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Referral for Profit: Deprofessionalization of Health Care in America

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Abstract

Recently, sociologists have described an erosion of the trust historically given to professions within society. Traditionally elevated to a unique form of occupation, professions—medicine, law, teaching, and religion—were originally afforded special privileges, including the ability to self-regulate, the right to autonomous practice, and a high level of respect.[1] Antithetically, when medical professionals invest in services to which they refer, when consumers pay too much for visits, when patients don't get the consistently high quality care they deserve, and when the overall financial impact increases the economic burden on society, public trust is compromised. Physician-owned physical therapy practices (POPTS) provide a contemporary illustration of deprofessionalization in the current, troubled US health care system. Although these fee-splitting, kick-back, referral-for-profit arrangements have been deemed illegal, they continue to thrive. Valuing profit over integrity, POPTS violate the unique fiduciary relationship between a health care practitioner and the patient. This complex paradigm of practice and its consequences are illustrated through the following: an historic and social context of physical therapy; a detailed account of the relevant laws; an account of educating health care professionals for moral action; and a clinician's pragmatic perspective of ethical practice.

Introduction: a patient speaks out

When Barbara Kelley of Wichita, Kansas, followed her surgeon's recommendation for rehabilitation after knee surgery, she did so reluctantly. She had been comfortable with her physical therapist (PT), but she felt pressured to transfer to her physician's physical therapy clinic. There, she experienced treatment that prompted her to voice her concerns to the American Physical Therapy Association (APTA).[2] In contrast to her prior one-on-one PT care, Kelley said that her therapy sessions cost $300 more per session, took two hours longer, and were run by only two certified PTs per 45 patients).[3]

Kelley's distress begs the question: did the doctor refer the patient to this facility with her best interests in mind? Under what circumstances did the two PTs employed by the physician agree to practice in this scenario? Were the PTs or the physician acting unethically or illegally? Is Kelley's case an outlier, or does it indicate a larger trend? And if the latter, what, if any, are the ramifications for each patient, each practitioner, each institution, and the society at large? To approach these queries, it is necessary to investigate the fundamental socio-economic and political infrastructures, the supporting laws, and the philosophical values of the health care system in the United States, and one must place referral for profit in a global context. One hopes this investigation would validate the trust that society, including its most vulnerable members, gives to the medical profession. But instead, this investigation uncovers a rationale by which some medical professionals subordinate their fiduciary duty to the patient for monetary reward. This rationale is understandable because doctors are often financially burdened —the costs of

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1 Charles Christiansen, EDD, OTR, OT(C), FAOTA, "Creating Community: An Essay on the Social Responsibility of Health Care Professionals," in *Educating for Moral Action: A Source Book in Health and Rehabilitation Ethics* (Philadelphia: F. A. Davis Company, 2005), 56.

2 APTA White Paper (July 2007) *Reactions from Members and Patients on Physician-Owned Physical Therapy* Services (POPTS), 3.

3 Ibid.

medical school, of malpractice insurance, and of declining reimbursement—and they are paid for the procedures that they perform, known as the "fee-for-service" model. But the rationale is also disappointing because it violates ethical and fiduciary responsibilities that are normative for medical professionals.

What should health care look like?

Professions are unique forms of occupations, to which society affords special privileges, including the ability to self-regulate, the right to autonomous practice, and a high level of respect.[4] The professions influence human well-being; they require mastery of a complex body of knowledge and of specialized skills, requiring both formal education and practical experience; and they carry a responsibility to keep and advance a body of knowledge, to set credible, useful standards, and to self-govern.[5] Integral to this discussion is a crucial term, *fiduciary*:

> Fiduciaries have specialized expertise and are held to high standards of honesty, confidentiality, and loyalty. Above all, fiduciaries must avoid conflicts of interest that could prejudice their clients' interests.[6]

In return, society expects members of a profession to be worthy of these privileges. Implicitly understood to be guided by the intent to benefit the community in which he or she practices, a professional is expected to embody ethical behavior, to deliver community service, and to provide societal leadership.[7]

Because human welfare and, indeed, life itself are at stake, some argue that the ethical practice of social virtues is more important in health care than in other professions.[8] This is the argument of Dr. Edmund Pellegrino, a medical ethicist, medical doctor, Georgetown University professor, and former director of the Kennedy School of Ethics. He explains that, uniquely, a patient presents to the health care practitioner in "a predicament of illness"—a state of patient vulnerability.[9] In this place "where all the lights go out," a patient is anxious, in distress, and must trust her health care provider. To deal effectively with the pain, suffering, and grief that accompanies disease and illness, the health care professional is expected to be compassionate, trustworthy, and competent.

Not surprisingly, health care was the first profession to create its own code that promised ethical aspiration—holding the self to standards beyond the basic minimum. This code is the Hippocratic oath. According to Dr. Pellegrino, the Hippocratic oath is an expression of virtue

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4 Charles Christiansen, EDD, OTR, OT(C), FAOTA, "Creating Community: An Essay on the Social Responsibility of Health Care Professionals," in *Educating for Moral Action: A Source Book in Health and Rehabilitation Ethics* (Philadelphia: F. A. Davis Company, 2005) , 55.

5 APTA White Paper (January 2005) *Position on Physician-Owned Physical Therapy Services*: *POPTS* APTA), 2.

6 Albert R. Jonsen, Mark Siegler, William J Winslade. *Clinic Ethics, 6th Ed.* (New York: McGraw-Hill 2006), 163.

7 Charles Christiansen, EDD, OTR, OT(C), FAOTA, "Creating Community: An Essay on the Social Responsibility of Health Care Professionals," in *Educating for Moral Action: A Source Book in Health and Rehabilitation Ethics* (Philadelphia: F. A. Davis Company, 2005), 56; also see Jonson, 163.

8 Ibid, 55.

9 Edmund D. Pellegrino, MD MACP, Professor Emeritus of Medicine and Medical Ethics, *Theory and Practice of Virtue,* Intensive Bioethics Course, Kennedy School of Ethics, Georgetown University June 8-13 2004.

ethics in that it focuses on the autonomy of the provider and on the provider's integrity, trustworthiness, fidelity, and honesty, in the service of protecting the autonomy of the patient. Dr. Pellegrino explains, "The virtuous person is that person you can trust when no one is watching."[10] Health care is not intended to be a selfish profession—instead, it asks of its practitioner a life of empathetic service. It is based on the pledge to acknowledge and uphold human dignity as an inherent quality of every human being. In John Rawl's words, "Respect for the dignity of the individual is an overriding virtue in professional ethics."[11] People are precious; they deserve reverence, esteem, careful attention, and service. To devalue and abuse the dignity of others leads inexorably to the erosion of our own human dignity.[12] Echoing Kant, never should medical professionals use patients as a means to an end. From this perspective, the health care practitioner is driven by beneficence, by "the fundamental action and reverential response of a finite moral agent to human dignity."[13] In historical context (emphasis added):

> [T]he contemporary power of this approach to morality is manifested in the names of important social movements including the civil rights movement, the women's rights movement, the farm worker's movement, and the gay rights movement—not to mention the animal rights movement, which would extend rights to all sentient creatures. Most importantly for health care ethics, the *patient's rights movement* has for several decades shifted the locus of moral decision making in health care to patients and away from physicians.[14]

The goal of medicine is the good of the patient; the practitioner who embodies good action is a good person and a moral agent. "When you ask a patient, 'Can I help you,' it is a solemn vow—a promise of competence, integrity, fidelity, and truth."[15] Patient-centered care takes the practitioner beyond the basic legal and educational requirements. It requires an orientation of service, diligence, humility, and a lifelong commitment to a good, caring practice.[16]

The motivation of right action, in this construction of the ethical situation, ought not to come from expected rewards. In fact, some argue that external rewards thwart the cultivation of doing something because it is the right thing to do—from a place of internal motivation. There is an element of heroism in this non-greedy, selfless, admirable life, where one strives to embody ideals, asymptotically and ceaselessly striving for excellence in what one does. This, Pellegrino argues, is at the heart of one who claims to be a professional, especially in health care.

