Approved April 1, 1986
Date

MINUTES OF THE House COMMITTEE ON Judiciary.

The meeting was called to order by Chairman Joe Knopp at
Chairperson

3:30 ~~a.m.~~/p.m. on March 5, 1986 in room 313-S of the Capitol.

All members were present except:

Representatives Adam, Luzzati and Teagarden were excused.

Committee staff present:
Jerry Donaldson, Legislative Reserach Department
Mary Torrence, Revisor of Statutes Office
Jan Sims, Committee Secretary

Conferees appearing before the committee:
Rep. Marvin Barkis
Jerry Slaughter, Kansas Medical Society
Susan Hanrahan, Kansas Chapter of American Physical Therapy Association
Kenneth Schafermeyer, Kansas Pharmacists Association
Rep. Lee Hamm
Hon. Clarence, 30th Judicial District
Gordon Stull, Pratt County Bar Association
Marjorie Van Buren, Judicial Administartor's Office
Walter Scott

HB 2991 - An act concerning the Kansas healing arts act; relating to unprofessional conduct of licensees.

Rep. Marvin Barkis appeared before the committee in support of HB 2991 (Attachment 1). He said that with the creation of hospitals in Kansas for profit this bill will be needed more in the future than currently. He said the intent of the bill is to regulate through the imposition of professional ethics the referrals of medical providers to services or products in which the provider has a financial interest. He added there is a technical inconsistency in the bill as written. In an attempt to consolidate the best provisions of the California and Michigan laws both were included and the result has been an inconsistency that should be cleaned up prior to committee action on the bill by adding to (a)(12) that the referral could be made if a disclosure is made prior to referral. Rep. Barkis said the patient needs to be aware that if they are being referred to another hospital, thereapist, etc., the referring doctor may have a financial interest in that facility.

Jerry Slaughter of the Kansas Medical Society appeared on HB 2991 stating that his organization and Rep. Barkis' approach this from different sides, Rep. Barkis making the assumption that there are abuses of this situation and the Medical Society assuming that there are not abuses. If this legislation is needed at all, it should be simplified considerably and he presented a balloon reflecting his proposal. (Attachment 2).

Susan Hanrahan of the Kansas Chapter of American Physical Therapy Association appeared in support of HB 2991. (Attachment 3). She said her organization's feeling is that the patient should be aware of the choices available and that some of those choices could result in further financial gain to their physician.

Kenneth Schafermeyer of the Kansas Pharmacists Association appeared before the committee in support of HB 2991 (Attachment 4). He spoke to the situations involving physicians prescribing drugs and its affect on pharmacists if the pharmacist does not stock a drug manufactured by a company which has as major stockholders physicians prescribing their drugs and the instances of physicians informing patients of which pharmacy to patronize and implying that the patients have no choice of pharmacies.

HB 2825 - An act concerning judges of the district court.

Rep. Lee Hamm appeared before the committee in support of HB 2825 stating that the basis of the bill is a current situation in the 30th Judicial District where one of the magistrate judges has been ill for an extended period of time and it is unlikely that he will return to the bench.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE House COMMITTEE ON Judiciary,

room 313-S, Statehouse, at 3:30 a.m./p.m. on March 5, 1986

Judge Clarence Renner, Administrative Judge of the 30th Judicial District appeared before the committee in support of the bill. He said the current magistrate judge has suffered a number of heart attacks and it is unlikely that he will return to work. The case filings in the 30th district have increased more than any other in the state and are at a point to justify the request of a new district judge position. The 30th district is asking that upon the creation of a vacancy in the magistrate position that the position be changed to a district judge position. This would have the fiscal effect of obtaining a district judge position for half price.

Gordon Stull, President of the Pratt County Bar Association appeared in support of this bill stating that the members of the bar are concerned about the caseload of the judges and the fact that cases are needing to be heard timely.

Marjorie Van Buren of the Judicial Administrator's Office presented the fiscal note on this bill to the committee and responded to the committee members' questions. (Attachment 5)

HB 2672 - An act concerning hospitals; relating to liens upon personal injury damages recovered by patients.

Rep. Buehler appeared before the committee and explained the basis for the bill. He presented the written statement of the Kansas Hospital Association. (Attachment 6)

Walt Scott appeared before the committee in support of HB 2672 stating that the current law on lines 23 and 24 of the bill do present a problem for hospitals because workers' compensation is not included in the liens hospitals may file and there are cases settled in lump sums and the claimant is not required to pay the hospital bill as a part of the settlement and is further not required to pay the hospital bill because he then becomes immune from a hospital lien.

HB 3050 - An act concerning judges of the district courts; relating to elimination of the office of associate district judge and creation of new positions of district judge.

