hospitals Get Top Rankings From Consumer Reports, but They Remain on the Healthcare Reform Chopping Block (Aug. 11, 2009), available at http://www.prnewswire.com/news-releases/physician-owned-and-operated-hospitals-get-top-rankings-from-consumer-reports-but-theyremain-on-the-healthcare-reform-chopping-block-62207532.html. Such a response from patient satisfaction surveys is not surprising when these facilities are heralded for their upscale food, private rooms, and pleasant waiting areas with “muted colors, comfortable seating, soft lighting, and quality artwork.” Jessica Zigmond, Betting Big on Doc Ownership, MOD. HEALTHCARE, Dec. 11, 2006, at 6 (quoting Kamran Nezami, a founder of University Hospital Systems, a private, for-profit company that specializes in the recruitment of physician-investors and the development of physician-owned hospitals, describing his flagship facility, University General Hospital in Houston, Texas); see also LEAVITT, supra note 73, at 51 (reporting that patients in focus groups commented very positively on all the “extras” that they encountered in the physician-owned specialty hospital environment, such as the food, rooms, waiting areas, lower noise level, and treatment of family members). Thus, any critique of these facilities must inevitably confront what for some is the final arbiter of the debate, that is the patient survey data showing high levels of satisfied “customers.” For proponents of a competitive medical marketplace, the customer is always right, and the satisfaction and positive experiences reported by a majority of patients at these physician-owned specialty hospitals is a significant justification for their continued existence.

PHYSICIAN-OWNED SPECIALTY HOSPITALS’ ABILITY TO MANAGE MEDICAL EMERGENCIES, supra note 48.

Id. at 9.

Id. at i (“All hospitals that participate in the Medicare program must demonstrate to the [CMS] their initial and ongoing ability to meet a set of health and safety standards, referred to as the [CoP].”). Medicare's CoP do not require that hospitals have emergency departments, although many states do mandate “emergency treatment rooms.” See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 241.026 (West 2010).

PHYSICIAN-OWNED SPECIALTY HOSPITALS’ ABILITY TO MANAGE MEDICAL EMERGENCIES, supra note 48, at 10. Additionally, interviews with administrators of the physician-owned specialty hospitals that were investigated by the OIG revealed that only twenty-eight percent of these facilities have physicians onsite twenty-four hours a day, seven days a week. Id. at ii. Notably, the CoP do not require hospitals to have physicians physically on the premises at all times. Id. at i.
Examples of emergency policies at some physician-owned specialty hospitals include: “9-1-1 will be called to the scene to attempt resuscitation”; “[a]fter hours, call 9-1-1 for a Code Blue. Upon arrival, [county] EMS will assume responsibility for the patient”; and “[i]f conditions are such that staff should require additional assistance, 9-1-1 will be contacted.”

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

See Perry, supra note 6, at 26-27 (detailing the legislative reforms that criminalized physician kickbacks for referring Medicare and Medicaid patients to diagnostic and medical testing facilities). For citations to research demonstrating the correlation between economic incentives and overutilization of medical services, see RODWIN, supra note 6, at 55-96; James F. Blumstein, The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy, 22 AM. J.L. & MED. 205, 209 (1996); Jean M. Mitchell, Physician Joint Ventures and Self-Referral: An Empirical Perspective, in CONFLICTS OF INTEREST IN CLINICAL PRACTICE AND RESEARCH 219-317 (Roy G. Spece, Jr. et al. eds., 1996). Blumstein, Mitchell, and Rodwin cite numerous studies confirming the notion that economic incentives result in overutilization. The data are conclusive that financial interest influences medical decisions.

DEPT OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., OAI-12-88-01410, FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES ii (1989) [hereinafter FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES].


For additional background on the particular evidence establishing the connections between physician investments in health care clinics and concomitant increases in utilization and service costs that fueled Stark's legislative efforts, see generally FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES, supra note 106, at 11; Jean M. Mitchell & Elton Scott, Evidence on Complex Structures of Physician Joint Ventures, 9 YALE J. ON REG. 489, 497 (1992).

The exception was intended to accommodate rural hospitals where such ownership arrangements were already in place. See H.R. REP. NO. 111-443, pt. 1, at 355 (2010).

SPECIALTY HOSPITALS: PATIENTS SERVED, supra note 48, at 2.


See Iglehart, supra note 48, at 78.

151 CONG. REC. S4946 (daily ed. May 11, 2005) (statement of Sen. Grassley). Senator Charles Grassley was speaking in support of “The Hospital Fair Competition Act,” which he and Senator Max Baucus were sponsoring. This proposed legislation would, among other things, “[c]lose the ‘whole hospital’ loophole by prohibiting new specialty hospitals from having ownership or investment interest from physicians who refer Medicare or Medicaid patients to the hospital, effective June 8, 2005.” Id. at S4947. Effectively,
this bill would have permanently extended the moratorium and ceased any growth in the industry, while allowing existing facilities to continue operating. Much of this bill’s substance was ultimately incorporated into the PPACA.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 507(a), 117 Stat. 2066 (2003). The law included an exemption for facilities either already in operation or under development— that is, with complete architectural plans, secure funding, and requisite state government approvals. Id. § 507(b).