From this perspective, social responsibility is inherent in the role of a professional. Paraphrasing the French sociologist Emile Durkheim, since civility and the actions necessary to

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10 Ibid.
11 Donald L. Gabard and Mike W. Martin. *Physical Therapy Ethics* (Philadelphia: FA David Co.), p 115.
12 John W. Glaser, STD. Three Realms of Ethics: An Integrating Map of Ethics for the Future. *Educating for Moral Action: A Source Book in Health and Rehabilitation Ethic* (Philadelphia: F.A. Davis Company 2005), 171.
13 Ibid.
14 Donald L. Gabard and Mike W. Martin. *Physical Therapy Ethics* (Philadelphia: FA David Co.), p 26.
15 Pellegrino, MD MACP, Professor Emeritus of Medicine and Medical Ethics, *Theory and Practice of Virtue,* Intensive Bioethics Course, Kennedy School of Ethics, Georgetown University June 8-13 2004.
16 Ibid.

create social capital cannot be legislated, they must become a part of the social expectations of communities through the actions of individuals.[17] By "social capital," Durkheim intended to describe the degree to which a community or society cooperates, collaborates, and embraces norms and values to create trust and to achieve mutual benefits. Applying this notion of social capital to contemporary American society, Robert Putnam recently described the collapse and revival of the American ideal of community, discerning along the way that social capital implies a sense of trust, of reciprocal responsibility, and of social connectedness.[18] The professional contributes to social capital when engaging in behaviors, such as service and altruism, that enhance well-being. In accepting this task, all healthcare professionals, including physical therapists, ought ideally to embrace Ruth Purtilo's abiding conviction that health professionals can and should assume a strategic position to help shape the contours of today's health care environment, so that it embraces and protects cherished social values.[19]

Numerous ethical codes since Hippocrates' classic have further articulated ethical commitments for the practice of health care. Physical therapists turn currently to the APTA ethical Codes and Guide (currently under revision) and find within a call to social responsibility. Like medical doctors, PTs are to work for the good of their patients, putting the needs of others above the needs of the self, and answering the call to social responsibility, neither over-treating nor under-treating: "A PT shall endeavor to meet the health needs of society."[20] A more recent reaffirmation of the fiduciary primacy of the good of the patient, *The Physician's Charter,* claims (emphasis added):

> The principle of the primacy of patient welfare is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician-patient relationship. *Market forces, societal pressures, and administrative exigencies must not compromise this principle*.[21]

Agreement is found at the international level through *The Physician's Oath of the World Medical Association*. It requires that "the health of my patient will be my first consideration."[22] The Hippocratic Oath, the APTA Code and Guide, *The Physician's Charter,* and *The Physician's Oath of the World Medical Association:* these and other normative inspirations, important as they are, do not describe the reality of daily clinical practice in the US health care system.

Conflict of interest

In their sixth and most recent edition of the classic *Principles of Biomedical Ethics,* Tom

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17 K. Thompson *Emile Durkheim.* Tavistock Publications, London, 1982.

18 Robert D. Putnam. *Bowling Alone: The Collapse and Revival of American Community* (NY: Simon & Schuster, 2000)

19 Ruth Purtilo. *Ethical Dimensions in the Health Care Professions,* 4th ed. (Boston: Elsevier Saunders, 2005).

20 APTA House of Delegates. *Code of Ethics* (HOD 06-00-12-23). American Physical Therapy Association. 2000. Available at http://www.apta.org/governance/HOD/policies/HoDPolicies/Section_I/ETHICS/HOD_06001223. (Accessed November 7, 2008).

21 Harold C. Sox, MD, Editor. *Medical Professionalism in the New Milennium: A physician charter. Ann Intern Med* 2002;136: 243-246.

22 Ibid.

Beauchamp and James Childress continue to hold health care practitioners to high moral standards. In particular, they call all practitioners to constant vigilance regarding conflicts of interest, a "fairly new threat to provider/patient trust,"[23] which exists when (emphasis added):

> [A]n individual's personal interests would lead an impartial observer to question whether the individual's professional actions or decision are unduly influenced by considerations of significant personal interest.... Because the provider might be biased or tempted to act outside role expectations, it is crucial that *even a potential conflict* which might possibly taint judgments be avoided.[24]

In another classic guide to ethical decision making, Albert Jonsen and his colleagues' most recent edition of *Clinical Ethics* likewise reminds health professionals to avoid conflicts of interest. Even one with the highest aspirations for ethical practice might find herself in a position that tempts her to neglect her duties and to use power for self enrichment and personal gain. In other words, she may be tempted to do those things

> that are at variance with the acknowledged duties of that role.... [I]t is clearly unethical for a physician to do anything to a patient that is not intended to benefit the patient but rather to benefit the physician or some other party.... [A]ltruistic duty absolutely prohibits exploitation of patients."[25]

In agreement with Jonsen, Beauchamp, and Childress, physical therapists have also acknowledged specific ethical prohibitions fundamentally rooted in conflicts of interest. For example, the APTA Code of Ethics[26] and Guide for Professional Conduct[27] require that a physical therapist shall seek only such remuneration as is deserved and reasonable for physical therapy services (Principle 7). The Guide contains specific prohibitions against placing one's own financial interest above the welfare of individuals under his/her care (7.1.B), as well as prohibitions against over-utilization of services (7.1.D). The Guide also requires physical therapists to disclose to patients/clients if the referring physician derives compensation from the provision of physical therapy (7.3).

Beyond the individual responsibility emphasized in these codes, there is also a recognition that every human being is highly influenced by the institutions and societies in which one practices. Lest we think we are immune to the power of conformity, we need only remember the (literally) shocking human tendency to obey figures of authority portrayed in

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23 Tom L. Beauchamp and James F. Childress. Principles of Biomedical Ethics, 6th ed. (New York: Oxford University Press, 2009), 317.

24 Ibid

25 Jonsen et al., "Clinical Ethics," 159-167.

26 APTA House of Delegates. Code of Ethics (HOD 06-00-12-23). American Physical Therapy Association. 2000. Available at http://www.apta.org/governance/HOD/policies/HoDPolicies/Section_I/ETHICS/HOD_06001223. (Accessed December 7, 2008).

27 APTA Ethics and Judicial Committee. Guide for Professional Conduct. American Physical Therapy Association. 2001. Available at http://www.apta.org/governance/HOD/policies/HoDPolicies/Section_4/GUIDEFORPROCONDUCT. (Accessed December 7, 2008).

Stanley Milgram's classic research,[28] recently replicated,[29] which reminds us that ordinary people will commit acts that conflict with their personal conscience and moral convictions if instructed to do so by an authority figure. As professionals, we are called to keep our eyes on our duties and to question the power structures of our institutions and our societies if they threaten the fiduciary tasks for which we have accepted responsibility. In other words, it's normative to do what we're told by a superior, but not if our superior tells us to do something that violates the conditions of our professional identity or some other code. In obeying ethical norms, then, we must be willing to transgress the boundaries of authority structures. In this vigilance and questioning, we join rich traditions of like-minded individuals committed to unveiling truth and to defending dignity—world views espoused in, among other approaches, the analytic pragmatism of feminist bioethics and of educators who "celebrate teaching that enables transgression—a movement against and beyond boundaries...that makes education the practice of freedom."[30] Grounded in critical awareness, rational thought, and earnest service, individual practitioners must practice constant vigilance; the institutions and social contexts in which we attempt to be good practitioners require every bit as much scrutiny as our own conduct within them.

Normative ideals of organizational and public policies, then, must also discourage conflicts of interest, and practitioners, administrators, and policy makers must strive to create a workplace where human dignity can flourish, where "they make dignity-respecting behavior the easier rather than the harder thing to do."[31] In doing so, we are moved to examine, to critique, and ultimately to remove the temptation inherent in fee-for service templates. We can then better serve the common good, nurture social beneficence, and facilitate "the good life," thereby upholding the fiduciary responsibility to produce optimal health outcomes for our professional clients and, in doing so, to avoid conflict of interest.

But what do we find at the heart of the current health care crisis in America? We find institutionalized conflict of interest in a fee-for-service public policy that does not protect practitioners or patients from the temptations of self referral or of referral for profit. This is a model of health care as a fee-for-service, for-profit business, stripped of the consensually based ethical norms which are the historic heritage of the health professions.

Health care as a business

Unfortunately, our initial case study, Kelley, did not experience "one bad apple" in an otherwise commendable health system. On the contrary, her health care experience can be viewed as a logical end product of the public policy underlying the US health care system, which allows the fee-for-service model to set the tone for profit orientation in health care, and replace the

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28 Stanley Milgram. *Obedience to Authority.* New York, NY: Harper and Row; 1974.

29 Audrey Grayson. Researcher Revives 'Shocking' Human Experiment; After Four Decades, Torture Experiment Still Raises Eyebrows, http://abcnews.go.com/Health/MindMoodNews/story?id=6496911&page=1 (Accessed 12/19/2008).

30 bell hooks. *Teaching to Transgress: Education as the Practice of Freedom.* (Routledge: New York. 1994), 12.

31 Glaser, 173.

intrinsically motivated professional with the extrinsically motivated vendor of medical services.