Mary Torrence stated that this bill is basically a cleanup bill. She said there should be an amendment on pages 6 and 7 at lines 232-251 striking that language as those judges have now gone through the change process.

Rep. Solbach moved that HB 2825 be reported favorable for passage. Seconded by Rep. Wunsch. Motion carried on a voice vote.

Rep. Solbach moved to amend HB 3050 to strike lines 232 through 251. Seconded by Rep. Fuller. Motion carried on a voice vote. Rep. Solbach moved to report HB 3050 as amended favorable for passage. Seconded by Rep. Fuller. Motion carried on a voice vote.

The Chairman adjourned the meeting at 5:05 P.M.

STATE OF KANSAS

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HOUSE OF
REPRESENTATIVES

TESTIMONY

ON

HB 2991

Presented by: Representative Marvin Wm. Barkis

March 5, 1986

Thank you, Mr. Chairman. I appreciate the opportunity to testify in support of H.B. 2991 today. This bill amends K.S.A. 65-2837, the professional imcompetency and unprofessional conduct statute for physicians. The point of the bill is to regulate through the imposition of professional ethics, the referrals of medical providers (medical doctors, osteopaths, and chiropractors) to services or products in which that provider has a financial interest.

Let me state clearly, this bill does not prohibit such referrals or prescriptions for treatment. It merely requires the provider to make the patient aware of the financial interest through written disclosure and to advise the patient of her/his option to choose any organization for the purpose of obtaining the services ordered or requested.

The bill adds to an existing list of 11 examples of unprofessional conduct. For example, "willful betrayal of confidential information", "receipt of fees on the

Attachment I
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3-5-86

assurance that a manifestly incurable disease can be permanently cured," and "failure to comply with a patient's living will declaration" are three of the eleven examples of unprofessional conduct. The twelth and newest prohibition would read as follows:

"promotion for personal gain of an unnecessary drug, device, treatment, procedure or service, or directing or requiring an individual to purchase or secure a drug, device, treatment, procedure or service from another person, place, facility or business in which the licensee has a financial interest."

This prohibition includes treatment, services, and devices, etc. in which not only the provider, but also the provider's immediate family has a significant beneficial interest.

Significant beneficial interest would be defined as financial interest equal to or greater than the lesser of five percent of the whole or five thousand dollars. It includes both ownership of buildings where space is leased to the organization which provides the product or services in question, and to interest in publicly traded stocks.

Specifically exempted from this disclosure requirement are medical providers arranging or delivering health care services under the state medical assistance program. The bill adds a new section 2 to the statute which explains the disclosure requirements.

Disclosure would be required in writing to the patient if referrals are made or treatment is prescribed which involves services or products in which medical provider has a financial interest.

This is not a stringent disclosure requirement. It would, in fact be possible to satisfy this disclosure requirement either by posting a conspicious sign in an area where all patients are likely to see it, or by distribution of a written disclosure statement to all patients.

Standards of professional conduct must be adapted to suit the changing realities of each profession. In this case of physicians and medical providers, a trend toward "for-profit" health care and the increasing diversification of physicians' financial investment into other type of medical organizations, products and services demands this addition to the Kansas statutes. Just as the standard regarding compliance with the living will of a patient was added a few years ago to this statute in recognition of changing ethical questions in medicine, so to does the "commercial-ization of medicine" demand comparable ethical controls.

This statute is modeled after the California and Michigan statutes. Where California requires disclosure of financial interest in health care organization to which they refer patients, the Michigan

statute prohibits doctors from referring patients to such facilities. The Kansas approach is a reasonable compromise to protect patients against the chance that professional discretion of the medical provider might be superceded by financial motivations. While such exploitation is expected to be rare, clearly the unprofessional conduct statute should address it.

There is a growing concern within the not-for-profit, hospital community that the rise in for-profit health care facilities may undermine the quality of available care. Within just the last year we have seen an increase in the number of free-standing, for-profit, physician owned medical facilities such as "Surgi-Center" in Topeka, "Alternicare/Surgicenter" in Kansas City, and "Now Care/Hershberger, Hertzler and Crossroads Clinic" in Wichita. There are more and more private for-profit hospitals locating in Kansas or buying existing facilities, such as Humana in Dodge City and Wesley Hospital in Wichita, recently purchased by Hospital Corporation of America.

If there is a chance that the professional discretion of physicians has been influenced by economic gain, the patient ought to be at least made aware by mandated disclosure of that possibility of the provider's financial interests.

Accountants, lawyers and legislators are subject to disclosure laws. These professions are based on the trust which an average person must place in someone

else to accomplish what they are unable to do. People risk a great deal by trusting professionals, so the law protects their interests more diligently than when they deal with someone on equal footing. This bill is necessary to provide protection to medical patients in the modern health care industry.

I ask for your support of this legislation. Thank you.