For the approximately sixty physician-owned facilities under construction or in some stage of development as of the PPACA’s passage, the new law set a deadline of December 31, 2010, for these facilities to secure status as a Medicare-eligible provider. 42 U.S.C.A § 1395nn(i)(l)(A). See generally Hogberg, supra note 124 (reporting on the impact of the PPACA on new physician-owned hospitals). Of course, nothing in the PPACA would prevent these facilities from being completed and treating non-Medicare patients after December 31, 2010, but without Medicare-provider status, these facilities would be reliant upon self-paying and privately insured patients. Without the ability to bill Medicare for self-referrals, physician-owned specialty hospitals generally are not economically viable. See Physician Hosps. of Am. v. Sebelius, 781 F. Supp. 2d 431, 448 (E.D. Tex. 2011) (noting that the expansion projects at issue in the case were halted because they “were not economically viable without the ability to bill for Medicare self-referrals”).

42 U.S.C.A. § 1395nn(i)(l)(B). The exception clause sets a February 1, 2012, deadline for the Secretary of HHS to create a process by which either “applicable” or “high Medicaid” physician-owned specialty hospitals may apply, once every two years, for permission to expand their capacity by up to one hundred percent. Id. § 1395nn(i)(3).
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128  Id.
129  Id.
130  Id. § 1395nn(i)(l)(D)(i)-(vii).
131  Id. § 1395nn(i)(l)(E)(i).
132  Id. § 1395nn(i)(l)(E)(ii). These safety mandates were first required by CMS in 2007. See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates, 72 Fed. Reg. 47,130, 47,413 (Aug. 22, 2007) (codified at 42 C.F.R. §489.20(w)(l) (2011)).
134  Id. at 2.
135  Id. at 3. Texas Hospital was rated number one in the state of Texas in 2009 for spine surgery by the Eleventh Annual HealthGrades Hospitals in America Study. Id.
136  Id. at 3.
138  Id. at 439, 442.
139  Id. at 442.
140  Id.
141  Id. at 446.
142  Id. (citing Vance v. Bradley, 440 U.S. 93, 111 (1979); Ferguson v. Skrupa, 372 U.S. 726, 730 (1963); Shelton v. City of College Station, 780 F.2d 475, 479 (5th Cir. 1986) (en banc)) (internal quotation marks omitted).
143  Id. at 447.
144  Id.
145  Id. at 448.
146  Id. at 449.
147  Id.
148  Id.
149  Id. at 450.
150  Id.
151  Id.
152  Id. at 453.


155 Brennan, supra note 15, at 38.

156 See BEAUCHAMP & CHILDRESS, supra note 23, at 113.

157 See Brennan, supra note 15, at 50-51.

158 See Perry, supra note 11, at 190-201 (describing empirical data suggesting that issues related to commercialism in medicine are frequent and serious causes of moral distress in the professional lives of physicians).

159 See supra Part II.B.

160 See supra note 96 and accompanying text. Any critique of these facilities must inevitably confront what for some is the final arbiter of the debate, namely, the patient survey data showing high levels of satisfied customers.

161 See supra note 25 and accompanying text.

162 PHYSICIAN-OWNED SPECIALTY HOSPITALS’ ABILITY TO MANAGE MEDICAL EMERGENCIES, supra note 48, at 5.

163 PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED, supra note 51, at 7.

164 Id.

165 Id. at 8.

166 Id.


168 Brennan discusses these ethical concerns in terms of conflicts that compromise the “altruism of healing.” See Brennan, supra note 15, at 51-52.

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

170 As Kenman Wong observes, “[W]henever money changes hands, the prospect of a conflict of interest is insidiously present.” WONG, supra note 5, at 68.


172 See supra notes 80-85, 105-06, and accompanying text. See generally Jean M. Mitchell, Effect of Physician Ownership of Specialty Hospitals and Ambulatory Surgery Centers on Frequency of Use of Outpatient Orthopedic Surgery, 145 ARCHIVES SURGERY 732 (2010) (concluding that financial incentives linked to ownership of either specialty hospitals or ambulatory surgery centers influence...
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physicians' practice patterns); Maureen Kwiecinski, Comment, Limiting Conflicts of Interest Arising From Physician Investment in Specialty Hospitals, 88 MARQ. L. REV. 413 (2004) (discussing empirical data that demonstrate patterns of overutilization of medical services when physicians refer patients to providers of medical services in which they have an ownership interest).


See Churchill, supra note 22, at 53.