Unlike most of the other industrialized democracies, US health care (Medicare and Medicaid non withstanding) is not conceptualized as an obligatory duty of the government, nor paid for through taxes. In fact, "the US is one of the few industrialized democracies that has not recognized health care as a basic human right."[32] Instead, the development of the US health care system in recent decades can best be understood in cultural context, in that it reflects philosophical orientation towards a certain conception of the free market socioeconomic policy in American society, which has carried its entrepreneurial ideology and practice to health care, conceptualized as a good provided and measured, based on one's ability to pay. Those who benefit from this arrangement describe an inherent logic of the system, defending it as built on:

> [A] free-market system that is open to profit-seeking in virtually all areas of health care...a strong sense of individualism and self-reliance that places responsibility for health on individuals... and, since the 1930s, a commitment to providing basic "goods" when they are available within the community, to individuals unable to secure them (welfare).[33]

Increasingly, observers of the outcomes of this system are calling this entrepreneurial health care model into question. Health care policy expert Dr. Steffie Woolhandler, an associate professor of medicine at Harvard Medical School, cites the US as "unique among developed nations (in that) the US views health care as a business."[34] For those businesses that are for-profit—and the US is the only place in the world with a thriving for-profit health-insurance industry—the overarching value is, precisely, in making a profit; all other considerations are secondary to this aim.[35] Dr. David Brown, chief of cardiology at Stony Brook University Medical Center, recently elaborated on the inherent conflict of interest in having for-profit companies involved in health care: "The fiduciary responsibility of a for-profit public company is to provide a profit to their shareholders—not to ensure the best health care for their customers."[36] Dr. Brown calls for the elimination of for-profit companies in health care, instead upholding successful nonprofit plans in which allied health care professionals are salaried employees or are paid on a simplified fee schedule, while preserving individual decisions to patient and doctor—the aim here, in other words, would be to create a system in which professionals are not paid a fee for service, and therefore would they have no incentive to self refer for financial gain; in such a system they would focus on patient care instead of profit. In agreement with Dr. Brown's formulary, Dr. Woolhandler points to successful countries in which health care is viewed as a public good;

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32 Lee Nelson PT DPT MS. "Professional Responsibility and Advocacy for Access to Rehabilitation Services: A Case Study in Lymphedema Services in Vermont," in *Educating for Moral Action: A Source Book in Health and Rehabilitation Ethics* (Philadelphia: F. A. Davis Company, 2005), 115.

33 Ibid, 189.

34 Steven Reinberg. Skyrocketing health-care costs could double premiums for many Americans; http://www.washingtonpost.com/wp-dyn/content/article/2009/01/28/AR2009012801751_pdf.html (Accessed 1/28/2009).

35 Ibid.

36 Dr. David Brown. A proposal for health care reform for the U. S.; http://www.timesofsmithtown.com/Articles-i-2009-01-15-77781.112114_A_proposal_for_health_care_reform_for_the_U_S.html (Accessed 1/23/2009).

instead of for-profit scenarios, she also espouses nonprofit, national health insurance, and suggests we look to affluent nations such as the United Kingdom, Canada, France, and other European countries whose health outcomes are much better and whose costs are much less—about half as much as Americans spend.[37]

A few sobering statistics: over 45 million Americans, or 15% of the US population, are without health care coverage; as a percentage of personal income, the cost of health care nearly doubled from 1987 to 2002; despite the highest gross national product in the world,[38] even as far back as 1999 the National Institutes of Health ranked the US last of the G-7 industrialized nations.[39] According to the World Health Organization (WHO) [40] health outcomes in the US ranked first in per capita government health care expenditure, 37th in health care performance, and 72nd in disability-adjusted life expectancy. According to Congressional Budget Office projections, total spending on health care is expected to rise from 16% of GNP in 2007 to 25% in 2025 and 49% in 2082.[41] Impetus for change, such as it is, comes from the prospect of a pending economic meltdown, as much or more so than from the perspectives of justice, humanitarianism, and national pride.[42] Change would seem to be imperative, but resistance is strong.

Resistance to change comes from those who benefit from the current system, both providers and administrators receiving high profits, as well as patients receiving high quality, state-of-the-art care, of which "only those in the highest income categories can afford unrestricted access to superlative care."[43] Resistance also comes from those who argue that the United States cannot afford universal care. This common claim is easily countered when one understands that we are already paying more than enough to afford it, but we're giving away a large percentage of our health care dollar to stockholders and to administrative overhead costs. According to Dr. Brown, it is because we pay for health care through a patchwork of private insurance companies that one-third of our health care dollar goes to administrative costs and profits:

> Replacing private insurers with a national health program would save about $1,150 per person (which) goes to administrative costs and profits....[T]he Canadians, who live, on average, 3 years longer than Americans, spend only

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37 Steven Reinberg. Skyrocketing health-care costs could double premiums for many Americans; http://www.washingtonpost.com/wp-dyn/content/article/2009/01/28/AR2009012801751_pdf.html (Accessed 1/28/2009).

38 C. Kaul, Tomaselli-Moschovitis V. *Statistical Handbook on Poverty in the Developing World.* (Phoenix AZ: Oryx Press; 1999), 26.

39 National Institutes of Health. Life expectancy in G-7 industrialized nations may exceed past prediction, study suggests. http://www.nia.nih.gov/NewsAndEvents/PressReleases/PR20000614LifeExpectancy.htm (Accessed 12/1/08).

40 World Health Organization. World Health Report 2000. Annex Table 1. http://www.who.int/whr/2000/en/report.htm. (Accessed 11/12/2005).

41 Congressional Budget Office, *The Long-Term Outlook for Health Care Spending* (November 2007). http://www.cbo.gov/ftpdocs/88xx/doc8880/20071120_OrszagPresentation.pdf (Accessed 2/5/09).

42 Donald L. Gabard, MW Martin, *Physical Therapy Ethics,* (Philadelphia: F. A. Davis Company 2003), 190.

43 Ibid.

> $3,900 for universal care as compared to $7,000 per person per year in the US for far from universal care....Canadians utilize more hospital days, nursing home days, more out-patient visits and...more drugs per capita than Americans....[W]e already pay enough for universal health care—we just don't get it.[44]

From this perspective, health care reform is the intelligent response to a failed private insurance system that costs too much and delivers too little. Nurse and attorney Eileen Weber, deftly defending the idea that the economy exists to serve the people, argues that a public-plan choice for the country would "reassert the idea that health care insurance exists to provide economic security for enrollees, not that enrollees exist to provide economic security to insurance companies."[45]

Such analyses help one to understand why Ivan Eidenberg, chair of the Business Roundtable (a group of corporate executives from major companies who recently met with President Obama), said "the system's business model supporting...health care in the US...doesn't meet American's needs."[46] It can also help us understand why even Rich Martin, senior vice president for Premera Blue Cross, one of the Pacific Northwest's largest insurers, says "fee for service is a large part of the problem."[47] Or why Dr. Robert Zarr of the Washington Chapter of Physicians for a National Health Program warns "we cannot rely on private health insurance any longer because of its waste and its greed"[48]—$730 billion of waste, according to a recent report from a Public Interest Research Group (PIRG): waste for costs that have nothing to do with patient care and everything to do with private insurance's administrative costs, as well as inappropriate and unnecessary care.[49] As explained in a Dartmouth University study, continued cost increases risk much:

> The United States now faces the worst recession in decades. While the immediate cause of the current crisis is the failure of banks and Wall Street, over the long term the most important threat to the nation's fiscal health is rising health care costs (which will) have an impact not only on the federal budget, but also the capacity of American companies to compete in the global marketplace.[50]

At the White House Forum on Health Reform March 5, 2009, President Obama said:

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44 Dr. David Brown. A proposal for health care reform for the U. S.; http://www.timesofsmithtown.com/Articles-i-2009-01-15-77781.112114_A_proposal_for_health_care_reform_for_the_U_S.html (Accessed 1/23/2009).

45 Nancy Weber. Viewpoint: private health care is best? Prove it. South Washington County Bulletin; http://www.swcbulletin.com/articles/index.cfm?id=12248&section=Opinion (Accessed 4/10/09).

46 The Business Roundtable health care value comparability study, executive summary http://www.businessroundtable.org (Accessed 3/13/2009).

47 seattletimes.newsource.com/htlm/home (Accessed 1/18/2009).

48 Alex Wayne. Liberal Groups Seek Single-payer Health Care Bill. Http://www.cqpolitics.com/frame-templates/print_template.html (Accessed 1/29/09).

49 http://www.uspirg.org/home/reports/report-archives/health-care/health-care/health-care-in-crisis-how-special-interests-could-double-health-costs-and-how-we-can-stop-it (Accessed 1/28/09).

50 An Agenda for Change: Improving Quality and Curbing Health Care Spending: Opportunities for the Congress and the Obama Administration. http://tdi.dartmouth.edu/press_releases/Policy%20Paper%20E-vfnl.pdf (Accessed 1/21/09).

> And today, there are those who say we should defer health care reform once again—that at a time of economic crisis, we simply cannot afford to fix our health care system as well. Well, let's be clear: the same soaring costs that are straining our families' budgets are sinking our businesses and eating up our government's budget too. Too many small businesses can't insure their employees. Major American corporations are struggling to compete with their foreign counterparts.[51]

It is from this perspective that "America's health care system has become a liability in a global economy."[52] And from this perspective comes the call to remove corporate profit from health care.