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DEALING WITH CONFLICTS OF INTEREST

THE medical profession in this country has always had its entrepreneurs and hustling businessmen, but until recently they were on the fringe and in a small minority. Most practicing physicians concentrated on providing or supervising services to their patients, and their professional income was largely limited to the fees or salaries paid for such services.

Lately, however, a new entrepreneurial fever has begun to affect the profession, and what was formerly on the fringe seems to be moving into the mainstream. More and more practitioners are seeking profits from business arrangements with hospitals, equipment manufacturers, and most recently, companies providing ambulatory health care services. Practicing physicians now have financial interests in diagnostic laboratories, radiologic imaging centers, walk-in clinics, ambulatory surgery centers, dialysis units, physical therapy centers, and other such facilities. In most of these business ventures, the investing physicians' profits depend, at least in part, on referral of patients to these facilities or on other decisions they make in the care of their patients.

A few examples will illustrate the conflicts of interest involved in such arrangements. Consider, first, the various ways some enterprising surgeons are augmenting their professional income through business connections with the facilities in which they operate on their patients. Free-standing investor-owned ambulatory surgical centers are springing up everywhere. To increase the use of their facilities, which are often in competition with similar units in the community hospitals, these companies offer local surgeons a share in the profits. Some ambulatory surgical centers are owned by the surgeons who use the facility, and they share in the profits from its use. A few investor-owned hospitals have also offered profit-sharing deals to surgeons. According to public statements made by its management, one large hospital chain substantially increased the use of its operating rooms by sharing the profits with its staff surgeons. In each of these examples, surgeons have benefited financially not only from providing professional services but from referring their patients to a facility in which they have an interest.

Free-standing radiologic imaging centers (usually featuring CAT scanners and magnetic resonance imaging units) are another recent phenomenon that is attracting increasing entrepreneurial interest from physicians. Radiologists and nonradiologists are now investing in these centers, often in partnership with venture capitalists. For the nonradiologist investors, such arrangements constitute an economic incentive to refer their own patients to the imaging center and to use radiologic procedures. The radiologist investors in such centers may have less opportunity for self-referral than their nonradiologist partners, but

since they are acting as radiologic consultants, they can recommend follow-up studies. In any case, their entrepreneurial interests in the financial success of the center may be even more compelling than their partners', because they benefit twice — once as professional supervisors and interpreters of the diagnostic procedure, and again as investors in the facility.

Another kind of business arrangement was in the news recently when a congressional committee investigating Medicare payments for cataract surgery[1] reported that some ophthalmologists accept inducements from manufacturers of intraocular lens implants, which are intended to persuade the physician to use a particular brand of lens. These include quantity discounts, cash rebates, shares of stock in the company, and a variety of gifts, such as free vacations, the use of a yacht, and expensive office equipment. The ophthalmologist makes a profit beyond the professional fee for doing the operation by charging Medicare a large markup on the implanted lens, in addition to whatever consideration he or she receives from the manufacturer for using the product.

Many other examples could be cited to demonstrate that entrepreneurialism among physicians is a widespread and rapidly growing phenomenon that is creating conflicts of interest in almost all sectors of the medical profession. Considering the manifold forces now moving medical practice in the direction of commerce,[2] this is hardly surprising. But is it in the best interests of society and the profession? And, if it is not, what if anything can be done to change the trend?

Defenders of the marketplace approach to health care say there is nothing wrong with physicians acting as entrepreneurs. They argue that fee-for-service practice is essentially a business anyway and the economic conflicts of interest that arise when physicians make financial arrangements with health care businesses are in principle not much different from those already existing in private practice.

There is something to be said for that latter point, particularly when practitioners benefit financially from special tests or procedures that they have recommended for their patients and that they themselves then supervise or carry out. However, this argument ignores the basic social role of the physician, which is to be an agent and trustee for the patient. Physicians are ethically bound to place the medical care needs of their patients before their own financial interests — an obligation that clearly sets the practice of medicine apart from business. Conflicts of interest may be inherent in the fee-for-service system, but ethical practitioners minimize them 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. Furthermore, whatever conflicts of interest may exist in the fee-for-service relation between doctor and patient are clearly visible to all concerned and have long been accepted by society. When patients have any doubts, they are free to seek other advice.

The situation is different when physicians seek income beyond fee for service and make business arrangements with other providers of services to their patients. Such arrangements introduce a new and unnecessary conflict, which strains the physician's fiduciary commitment to the patient. Unlike the conflicts of interest in the fee-for-service system, these new arrangements are usually not fully disclosed to the patient, and therefore are more difficult to control.

The new entrepreneurialism among physicians is beginning to attract legislative attention. The state of Michigan now prohibits physicians from referring their patients to any facility in which the practitioner has a financial interest. Pennsylvania has recently enacted a similar law, but it applies only to patients receiving state medical assistance. California law currently requires that physicians disclose any financial interests in free-standing diagnostic facilities to which they refer their patients, but the legislature is now considering a bill (AB 1325) that would prohibit such referrals regardless of disclosure.

State laws dealing with this issue are likely to multiply as the commercialization of our medical care system becomes ever more pervasive and public concern mounts. In my view, however, legal measures alone are not the answer. There can be no really satisfactory solution until the medical profession itself faces up to the threat of entrepreneurialism and decides to take a firm stand in defense of professional ethics. That is why I have been pleased to see the American Medical Association (AMA) debate this subject at its last few meetings and attempt to develop policy guidelines. The AMA has quite properly reminded physicians that "medicine is a profession, a calling, and not a business . . . ,"[3] and it has reaffirmed that physicians must put the needs of their patients above economic self-interest. But it has also said that physicians may ethically invest in facilities and share profits with hospitals or pharmaceutical or equipment manufacturers, provided that the arrangements are lawful, do not lead to overutilization or improper care of patients, are disclosed in advance to patients, and do not involve profit sharing with institutions being paid under the Medicare system of diagnosis-related groups (DRGs).[4,5] At its recent annual meeting, the AMA vigorously denounced a chain of investor-owned hospitals that has been sharing profits with its medical staff as a means of inducing the staff to reduce expenditures on Medicare patients.[6]

The AMA thus seems to be drawing a distinction between profit sharing in the traditional reimbursement system (ethically permissible if certain conditions are met) and profit sharing in the Medicare DRG-based prospective payment system (ipso facto unethical, a form of "kickback"). It is a distinction

that defies logic, however, and I doubt that it will withstand further reflection and discussion. If profit sharing with hospitals under a DRG system is unethical (and I agree that it is), then so is profit sharing under a charge reimbursement system, since there are possibilities for abuse and exploitation of patients in both systems and profit sharing by physicians in either system creates temptations that may be difficult to resist. Withholding or skimping on needed services (the possible abuse in the prospective payment system) is no more reprehensible than providing uneeded or inappropriate service (the possible abuse in the charge reimbursement system). Financial arrangements that tempt physicians in either direction ought to be avoided.

The AMA's present position has an even more troublesome aspect. In admitting that business deals create conflicts of interest for physicians, but arguing that we need be concerned only about arrangements that demonstrably lead to bad practice, the AMA's statements ignore the damage done to the public trust in the medical profession by even the *appearance* of conflicts of interest. That, after all, is a major problem with conflicts of interest. Full disclosure might help prevent that loss of trust, but there is already a strong popular sense that physicians are too interested in exploiting the financial advantages of their position, and disclosure is not likely to do much to change that. The continued unchecked growth of entrepreneurialism will only strengthen public suspicion and give further impetus to the kinds of legislative action now being taken in some states.

I would therefore hope that the current position of the AMA on this issue is in transition and that, after further deliberation, a stronger policy statement will emerge. The American College of Physicians, in its recently issued Ethics Manual, has taken such a position.[7] It says, "The physician must avoid any personal commercial conflict of interest that might compromise his loyalty and treatment of the patient." A similarly firm and unequivocal statement of conscience from all the important sectors of organized medicine in the United States would be salutary. Of course, we will need much more than a statement of conscience to reverse the trend, but it is a good way to begin. We cannot expect to take any practical steps in defense of our professionalism until we publicly agree that physicians serve their patients' interests best when they divorce themselves from financial interests in the medical marketplace.

ARNOLD S. RELMAN, M.D.

REFERENCES

1. Cataract surgery: fraud, waste, and abuse: a report by the Chairman of the Subcommittee on Health and Long-Term Care of the Select Committee on Aging of the House of Representatives, Ninety-Ninth Congress, July 19, 1985. Washington, D.C.: Government Printing Office, 1985. (Committee publication no. 99-506).
2. Relman AS. The future of medical practice. Health Affairs 1983; 2(2):5-19.
3. House of Delegates of the American Medical Association. Commercialism in the practice of medicine: report of the Board of Trustees of the American Medical Association, June 1983.
4. House of Delegates of the American Medical Association. Conflict of interest — guidelines: report of the Judicial Council of the American Medical Association, December 1984.
5. House of Delegates of the American Medical Association. Ethical implications of hospital-physician risk-sharing arrangements under DRGs: report of the Judicial Council of the American Medical Association, December 1984.
6. Kickback plan by hospital hit. American Medical News. June 28-July 5, 1985:1, 34.
7. Ad Hoc Committee on Medical Ethics of the American College of Physicians. American College of Physicians ethics manual. Part 1. History of medical ethics, the physician and the patient, the physician's relationship to other physicians, the physician and society. Ann Intern Med 1984; 101:129-37.