Fee for service

Instead of paying to keep people well, the US has generally paid providers for procedures performed, which we characterize here as "fee for service." Although it has long been the US's foundational payment method, this approach has long been criticized, most persuasively from within the medical profession itself. In 1945, Dr. Michael Shadid, who founded America's first cooperatively owned and managed hospital in Elk City, Oklahoma, spoke in Seattle, Washington, to expose fee-for-service as a "dark and unwholesome medical practice, dominated by solo general practitioners, expensive specialists, and private hospitals and clinics."[53] In 1946, Dr. Sandy MacColl spoke for himself and his 15 colleagues against "conventional, fee-for-service medicine," commenting that it seemed "chiefly dedicated to enriching its practitioners at the expense of sick and desperate people."[54]

More recently, in 1985, Arnold S. Relman, MD, former editor of *The New England Journal of Medicine,* spoke to the inherent conflict of interest in the traditional fee-for-service model characteristic of the current American health care system. Labeled "the most outspoken critic of the increasing role that profit making has assumed in American medical care,"[55] Dr. Relman wrote, "Ethical practitioners minimize (conflicts of interest) by avoiding self-referral whenever possible, by conservative use of tests and procedures, and by conscientiously attempting to meet their fiduciary responsibilities to their patients."[56] But Relman warned that "the medical-industrial complex" creates a scenario facilitating overuse, fragmentation of services, and "cream-skimming," emphasizing "the situation is different when physicians seek income beyond fee for service and make business arrangements with other providers of services

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51 Quoted in The Business Roundtable health care value comparability study, executive summary http//www.businessroundtable.org, p. 4 (Accessed 3/13/2009).

52 Report: U.S on the short end of health care 'value gap'; http://www.nytimes.com/aponline/2009/03/12/health/AP-Health-Value-Gap.html (Accessed 3/13/09).

53 Walter Crowley, *To Serve the Greatest Number: A History of Group Health Cooperative of Puget Sound* (Seattle & London: University of Washington Press, 1996), 3.

54 Ibid, xii.

55 http://content.healthaffairs.org/cgi (Accessed 1/15/09).

56 Arnold S Relman, MD, "Dealing with Conflicts of Interest," *The New England Journal of Medicine*, Sept 19, 1985.

to their patients."[57]

What is the difference? What would prompt Dr. Pellegrino to proclaim, "We've abused the medical profession. We've commodified people, but health care is not a business."?[58] The key is stepping beyond the conflict of interest inherent in fee for service and entering into arrangements that amount to deliberate conflicts of interest. These schemes have been deemed a threat to the fidelity of providers to patient's interests:

> [B]y the temptation inherent in fee-for-service to provide unnecessary or excessively expensive care...physicians create these financial conflicts of interest by owning or investing in medical facilities or services, such as...physical therapy services, to which they refer patients.[59]

These are made even more objectionable when services are accessible only upon a physician's referral. Whether referral is required as a matter of state or federal law, or as a matter of third-party payer preference, physicians who are in the role of gatekeepers should be mindful and strict about avoiding even the appearance of any conflict of interest. This is the role of the professional—what society expects of one proclaiming oneself to be worthy of the social privileges associated with the title. And this is precisely what is violated in referral for profit schemes.

Referral for profit

According to the American Physical Therapy Association, the term "referral for profit," (RFP) in the context of physical therapy practice, refers to "a financial relationship in which a physician refers patients for physical therapy treatment and derives a financial benefit from the referral."[60] The most common referral for profit scheme is called "physician owned physical therapy services," known by the acronym POPTS, in which physicians have an ownership interest in the physical therapy practices to which they refer. [61] (Both terms—POPTS and RFP—will be used in the following account to appropriate specific language to specific historical and legal documentation.) Despite the AMA's declaration that it is unethical for physicians to own centers for self-referral, except when this is the only way to meet a social need,[62] they are thriving in the US today.

Indeed, many physicians see PT as a tool to augment profit, creating their own PT services for which they direct treatment and from which they profit financially. To illustrate the point, a member of the Missouri Physical Therapy Association requested anonymity in reporting active promotion of referral for profit schemes at the 2005 Conference on Physician Agreements

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57 Ibid.

58 Pellegrino, MD MACP, Professor Emeritus of Medicine and Medical Ethics, *Theory and Practice of Virtue,* Intensive Bioethics Course, Kennedy School of Ethics, Georgetown University June 8-13 2004.

59 Tom L. Beauchamp and James F. Childress. Principles of Biomedical Ethics, 6th ed. (New York: Oxford University Press, 2009), 314.

60 APTA White Paper (July 2007) Reactions from Members and Patients on Physician-Owned Physical Therapy Services (POPTS), 2.

61 APTA White Paper (January 2005) Position on Physician-Owned Physical Therapy Services (POPTS), 1.

62 Jonson, 166.

and Ventures, given by Harpeth Capital Investment Bankers, TherEx Onsite Rehab Solutions, and McDermott Will & Emery, which outlined the benefits of establishing physical therapy clinics and how to use exceptions to federal prohibitions.[63] Another example is the following advertisement:

One-Room Mini-Rehab Program
Generates $500,000 a year...
NET income!
No Expensive Equipment to Purchase or Leases to Sign!
Turnkey Program Trains Staff and Motivates Them for You!
Initial marketing and Promotional Materials Provided – FREE![64]

Given these examples, it is no surprise that POPTS have caught the attention of medical ethicists Beauchamp and Childress, who criticize them as follows:

> Physician ownership of...physical therapy services...can substantially increase use and costs, without compensatory benefits such as increased access. [Also]...self referral is generally more problematic than fee for service because the patient cannot easily identify the physician's potential economic gain...often, disclosure is not enough...a legal or professional prohibition should be adopted in many cases.[65]

These arrangements violate the unique fiduciary relationship between a health care practitioner and the patient. The addition of self referral to an already for-profit business venture threatens the integrity of the health care professional and fuels public distrust. RFPs offer a contemporary example of deprofessionalization in the current, troubled US health care system: when medical professionals invest in services to which they refer, when consumers pay too much for visits, when patients do not get the consistently high quality care they deserve, and when the overall financial impact increases the economic burden on society, public trust is repeatedly compromised. From this standpoint, one can begin to understand why, 27 years ago, Charles Magistro, then president of APTA, sounded a clarion call against physician owned physical therapy services, calling them "a cancer eating away at the ethical, moral, and financial fiber of our profession."[66]

In the presence of profession-negating practices like POPTS, even leaders of the professional community such as Susan Chalcraft, PT, MS (who works for an institution which includes in its mission statement the provision of pro bono physical therapy services for underserved populations) or Peter McMenamin, PT, MS, OCS (who has invested considerable time and money into specialty training and board certification) are limited in their efforts. These examples typify what is currently undercutting efforts at autonomous, professional practices

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63 APTA White Paper (July 2007) Reactions from Members and Patients on Physician-Owned Physical Therapy Services (POPTS), 3.

64 Justin Elliott, Associate Director, APTA State Government affairs at PTWA Fall Conference: Referral for Profit in Physical Therapy: October 25, 2008, Seattle WA.

65 Tom L. Beauchamp and James F. Childress. Principles of Biomedical Ethics, 6th ed. (New York: Oxford University Press, 2009), 315.

66 Charles M Magistro, Physician-Physical Therapist Financial Arrangements. Read at Combined Sections Meeting of the APTA, San Diego, Calif. February 14-17, 1982.

being made by these current presidents of the Washington and Illinois state physical therapy chapters, respectively.[67] Well established professionals in their respective communities, both Susan and Peter describe a diminution in their ability to provide professional services to the community after the RFP organizations came to town, cream-skimming the most lucrative referrals for their own practices.

We shall now turn our attention to the fact that, although originally stunted by federal laws intended to make such practices illegal, RFP schemes have more recently slithered through legal loopholes and, subsequently, flourished in recent years. RFPs undermine the health care profession: they call into question the motivation of the provider because a financial gain can be made with each self referral, and they discourage referrals to independent, ethically motivated practitioners outside the RFP system.

Conflict of interest and kickbacks: An historical review

Real and potential conflicts of interest among physicians with financial interests in entities to which they refer were recognized by members of Congress in the 1980s. The correlation between financial ties and increased use prompted Congress to enact the "Stark I" law in 1989,[68] preventing Medicare from paying for clinical laboratory services if the referring physician had a financial interest in the facility. In 1993, Congress enacted the "Stark II" law, which expanded the list of services to which the law applies to include "designated health services" specifying physical therapy services.[69] The law states that, unless an exception applies, if a physician or member of a physician's immediate family has a financial relationship with a health care entity, the physician may not refer to that entity for the furnishing of designated health services, including physical therapy services under the Medicare program.