VASCULAR DISEASE AND HOMOCYSTEINE METABOLISM

ELSEWHERE in this issue, Boers and co-workers[1] present evidence that among 50 patients with early occlusive peripheral arterial or cerebrovascular disease, far more heterozygotes for deficiency of the enzyme cystathionine synthase were detected than would be expected in a random sample of the general population. This finding lends important support to the emerging hypothesis that there may be an association between premature vascular disease and mild impairments of homocysteine metabolism.

Homocysteine is an amino acid formed during the metabolism of methionine. Several genetic diseases of human beings are now known to interfere with the further use of homocysteine, affecting either its conversion to cystathionine (cystathionine synthase deficiency) or its reconversion to methionine by a pathway that requires the formation of methylated derivatives of both vitamin B_{12} and folic acid.[2,3] In each of these diseases, homocysteine accumulates abnormally in body fluids, chiefly as the disulfide homocystine (homocysteine–homocysteine), and spills into the urine.[2] In cystathionine synthase deficiency, methionine also accumulates abnormally; in the other diseases, the methionine level is low or normal. The association of cystathionine synthase deficiency with premature thromboembolic disease has been demonstrated in studies of more than 600 patients.[3] Among the few patients with the other forms of severe homocystinuria whose tissues have been examined pathologically, most had severe atherosclerotic changes, one as early as the age of 7½ weeks.[2] In some but not all studies, the administration of homocystine or its derivatives caused atherosclerotic changes in laboratory animals.[1,2] Together, these findings have led to the general acceptance of the notion that severe homocystinemia leads to early vascular disease.

Is the same true for milder homocysteinemia and less drastic impairments of homocysteine metabolism? Until very recently, the search for cases of mild homocysteinemia, with or without methionine load-

Kansas Medical Society
3/5/86

Attachment 2
House Judiciary
March 5, 1986

0046 (8) Advertising to guarantee any professional service or to
0047 perform any operation painlessly.
0048 (9) Participating in any action as a staff member of a medical
0049 care facility which is designed to exclude or which results in the
0050 exclusion of any person licensed to practice medicine and sur-
0051 gery from the medical staff of a nonprofit medical care facility
0052 licensed in this state because of the branch of the healing arts
0053 practiced by such person or without just cause.
0054 (10) Failure to effectuate the declaration of a qualified pa-
0055 tient as provided in subsection (a) of K.S.A. 65-28,107 and
0056 amendments thereto.
0057 (11) Prescribing, ordering, dispensing, administering, sell-
0058 ing, supplying or giving any amphetamines or sympathomimetic
0059 amines, except as authorized by K.S.A. 65-2837a *and amend-*
0060 ments thereto.
0061 (12) ~~*Promotion for personal gain of an unnecessary drug,*~~
0062 ~~*device, treatment, procedure or service, or directing or requir-*~~
0063 ~~*ing an individual to purchase or secure a drug, device, treat-*~~
0064 ~~*ment, procedure or service from another person, place, facility*~~
0065 ~~*or business in which the licensee has a financial interest.*~~
0066 ~~*(13) Failure to comply with the provisions of section 2.*~~
0067 (c) "False advertisement" means any advertisement which is
0068 false, misleading or deceptive in a material respect. In deter-
0069 mining whether any advertisement is misleading, there shall be
0070 taken into account not only representations made or suggested
0071 by statement, word, design, device, sound or any combination
0072 thereof, but also the extent to which the advertisement fails to
0073 reveal facts material in the light of such representations made.
0074 (d) "Advertisement" means all representations disseminated
0075 in any manner or by any means, for the purpose of inducing, or
0076 which are likely to induce, directly or indirectly, the purchase of
0077 professional services.
0078 ~~New Sec. 2. (a) No person licensed under the Kansas healing~~
0079 ~~arts act shall charge, bill or otherwise solicit payment from a~~
0080 ~~patient on behalf of, or refer a patient to, an organization in~~
0081 ~~which the licensee, or the licensee's immediate family, has a~~
0082 ~~significant beneficial interest, unless the licensee first discloses~~

Providing or prescribing unnecessary drugs, treatments or services, or directing or referring an individual to purchase or utilize a drug, treatment or service from a health facility or organization in which the licensee has a financial interest, without first disclosing such financial interest.

0083 in writing to the patient that there is such an interest and advises
0084 the patient that the patient may choose any organization for the
0085 purpose of obtaining the services ordered or requested by the
0086 licensee.
0087 (b) The disclosure requirements of subsection (a) may be met
0088 by posting a conspicuous sign in an area which is likely to be
0089 seen by all patients who use the facility or by providing those
0090 patients with a written disclosure statement. Where referrals,
0091 billings or other solicitations are between licensees who conduct
0092 their practice as members of the same professional corporation or
0093 partnership and the services are rendered on the same physical
0094 premises, or under the same professional corporation or part-
0095 nership name, the requirements of subsection (a) may be met by
0096 posting a conspicuous disclosure statement at a single location
0097 which is a common area or registration area or by providing those
0098 patients with a written disclosure statement.
0099 (c) For the purposes of this section, the following terms shall
0100 have the following meanings:
0101 (1) "Immediate family" includes the spouse and children of
0102 the licensee, the parents of the licensee and the licensee's
0103 spouse, and the spouses of the children of the licensee.
0104 (2) "Significant beneficial interest" means any financial in-
0105 terest that is equal to or greater than the lesser of the following:
0106 (A) Five percent of the whole.
0107 (B) Five thousand dollars.
0108 (d) This section shall apply to a "significant beneficial inter-
0109 est" which is limited to ownership of a building where the space
0110 is leased to the organization at the prevailing rate under a
0111 straight lease agreement or to any interest held in publicly
0112 traded stocks.
0113 (e) (1) This section does not prohibit the acceptance of eval-
0114 uation specimens for proficiency testing or referral of specimens
0115 for assignment from one clinical laboratory to another clinical
0116 laboratory, if the report indicates clearly the name of the labora-
0117 tory performing the test.
0118 (2) This section shall not apply to relationships governed by
0119 other provisions of the Kansas healing arts act nor is this section

KANSAS CHAPTER

AMERICAN PHYSICAL THERAPY ASSOCIATION

March 5, 1986

Susan Hanrahan, RPT
Legislative Chairperson
Kansas Chapter,
American Physical Therapy Association
3731 Southeast 27th
Topeka, Kansas 66605
(913) 295-6619 [work]

Mr. Chairman and Members of the Judiciary Committee:

My name is Susan Hanrahan and I represent the Kansas Physical Therapy Association. Our Association serves over 500 physical therapists and physical therapist assistants in this state, which is over 90% of the practicing physical therapy personnel in Kansas. My purpose today is to support HB 2991 relating to licensees of the Board of Healing Arts.

Our Association would like to provide specific support to the new language in HB 2991 which mandates that licensees shall inform patients of services they might be receiving from an organization that the licensee has a financial interest in. In the case of physical therapy, there are a number of physician-owned physical therapy services throughout the State. Our Association is not objecting to the ownership of these services but to the specific referral of those physicians' patients to those services. Our patients should have a choice in choosing any physical therapy, laboratory or pharmacy facility they desire and must not be directed to one service just because the physician has a financial interest in that organization. These types of operations can lead to a physician receiving monetary rewards for a referral and can become a very unethical practice situation.

Attachment 3
House Judiciary
March 5, 1986

We strongly support HB 2991 as it gives the patient a choice in selecting their health care. Patient education and awareness are the trend in medicine and this legislation would be consistent with that movement. At this time I'd like to address any questions that your might have. Thank you for the opportunity to testify before your Committee.

THE KANSAS PHARMACISTS ASSOCIATION
1308 WEST 10TH
PHONE (913) 232-0439
TOPEKA, KANSAS 66604

KENNETH W. SCHAFERMEYER, M.S., CAE
PHARMACIST
EXECUTIVE DIRECTOR

STATEMENT TO THE HOUSE JUDICIARY COMMITTEE

MARCH 5, 1986

SUBJECT: HB 2991 REGARDING PHYSICIANS' DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

MY NAME IS KEN SCHAFERMEYER AND I AM EXECUTIVE DIRECTOR OF THE KANSAS PHARMACISTS ASSOCIATION--AN ORGANIZATION REPRESENTING APPROXIMATELY 1,000 PRACTICING PHARMAICSTS IN THE STATE OF KANSAS. I APPRECIATE THE OPPORTUNITY TO ADDRESS YOU ON HOUSE BILL 2991 REGARDING PHYSICIAN DISCLOSURE OF CERTAIN FINANCIAL INTERESTS.

I HAVE DISTRIBUTED TO EACH MEMBER OF THE COMMITTEE A PACKET CONTAINING AN ARTICLE FROM THE NEW ENGLAND JOURNAL OF MEDICINE AND COPIES OF MATERIALS FROM HORIZON PHARMACEUTICALS OF KANSAS CITY. THE MATERIAL FROM HORIZON STATES THAT THEIR MAJOR STOCKHOLDERS AND THE BOARD OF DIRECTORS ARE OPHTHALMOLOGISTS. THE MATERIALS ALSO SAY THAT THE DRUG PRODUCTS COST 25 TO 45% LESS THAN COMPARABLE MAJOR LINE PRODUCTS. WHILE THESE DRUGS ARE, IN SOME CASES, LESS EXPENSIVE THAN CERTAIN BRAND NAME EQUIVALENTS, THE HORIZON PRODUCTS ARE SIGNIFICANTLY MORE EXPENSIVE THAN OTHER GENERIC EQUIVALENTS. THE JANUARY 22 LETTER FROM HORIZON STATES THAT A LOCAL PHYSICIAN HAS REQUESTED THAT THE PHARMACIST STOCK THE HORIZON