According to Justin Elliott, Associate Director of the APTA State Government Affairs, fear of stronger regulation had a "chilling effect" on the growth of POPTS for about five years, but, in the 1990s, Stark "lost its punch," with declining reimbursement motivating physicians to seek "creative business models"[70] in the exceptions to Stark II. Final regulations were altered to, in effect, reverse the intent of Stark I and II: bowing to physician interests, the agency wrote rules allowing physicians to furnish physical therapy in their offices, classifying it as an "incident to" services exception. Physicians' groups defend this practice as follows: when service is provided in the physician's office and is provided as an "ancillary service" or "incident to" physician practice, no conflict of interest exists.[71] However, physical therapy is not an ancillary service (like laboratory work or X-rays); physical therapy is a separate professional service.[72] So it follows that RFP involves control of one profession over another for the sole

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67 Peter McMenamin PT, MS, OCS; Susan Chalcraft PT., MS, President PTWA. Referral for Profit: Strategic Planning, PTWA State Conference, 10/25/08.
68 APTA White Paper (January 2005) Position on Physician-Owned Physical Therapy Services (POPTS), 5
69 Julie Kass JD "Remaining compliant: what PTs need to know" APTA Audio Conference 11/19/08.
70 Justin Elliott, Associate Director, APTA State Government Affairs, Referral for Profit in Physical Therapy PTWA Fall Conference 10/24/2008.
71 Ibid.
72 Ibid.

purpose of financial gain,[73] begging the question, "Should one profession be able to claim financial control over another?"[74]

After Stark I and II were enacted, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) issued the final Stark regulations on January 4, 2001. By this time, the referral for profit revival was well underway, with physicians reverting to the simplest referral for profit model: direct employment of physical therapists.[75] After this, lack of response at the federal level pushed this issue to the states. And RFPs have since flourished.

The incidence of RFPs in Illinois helps to illustrate their prevalence. As of fall 2008, the percentage of orthopedic surgeons involved in RFPs were as follows: 57% statewide across Illinois; 62% in Chicago proper; and 80% in the western suburbs of Chicago.[76] Nationally, 57% of APTA members are in RFPs, this representing only 42% of practicing physical therapists.[77] In other words, less than half of working PTs are members of their professional organization, but more than half are—unwittingly or not—accepting a role in the deprofessionalization of physical therapy services. These are sobering statistics, indeed.

But there is hope. The American Medical Association (AMA), like APTA, rejects the conflict of interest that is inherent in referral for profit. The AMA Council on Ethics and Judicial Affairs (CEJA) has said, "[U]nder no circumstances may physicians place their own financial interests above the welfare of their patients,"[78] and, "physicians should not refer patients to a health care facility which is outside their office practice and at which they do not directly provide care or services when they have an investment interest in that facility."[79] This final statement can easily be interpreted to prohibit referral to physical therapy practices in which a physician has an investment interest when the physician does not directly provide care or services to the referred patient.

In agreement with the AMA, the APTA has held a formal, active stance against RFP/POPTS, and it has consistently articulated this over the past 25 years. Since the late 1970s, policies and campaigns instigated by the APTA clearly opposed POPTS/RFP schemes.

Referral For profit: The states' legal wranglings

For a legal view into what has been called "the most dangerous threat to PT autonomy,"[80] we turn to several key rulings. As of this writing, POPTS are banned in Delaware, South Carolina, and Missouri, but they are legal in Tennessee, Alabama, and Rhode Island; cases are pending in

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73 Ibid.
74 APTA White Paper (January 2005) Position on Physician-Owned Physical Therapy Services (POPTS), 1.
75 Justin Elliott, Associate Director, APTA State Government Affairs, Referral for Profit in Physical Therapy PTWA Fall Conference 10/24/2008.
76 Peter J. McMenamin, PT, MS, OCS Referral for Profit: Strategic Planning, PTWA State Conference, 10/25/08.
77 Ibid.
78 AMA Council on Ethics and Judicial Affairs. Current Opinions. American Medical Association. http://www.ama_assn.org/ama/pub/category/2498.html. (Accessed 11/23,/2008).
79 American Medical Association Council on Ethics and Judicial Affairs. Current Opinions. E-8.03. Conflicts of Interest: Guidelines and E08.02 Conflicts of Interest: Health Facility Ownership by a physician. http://www.ama_assn.org/ama/pub/category/2498.html (Accessed 11/23/2008).
80 Peter J. McMenamin, PT, MS, OCS. Will we own our profession? PTWA State Conference, 10/25/08.

Washington and Illinois.

In the 1980s, efforts focused on state legislation, primarily on making involvement in RFPs grounds for loss of a PT practitioner's license. These efforts succeeded in only two states, Delaware and Missouri, due to significant opposition from physician groups in other states.[81] In this environment, most states allowed physicians to use legal loopholes to engage in referral for profit. For example, Washington State allows for referral for profit schemes under the following guidelines:

> Ownership of a financial interest...shall not be prohibited under this section where: A. The referring practitioner affirmatively discloses to the patient in writing the fact that such practitioner has a financial interest in such firm, corporation, or association; B. The referring practitioner provides the patient with a list of effective alternative facilities, informs the patient that he or she has the option to use one of the alternative facilities, and assures the patient that he or she will not be treated differently by the referring practitioner if the patient chooses one of the alternative facilities...any person violating this section is guilty of a misdemeanor.[82]

In 2002, the Delaware Attorney General declared that POPTS constitute illegal fee splitting and kickbacks, issuing an opinion that the Delaware Physical Therapy Act prohibits physical therapists from having financial relationships with referring physicians. The Attorney General construed such relationships as fee splitting:

> A physical therapist is prohibited from participating in certain financial relationships with a referring person. Physical therapists cannot share fees with persons who have referred patients to them. Physical therapists are also prohibited from accepting monetary gain from persons who have referred patients to them for professional services. Physical therapists and athletic trainers may belong to lawful business entities in the State of Delaware so long as they do not enter into the prohibited fee splitting financial relationships with referring persons as specified in 24 *Del. C.* § 2616 (a)(8). [83]

In 2006, the South Carolina Supreme Court declared that POPTS constitute illegal fee splitting and kickbacks, ruling that it was the legislative intent of the PT Act to " prohibit a physical therapist from working as an employee of a physician when the physician refers patients to the physical therapist for services," recognizing such prohibited referrals for pay as "kickbacks."[84]

Also in 2006, the US Office of the Inspector General (OIG) declared that "91% of physical therapy billed by physicians failed to meet program requirements, resulting in $136 million in improper payments."[85] In 2007, three additional cases came to public attention. The

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81 APTA *A Guide to Surviving Physician-Owned Physical Therapy Services: Practice Position Strategies*, 2008, p. 3.

82 RCW19.68.010 (www.leg.wa.gov/rcw.index.cfm, accessed 11/8/08).

83 Delaware Attorney General Opinion, October 10, 2002, RE Referrals Prohibited to Physical Therapists pursuant to Del. C. § 2616 (a)(8).

84 *Sloan v. South Carolina Board of Physical Therapy Examiners*, 370 S.C. 452 (2006).

85 "Physical Therapy Billed by Physicians." Washington, DC: Department of Health and Human Services, Office

US Justice Department fined two nationally renowned orthopedic surgeons and Health South Corporation $15 million for kickbacks involving physical therapy:

> HealthSouth Corp. and one the nation's most prominent orthopedic surgeons agreed to pay almost $15 million to settle civil claims over what the government said Friday was an illegal kickback scheme....[T]he settlement involved claims made by HealthSouth to Medicare and Medicaid for services provided to patients referred by Andrews and Lemak when the company had a financial relationship with the doctors. Jeffrey S. Bucholts, acting assistant Attorney General for the Justice Department's Civil Division, said "Medicare beneficiaries deserve their physicians' unbiased judgment regarding their treatment, free of improper financial influences."[86]

That same year, the Justice Department charged makers of hip and knee joint replacements with giving kickbacks, disguised as "consulting fees," to prominent orthopedic surgeons across the nation; the case settled with fines of $311 million.[87] Additionally, the Illinois Attorney General has sued 20 MRI facilities for consumer fraud, kickbacks, and fee-splitting.[88] Clearly, kickbacks are an issue in referral for profit, including but not limited to physical therapy services.

Financial harm

As detailed above, harm done by RFP is not only a matter of principle or abstract ethics. Health policy researchers have shown specific harms from conflict of interest in physical therapy referrals. Their studies have demonstrated that RFP arrangements have a significant adverse economic impact on patients, third-party payers, and physical therapists.

In 1992, a study published in *The Journal of the American Medical Association*[89] found that visits per patient were 39% to 45% higher in jointly owned facilities; that gross and net revenue per patient were 30% to 40% higher in facilities owned by referring physicians; that percent operating income and markup were significantly higher in joint-venture facilities than in non-joint-venture facilities, spending about 60% more time per visit treating patients; and that joint ventures also generate more revenues from patients with well-paying insurance. Data was collected from 118 outpatient physical therapy facilities and 63 outpatient comprehensive rehabilitation facilities, with statistical comparison by physician joint venture ownership status.

In a study examining costs and rates of use in the California Workers' Compensation system, Swedlow et al. reported that physical therapy was initiated 2.3 times more often by the

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of Inspector General: May 1, 2006. (http://www.oig.hhs.gov/oei/reports/oei-09-02-00200.pdf accessed on 1/18/2008).