Attachment 4
House Judiciary
March 5 1986

PRODUCTS. AS YOU WILL NOTE FROM THE ATTACHED PRESCRIPTION COPY, THIS SAME PHYSICIAN HAS SIGNED THE PRESCRIPTION ON THE "DISPENSE AS WRITTEN" LINE, EFFECTIVELY PREVENTING THE PHARMACIST FROM SELECTING A LOWER COST GENERIC ALTERNATIVE. THIS INFORMATION WAS BROUGHT TO MY ATTENTION BY A CONSCIENTIOUS PHARMACIST WHO IS CONCERNED ABOUT A POTENTIAL CONFLICT OF INTEREST. HE HAS REFUSED TO STOCK THE HORIZON PRODUCTS.

THE ARTICLE FROM THE NEW ENGLAND JOURNAL OF MEDICINE ADDRESSES THE ISSUE OF CONFLICT OF INTEREST FROM PHYSICIANS OWNING AMBULATORY SURGICAL CENTERS, RADIOLOGIC CENTERS, PHARMACEUTICAL MANUFACTURERS AND CLINICAL LABORATORIES. THIS ARTICLE DOES NOT STATE ANYWHERE THAT PHYSICIANS ALSO OWN PHARMACIES. THIS IS THE CASE IN MANY LOCATIONS IN THE STATE OF KANSAS. A SOUTHEAST KANSAS PHARMACIST (WHO PREFERS TO REMAIN ANONOMYOUS AT THIS TIME) CALLED TO COMPLAIN THAT MANY OF HIS NURSING HOME PATIENTS HAVE MYSTERIOUSLY DECIDED TO SWITCH TO ANOTHER PHARMACY. ALL THESE PATIENTS CHANGED TO THE SAME PHARMACY THAT WAS OWNED BY THEIR PHYSICIAN. THE PHARMACIST STATED THAT THE PATIENTS SEEMED TO THINK THAT THEY HAD NO CHOICE.

ACCORDING TO THE JOURNAL ARTICLE WHICH YOU HAVE RECEIVED, MICHIGAN, PENNSYLVANIA, AND CALIFORNIA HAVE ADDRESSED THIS ISSUE. MICHIGAN HAS A LAW VERY SIMILAR TO THE BILL WHICH HAS BEEN INTRODUCED.

SECTION II OF THE BILL STARTING ON LINE 78 SEEMS TO BE A MATTER OF COMMON SENSE. PHYSICIANS SHOULD DISCLOSE POTENTIAL CONFLICTS OF INTEREST. SINCE THERE DOES NOT SEEM TO BE MUCH POTENTIAL CONFLICT THROUGH OWNERSHIP IN PUBLICLY-HELD CORPORATIONS, THE COMMITTEE WOULD BE REASONABLE IN EXEMPTING SITUATIONS WHERE PHYSICIANS HAVE A SMALL PERCENTAGE OF OWNERSHIP IN A PUBLICLY-TRADED STOCK.

SUBSECTION ~~XII~~ 12, ON LINE 61, SEEMS TO BE SOMEWHAT VAGUE SINCE IT REFERS TO "UNNECESSARY" SERVICES. A CAUTIOUS PHYSICIAN MAY SOMETIMES ORDER TESTS OR TREATMENTS THAT MAY LATER TURN OUT TO BE "UNNECESSARY" ON A RETROSPECTIVE REVIEW. NEVERTHELESS, THE PHYSICIAN FEELS THAT IT IS IMPORTANT TO PLAY IT SAFE AND ORDERS THE TEST OR SERVICE. THE WORD "UNNECESSARY" SHOULD PROBABLY BE MORE CAREFULLY DEFINED OR THIS SECTION SHOULD BE ELIMINATED FROM THE BILL.

WE DO, HOWEVER, FEEL THAT AN IMPORTANT FIRST STEP IN PREVENTING POTENTIAL CONFLICTS OF INTEREST IS TO DISCLOSE THESE SITUATIONS. IT SEEMS THAT MOST ETHICAL PHYSICIANS WOULD WANT TO DO THIS AND THIS SHOULD NOT BE AN UNDUE BURDEN.

THANK YOU, MR. CHAIRMAN, FOR THE OPPORTUNITY TO SPEAK ON THIS BILL. I WILL BE GLAD TO ANSWER ANY QUESTIONS.