86 Jay Reeves, *Associated Press* Saturday, 12/15/07: "HealthSouth, surgeons settle in kickback case."

87 US Department of Justice, Michael Drewniak, Public Information Officer, 973-645-2888 Sept 7, 2009. Five Companies in Hip and Knee Replacement Industry Avoid Prosecution by Agreeing to Compliance Rules and Monitoring, Newark.

88 Press Release, Attorney General Lisa Madigan, January 17, 2007: "Madigan Joins Suit Against Radiology Centers Over Illegal Payment of Kickbacks To Doctors." Chicago, Illinois.

89 Jean M. Mitchell, PhD, Elton Scott, Ph.D., "Physician Ownership of Physical Therapy Services" *The Journal of the American Medical Association* October 21, 1992.

physician in self-referral relationships than by those referring to independent practices.[90] Conducted by William M. Mercer, Inc., this study found that if an injured worker received initial treatment from a provider with an ownership interest in physical therapist services, that patient received a referral to physical therapy 66% of the time. By contrast, if the injured worker received initial treatment from a provider with no ownership interest in physical therapy, the patient was referred to physical therapy 32% of the time.[91]

According to the State of Florida Health Care Cost Containment Board,[92] 40% of the physical therapy rehabilitation centers in Florida involved some degree of physician ownership in 1992. An examination of the physicians who had investment interests in these centers revealed that 95% of these owners were in a position to refer patients for physical therapy. Also in Florida, a study determined that consumers pay too much for physical therapy visits,[93] revealing the number of visits per patient as significantly higher in physical therapy facilities in which referring physicians invest than in those in which there is no such incentive for referral. In fact, patients treated at physician-owned facilities received 43% more visits per patient than did patients treated at non-joint-venture physical therapy centers. These additional visits resulted in an average of 31% higher revenues per patient to the joint-venture facilities, or $200 more revenue per patient.

A final example of financial harm comes from the Office of the Inspector General (OIG) of the US Department of Health and Human Services, raising quality concerns for services billed to Medicare as physical therapy within physicians' offices. The OIG study, released in March 1994,[94] found that "[a]lmost four out of five cases (78 percent) reimbursed as physical therapy in physicians' offices do not represent true physical therapy services." This study was a stratified random sample of 300 beneficiary cases receiving physical therapy, interviewing 42 insurance carriers, with a medical review conducted to determine the percentage of cases meeting coverage guidelines. Almost $47 million was inappropriately paid, yet the great majority of independently practicing physical therapy services met all Medicare coverage guidelines. Concern was found to be widespread among carrier respondents, a third of which felt there are problems with the frequency of physical therapy in physician's offices.[95]

Since financial resources are limited, any effort to unfairly claim payment suggests that unless taxpayers bear the responsibility of payment, patients in need of services will have to be denied. This clearly compromises distributive justice in health care.

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90 Swedlow A, Johnson G, Smithline N, Milstein A. "Increased costs and rates of use in the California worker's compensation system as a result of self-referral by physicians" *New England Journal of Medicine* 327, No. 21 (1992): 1502-1506.

91 Ibid.

92 "Impact of Physician Joint Venture Activity on Medical Care Costs in Florida." Columbia, Md: Center for Health Policy Studies; January 1992.

93 "Joint Ventures Among Health Care Providers in Florida, Volume 1." Tallahassee, Fla: State of Florida Health Care Cost Containment Board; 1991.

94 Department of Health and Human Services, Office of Inspector General, "Physical Therapy in Physician's Offices," March 1994.

95 Ibid.

Are consumers getting better care?

As documented repeatedly in 20 years of research by the Dartmouth Atlas Project, more spending on health care, more procedures, and more hospitalizations do not result in better health outcomes for patients.[96] This is precisely the type of practice Shannon Brownlee wrote about in 2007 in *Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer.*[97] The national delusion that more care is better care, Brownlee postulates, is rooted in the fee-for-service structure that rewards doctors and hospitals for how much care they deliver, rather than how effective that treatment is. Contrary to the common belief in health care that more is better (more tests, more procedures, more medication, more physical therapy services), Brownlee documents that the opposite is actually true—that less can be more. Among her more compelling citations is the 2003 study of one million Medicare recipients, published in the *Annals of Internal Medicine,* which showed that patients in hospitals who spent the most were 2% to 6% more likely to die than patients in hospitals that spent the least.[98]

Brownlee and others recommend that health care reformers look to the success of the Veteran's Health Administration (VA), which removes profit motives by paying its health care workers reasonable salaries instead of paying them for each service rendered. In this climate, where health care professionals can make medical decisions based more on what works that on what pays, it is no surprise the VA outperforms the rest of the American health care system on multiple measures of quality.[99] Like the VA, other institutions were hailed in the previously cited Dartmouth White Paper, (recently presented to President Obama), describing cases of "organized care where patients are less likely to get overly aggressive treatment, but still get the kind of care that's widely recommended, and is better care."[100] Better care is key, for "personalized care will become extinct if physicians are not able to set aside the business of doctoring and resurrect the art of medicine...because it is in the best interest of the patient, not the bottom line."[101] Speaking on behalf of one of these "islands of excellence in the sea of high cost mediocrity,"[102] Scott Armstrong, CEO of a non-profit, consumer-driven organization—one of the three largest insurers in Washington State—said "we should pay providers not for providing more care but for producing better results."[103] A prevention-oriented health care system since its inception in 1947, (and predating the Stark initiatives by several decades), this non-profit system was created

> by a small group of forward looking physicians and patients who, frustrated with

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96 John E. Wennberg, Shannon Brownlee, Elliott S. Fisher, et al.: *An Agenda for Change: Improving Quality and Curbing Health Care Spending: Opportunities for the Congress and the Obama Administration: A Dartmouth Atlas White Paper* (December 2008) http://www.dartmouthatlas.org (Accessed 1/23/09).

97 Shannon Brownlee. *Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer.* (New York: Bloomsbury USA) 2007.

98 Ibid.

99 Ibid.

100 Wennberg, et al., Dartmouth White Paper.

101 Mary B Marcus. *Ethicists debate doctors who keep it personal.* http://usatoday.com/news/health/2009-12-12-doctors_N.htm (accessed 2/2/2009).

102 Wennberg, et al., Dartmouth White Paper, i.

103 Peter Neurath. *Regence goes on the offensive for its vision of health reform* http://seattle.bizjournals.com/seattle/stories/2009/02/02/story11.html (Accessed 1/30/2009).

> the costs in care and the disease-oriented approach in the traditional medical model, struck out to create a revolutionary health care system, one in which patients signed on as willing, active participants in preventative health care and disease management.[104]

Like the VA, health care practitioners at this not-for-profit institution are not reimbursed through a fee-for-service model, thereby removing the conflict of interest on referrals for imaging studies, laboratory studies, medications, or specialty services—including referral to physical therapy. With one of the largest physical and occupational therapy operations in the Washington state, employment as a physical therapist in this system has distinct advantages over many others:

> Since we're not driven by profit, we have no incentive to encourage over-utilization to improve the bottom line. Instead, we promote timely and efficient care, working closely with patients to develop recovery plans and provide information about self-care and prevention. Smarter use of our resources keeps our costs—and member premiums—lower, and can save patients money spent on co-pays and gas.[105]

In addition, direct access to PT services is standard practice at both organizations;[106] therefore, in these settings, PTs have been practicing as autonomous professionals for decades, clearly defying the argument that PTs should be categorized as "incident to" MDs. Regardless, provision of physical therapy in organizations like these is less morally convoluted than POPTS.

In stark contrast, as seen in the previously mentioned Florida study, "joint-venture facilities provide a lower quality of care because both licensed therapy workers and non-licensed workers spend less time with each patient," yet, ironically, these facilities average 62% more visits per full time equivalent licensed PT. Unfortunately, this more closely describes the situation in which our patient, Barbara Kelley, found herself.

Is physical therapy a profession?

During the last few decades, physical therapy has come to be viewed by various health care entities as a business commodity to be exploited for its economic value, and physical therapists have found themselves increasingly succumbing to RFP/POPTS arrangements. A fundamental struggle for professional identity, for allied relationships between practitioners, and for the autonomy to deliver appropriate service to patients threatens to derail physical therapy as a profession. Ruth Purtilo, PT, PhD, FAPTA, and author of texts including *Ethical Dimensions in the Health Professions* (currently in its fourth edition), says that therapists need to grapple with "how we fit into the current environment and how we differ from 'businesses' that are driven

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104 Walter Crowley, *To Serve the Greatest Number: A History of Group Health Cooperative of Puget Sound* (Seattle & London: University of Washington Press, 1996), 3.

105 Craig Smith, director, quoted in. A Closer Look at PT/OT. *Pulse* fall 2008, 6.

106 Phillip Longman, *Best Care Anywhere: Why VA Health Care is Better Than Yours* (California: Polipoint Press, 2007).

strictly by economic and market forces."[107] Idealism notwithstanding, motivation for Purtilo's investigation does, in part, come from external sources, that is, "a health care environment that has forced us to look at ourselves more closely."[108] From this investigation of our motives and our actions, we find ourselves addressing fundamental questions such as the following: How does a practitioner provide just, compassionate, and quality care within the constraints of today's health care system? How does the busy clinician know how to recognize and resolve ethical situations that influence practice, whether at the individual, institutional, or societal level? How does the physical therapist act as a professional while being treated like a technician? In short, "How do we remain true to our basic identity as purveyors of an essential human service?"[109]

Fundamentally, does physical therapy meet the criteria of a profession? To review the definition proposed at the beginning of this essay, the criteria for claiming the status of a professional include: the ability to self-regulate; the right to autonomous practice; mastery of a complex body of knowledge and specialized skills, requiring both formal education and practical experience; a responsibility to keep and advance a body of knowledge, to set credible, useful standards, and to self-govern; and a duty to benefit human well being through a life of service. That PTs meet these criteria is illustrated though a condensed overview of the evolution of physical therapy in the US.[110] Originally, form followed function: the needs of World War I soldiers and veterans were met by a small group of women providing rehabilitation services, which, over the next 80 years, blossomed to more than 110,000 men and women, now licensed as physical therapists and assistants. In 1921, PTs formed their first professional association that American Physical Therapy Association; in 1935 the Association's Code of Ethics was approved; by the end of the 1940s, the APTA established it's policy-making body, the House of Delegates; in 1981 the Guide for Professional Conduct was adopted, providing further interpretation of the code; in 1997 the profession was further described with the publication of *The Guide to Physical Therapist Practice;* and in the same year, the APTA assumed independent control for establishing educational standards through the Committee on Accreditation in Education (CAE), the forerunner of the Commission on Accreditation in Physical Therapy Education (CAPTE).

Reflecting the expansion of services and clientele, PT education evolved from certification in bachelor's and master's degrees to the current standard in which 80% of all entry level physical therapist education programs are at a doctoral level. Today, we graduate Doctors of Physical Therapy who are expected to screen, diagnose, examine, critically analyze, and determine a prognosis for care, while recognizing professional boundaries and referring to other health care providers as appropriate. Paralleling this development of rigorous educational standards, state licensure replaced a "registry" that had previously been controlled by a physician board. With regard to keeping and advancing a body of knowledge, the profession demonstrated a financial commitment to establishing a unique and complex body of knowledge

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107 Ruth B Purtilo, "Thirty-first Mary McMillan Lecture: A time to harvest, a time to sow: ethics for a shifting landscape," *Physical Therapy* 80 (2000): 1112-1119.

108 Ibid.

109 Ibid.

110 Ibid.

through the Foundation for Physical Therapy, which has awarded over $10 million in grants and scholarships to hundreds of researchers over the past 25 years. It is rooted in a scientifically grounded, research-oriented medical model based on evidence-based medicine and best practice models. Although this historical overview demonstrates how "physical therapy has met the definition of profession, and, as such, should expect the legal and ethical protections afforded other professions,"[111] the reality is quite the opposite.

In stark defiance of the subjugated, deprofessionalized stature to which RFP would have therapists succumb, the APTA Vision Statement for Physical Therapy 2020[112] recommitted the profession to the highest standards of ethical and professional conduct, calling on the profession to be of doctoral status, to be evidence-based, to be accessed by consumers directly, and to be recognized as the practitioner of choice for evaluation and treatment of musculoskeletal dysfunctions. In fact, Vision 2020 integrates ethics into the scope of practice of physical therapy (emphasis added):

> *Guided by integrity*, lifelong learning, and a commitment to comprehensive and accessible health programs for all people, physical therapists and physical therapist assistants will render evidence-based service throughout the continuum of care and improve quality of life for society.[113]

Emphasized in Vision 2020, which is APTA's professional augmentation tool, are seven core value aspirations: accountability (the acceptance of responsibility); altruism (the ability to place the needs of the patient ahead of all others; having devotion toward the interest of the patient); integrity (adhering to high ethical principles and professional standards); compassion/caring (the desire to identify with another's experience, leading to the concern, empathy, and consideration for the needs and values of others); professional duty (the commitment to meeting one's duties); and excellence (incorporating the use of current knowledge and therapy while understanding personal limits, integrating judgment and the patient perspective, embracing advancement, challenging mediocrity, and working toward the development of new knowledge).[114]

Because health care information rapidly evolves, each health care professional must continue to sacrifice time, money, and earnest effort to invest in a lifetime of learning not for the sake of theoretic acrobatics, but for true growth, which involves a willingness to adapt to inevitable changes in knowledge, skills, attitudes, values, and beliefs.[115] After all:

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111 Ibid, 2-3.

112 APTA House of Delegates. APTA Vision Sentence for Physical Therapy 2020 and APTA Vision Statement for Physical Therapy 2020 (HOD 06-00-24-35). American Physical Therapy Association. 2000. http://www.apta.org/governance/HOD/policies/HoDPolicies/Section_I/GOALS_AND_MISSION/HOD_06002435. (Accessed 9/1/2008).

113 American Physical Therapy Association. APTA Vision Statement for Physical Therapy 2020. www.apta.org/AM/Template.cfm?Section=About_APTA&TEMPLATE=/CM/ContentDisplay.dfm&CONTENTID=19078 (Accessed 9/1/2008).

114 Jim Scarpaci, PT, MHSPT Musing on Professionalism *Journal of Physical Therapy Education, Education Section of the American Physical Therapy Association*, (21:3, Winter 2007), 3.

115 Melissa Wolff-Burke PT, EdD, ATC, et al., Generic Inabilities and the Use of a Decision-Making Rubric for Addressing Deficits in Professional Behavior in *Journal of Physical Therapy Education, Education Section of the American Physical Therapy Association*, (21:3, Winter 2007), 13.

> Training, education level, skill, and behavior are all key elements of professionalism. It is more than simply being an authority in your field. It is possible to be a highly motivated, hardworking individual who is an authority in the field, yet lacks professionalism. To be a true professional requires much more.[116]

Can ethics be taught?[117] *Real-world educational and clinical tools*

In the interest of maintaining the ethical stand point laid out in the vision document quoted above, aimed at furthering professional independence and responsibility in physical therapists, it is pressing that we learn to answer the following questions: how do we nurture in each student, and in ourselves, mindful sensitivity to suffering, an habitual approach of empathetic caring, and genuine respect for the inherent dignity in every being under our care? How do we facilitate effective ethics in action for our students as they attempt to integrate evidence-based medicine and best-practice guidelines in the less-than-ideal institutional and social contexts in which they practice health care? In short, with what audacity can one confidently profess that ethics can be taught?

In the clinic, the classroom, and the community, practical opportunities abound for the physical therapist committed to educating for moral action. In a position paper addressing deficits in professional behavior, Melissa Wolff-Burke, PT, EdD, ATC, and her colleagues, admonish anti-role models to heed the following:

> [Those] who are not familiar with the core documents of their profession, who do not utilize evidence to support their decision making, who take little time to assess student performance and less time for reflecting on their own practice are anti-role models and should not be entrusted with teaching students.[118]

Indeed, if one chooses not to be a member of one's professional organization, the likelihood is great that one does not even know what the professional standards are, let alone how to apply them. Dr. Pellegrino maintains that ethics can indeed be taught, "or why else would we all be here (at the International Ethics Forum)?"[119] He maintains ethics are best learned from a clinical mentor: demonstrating mindful responses to specific ethical dilemmas in the actual heat of the moment is an incredibly powerful learning tool. APTA offers a formal training program to hone skills required for excellence in mentoring—the Credentialed Clinical Instructor (CCI) program, which emphasizes ethical deliberation in all student/CI interactions, with practical steps for recognition, problem solving, and resolution of issues as they arise.[120] Conveniently, one of the tools, *Professionalism in Physical Therapy*, encourages students to observe their own and their instructors' words and actions, to see "if (they) demonstrate that core value in his/her daily

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116 Scarpaci, 4.

117 Questioned posed by Dr. Pellegrino to attendees of *Intensive Bioethics Course,* Kennedy School of Ethics, Georgetown University, June 8-13, 2004.

118 Melissa Wolff-Burke, PT, EdD, ATC, et al., *Generic Inabilities and the Use of a Decision-Making Rubric for Addressing Deficits in Professional Behavior.* Journal of Physical Therapy Education (21:3, Winter 2007), 17.

119 Pellegrino, 2004.

120 APTA Credentialed Clinical Instructor Program, Revised July 2005.

practice."[121] For example, the eleventh Sample Indicator, "Integrity," challenges both student and CCI to contemplate whether or not they are "choosing employment situations that are congruent with practice values and professional ethical standards."[122]

In the formal academic setting, professors of allied health care professionals are invited to join the ground-breaking educator bell hooks in treasuring the actual classroom educational experience as a "practice in freedom," where teachers and students alike can

> open our minds and our hearts so we can...think and re-think, so that we can create new visions, (so that we) become more and more engaged, to become active participants in learning...(and the) knowledge offered students (will) empower them to be better scholars, to live more fully in the world beyond academe.[123]

This kind of classroom exploration blends characteristics of a liberal arts education, an education in science, and professional training. Real-world examples of such coordinated training actually exist. Ronald R. Thomas, current president of an acclaimed private university, defends the rightful place of a professional PT program in his liberal arts institution due in part to its significantly positive contributions to the community, noting,

> the things we strive for most deeply in a liberal arts education (include) developing an independence of spirit, cultivating a creative and curious turn of mind, the ability to think critically and express ideas clearly, (and) a determination to act ethically and responsibly in the world...."[124]

A staple of a liberal arts education, imaginative literature is also recommended for the health care professional. Anthropological explorations such as *The Spirit Catches You and You Fall Down*[125] are increasingly incorporated into ethical education, especially that portion devoted to medical ethics. Aspiring to develop the body of behaviors, attitudes, skills, and knowledge marking "cultural competency," literature facilitates the health care professional's capacity to "deliver sensitive, empathic, humanistic care that is respectful of patients, involves effective patient-centered communication, and responds to patients' psychosocial issues and needs."[126] This same dynamic quality is attributed to the practice of science, as seen through the eyes of evolutionary biologist and author Olivia Judson from the Imperial College in London, who recently wrote:

> In schools, science is often taught as a body of knowledge—a set of facts and equations. But all that is just a consequence of scientific activity. Science itself is something else, something both more profound and less tangible. It is an attitude, a stance towards measuring, evaluating, and describing the world that is based on

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121 Ibid. Section 1 p 9.
122 Ibid. Section 1 p 10.
123 bell hooks *Teaching to Transgress: Education as the Practice of Freedom.* New York: Routledge 1994 1-12.
124 Ronald R. Thomas, President, University of Puget Sound, *President's Report* (2008), 2.
125 Anne Fadiman *The Spirit Catches You and You Fall Down: A Hmong Child, her American Doctors, and the Collision of Two Cultures.* New York: Farrar, Straus, and Giroux 1997.
126 Renee C. Fox, Ph.D., Becoming a Physician: Cultural Competence and the Culture of Medicine. *New England Journal of Medicine* 12/25/2005: 353;13 p 1316-1319.

> skepticism, investigation and evidence. The hallmark is curiosity; the aim, to see the world as it is. This is not an attitude restricted to scientists, but it is, I think, more common among them. And it is not something taught so much as acquired during a training in research or by keeping company with scientists.[127]

Through the practice of liberal arts and science, "we aim to cultivate rather than disparage rational thought."[128] Pedagogic bridges linking liberal, scientific, and professional training in the PT doctoral curriculum[129] are expressed in ethical training practices,[130] from an appreciation of basic philosophical theories[131] and fundamental principles[132] to the application of specific clinical tools[133] and the exploration of formative reflective practices, such as journaling and mindfulness training,[134] which nurture critical thinking.[135] Students are instructed in the language of ethical inquiry and the use of tools with which to negotiate ethical dilemmas; they practice with actual case studies and integrate their clinical experiences. They explore metacognition—thinking about thinking—in such books as Groopman's *How Doctors Think,*[136] which encourage them to temper aspirations of excellence with the humility of the fallibility that is inherent in being human:

> [W]e see how essential it is for even the most astute doctor to doubt his thinking, to repeatedly factor into his analysis the possibility that he is wrong. We also encounter the tension between his acknowledging uncertainty and the need to take a clinical leap and act.[137]

All these efforts nurture the service learning, the civic engagement,[138] and the ethical behavior expected of a professional, and they encourage respect, cooperation, humility, empathy, and dignity between teacher and student, between allied health care professionals, and between doctor and patient. The critical thinking skills developed through the study of science, of liberal arts, and, indeed, of professional training in physical therapy lead one to a fundamental query:

> [A] challenge to all intellectuals, or at least those who express a commitment to democracy, to take a long, hard look in the mirror and to ask themselves in whose interests, and for what values, they do their work.[139]

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127 Olivia Judson, *Back to Reality* in the New York Times, December 2, 2008 http://judson.blogs.nytimes.com/2008/12/02/back-to-reality/?pagemode (Accessed 12/2/08).

128 Al Gore, *The Assault on Reason.* London: Penguin Books 2007.

129 Charles R. Fox, OD, Ph.D., FAAO, Considering Liberal Learning and the Health Professions *Journal of Physical Therapy Education (*22:2 fall 2008), 13.

130 Purtilo. *Ethical Dimensions in the Health Professions.*

131 Gabard and Martin. *Physical Therapy Ethics.*

132 Beauchamp and Childress. *Principles of Biomedical Ethics.*

133 Albert R. Jonsen, Mark Siegler, William J. Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine,* 6th ed. Mc-Graw-Hill, 2006.

134 R. Epstein *Mindful practice*. JAMA. 1999;282(9):833-839.

135 A. Vendrely. Critical thinking and learning styles of students in a problem-based, master's entry-level physical therapy program. *Journal of Physical Therapy Education.* 2005;19(1):55-59.

136 Jerome Groopman, M.D. *How Doctors Think Boston*: Houghton Mifflin Company 2007.

137 Ibid.

138 Paul R. Loeb *Soul of a Citizen: Living with Conviction in a Cynical Time*. New York: St. Martin's Griffin1992.

139 Noam Chomsky as described in the introduction by Robert W. McChesney in *Profit Over People:*

If health care is actually to be about care, which is "connection," if "being human" is a goal of a liberal arts education, which is also about connection, and if democracy requires that people feel a connection to their fellow citizens, then physical therapists ought to question a culture that has largely "cultivat[ed] consumers instead of citizens, [and] shopping malls instead of communities."[140] In prioritizing the fiduciary responsibility inherent in health care, we must cultivate care at individual, institutional, and societal levels, and we must reject the commodification of patients characteristic in the referral-for-profit, fee-for-service model of health care. We are called to build up services to give the best possible care to all patients instead of being tools for profit.

Another avenue of ethical instruction is available to the educational body itself: the PT program can opt out of RFP clinical affiliations. This is no small sacrifice. Pressed by increasing productivity standards and decreasing allotment of time for CI mentoring, many PT facilities have ceased taking students for internships, which makes the act of refusing RFP openings an act of moral courage and financial sacrifice. An experienced physical therapy director justifies this hardship as a commitment to the future of the profession, noting that the APTA has reached out to PT schools nationwide, educating them about the inherent conflict of interest in maintaining clinical affiliations with RFPs.[141] Directors are creating more work for themselves in ferreting out ethically sound clinical experiences in the context of diminishing options, but, in doing so, they are educating the next generation of physical therapists about the severity of this issue. Educators and practitioners, then, can "break the moral silence,"[142] training the next generation to be independent thinkers, compassionate co-workers, and informed citizens, who are cultivating, conceptualizing, and expressing moral courage in the service of the fiduciary responsibility to the patient, thereby reducing harm to both patient and professional. [143]

Conclusion

This paper has critiqued the deprofessionalization of health care in America, in which the conflict of interest inherent in a fee-for-service business model of health care decreases patient outcomes, increases economic burdens, and compromises public trust. The specific case of physician owned physical therapy services posed this dilemma: some MDs invest in services to which they refer, some consumers pay too much for visits, and some patients don't get the consistent high quality care they deserve. By identifying, questioning, and ultimately eschewing non-professional behavior, this paper offered the several alternatives. In the individual realm, MDs must stop profiting from referrals, PTs must refuse employment at RFPs, and patients must be informed of their health care options and responsibilities. At the institutional level, these

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neoliberalism and the global order. New York: Seven Stories Press 1998, 14.

140 Ibid, 11.

141 Kathie Hummel-Berry, PT Ph.D. Personal communication with the Director of the School of Occupational and Physical Therapy, University of Puget Sound, Tacoma WA, Sept 15, 2008.

142 Ernest Nalette Reflections on Student Learning, in Educating for Moral Action: *Educating for Moral Action: A Source book in Health and Rehabilitation Ethic* (Philadelphia: F.A. Davis Company 2005), 262 .

143 Schultz S. Commentary. apathy: our true threat *Journal of Physical Therapy Education,* 2001;15(3):23-24.

arrangements must be made illegal by state and national governments. At the societal level, health care reform must encourage arrangements other than RFPs. And at the philosophical level, commitment to distributive justice must challenge the very ethos of the entrepreneurial-based health delivery system. Realistically, and despite all good intentions, individual players will be hobbled if the infrastructure persists, relegating colleagues to non-professional status, thereby continuing to diminish professionalism in general, health care broadly, PT/MD/patient relationships specifically, and human dignity ultimately. Alternatively, as allied health care team members, we can engage in public policy changes, committed to our essential humanity, and serving one another and our patients with humility, respect, honesty, integrity, dignity, empathy, and loving kindness. We can care for ourselves, for each other, and for patients like Barbara Kelley, and, in doing so, begin to earn back the respect originally intended by the word "professional."

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