Horizon
PHARMACEUTICALS, INC. P.O. Box 9812 · Kansas City, Missouri 64134-0812 · (816) 966-0110
National Wats (800) 821-3078

NEW OPHTHALMIC PRODUCT INTRODUCTION

Dear Pharmacist,

HORIZON PHARMACEUTICALS, INC. is very proud to introduce, to you, our new line of prescription Ophthalmic medications. The eight new Ophthalmic products described on the enclosed product/price list are being aggressively promoted to all Ophthalmologists in your area. These products are available through your wholesaler at this time.

There are several factors to consider which I feel should warrant your stocking the HORIZON Ophthalmic Medications. These factors are as follows:

1. HORIZON will promote these products aggressively to Ophthalmologists.
2. HORIZON sales Representatives will be detailing Ophthalmologists.
3. HORIZON Ophthalmics are priced 25% to 45% less than comparable major line products.
4. HORIZON's major stockholders are Ophthalmologists.
5. HORIZON's Board of Directors are Ophthalmologists.
6. HORIZON's President has 18 years experience in the sales and marketing of Ophthalmic Pharmaceutical products.

Based on the above facts I would ask that you order the HORIZON Ophthalmic Products from your wholesaler today.

We at HORIZON PHARMACEUTICALS, INC. are dedicated to working with you, the Pharmacist, as an integral part of our organization. Should you now, or in the future, have any questions regarding either HORIZON PHARMACEUTICALS, INC. or our Ophthalmic Products please contact me personally at any time.

Sincerely,

Harold P. "Tim" Henry, President
HORIZON PHARMACEUTICALS, INC.

Horizon
PHARMACEUTICALS, INC. P.O. Box 9812 · Kansas City, Missouri 64134-0812 · (816) 966-0110
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January 22, 1986

Dear Pharmacists,

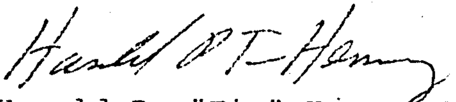
Dr. Ernest Kovarik of Topeka has requested that I contact you regarding the introduction of THE HORIZON PRESCRIPTION OPHTHALMIC MEDICATIONS. Dr. Kovarik, as well as other Ophthalmologists in your area are using these products extensively. I have been notified, by Dr. Kovarik, that his patients are having difficulty obtaining these medications once they leave Topeka. He has specifically indicated that we contact the stores in your town and once again urge you to place these items in your stock.

HORIZON PHARMACEUTICALS products are available through the following wholesalers serving your area: McPike, FoxMeyer, McKesson, C.D. Smith, Amfac and Pennington. All of our products are guaranteed sale items.

A copy of an introductory letter, which was sent to you in November, is enclosed along with the HORIZON PHARMACEUTICALS Product/Price List.

By copy of this letter I am informing Dr. Kovarik that your store has been contacted as per his request. We do appreciate your cooperation with HORIZON and look forward to working with you in the future.

Regards,



Harold P. "Tim" Henry, President
HORIZON PHARMACEUTICALS, INC.

cc: Ernest D. Kovarik, M.D.

WHOLESALE ITEM NUMBERS

McPike	FoxMeyer	McKesson	PRODUCT NAME
115-188	291435	182-6791	CHLORACOL 0.5% 7.5 ml. 3.43/1.83
115-915	308304	182-6916	CONJUNCTAMIDE 5 ml. 4.42/6.65
115-931	327973	182-7039	CONJUNCTAMIDE 15 ml.
115-535	341776	182-7195	LITE PRED 15 ml.
115-956	379123	182-7351	NAPHOLINE 15 ml.
115-949	389239	182-7427	NEOTROL 5 ml. 5.65 /6.26
115-212	393645	182-7526	SULFAMIDE 10% 15 ml. 2.96 /1.65
115-709	474478	182-7633	ULTRA PRED 10 ml. 5.25/8.58

TELEPHONE 233-1800

ERNEST D. KOVARIK, M.D., F.A.C.S.

900 WASHBURN — WASHBURN MEDICAL PARK — TOPEKA, KANSAS 66606

NAME [redacted]

ADDRESS ____________________ DATE 2/6/86

℞ Ultra Pred 1% ophth Sol. 10cc

Sig gtt 1 OS QID

EK M.D.

LABEL: ☒ YES ☐ NO — DISPENSE AS WRITTEN ____________ M.D.

REFILL: 2 — BRAND EXCHANGE PERMISSIBLE ____________ M.D.

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DEALING WITH CONFLICTS OF INTEREST

THE medical profession in this country has always had its entrepreneurs and hustling businessmen, but until recently they were on the fringe and in a small minority. Most practicing physicians concentrated on providing or supervising services to their patients, and their professional income was largely limited to the fees or salaries paid for such services.

Lately, however, a new entrepreneurial fever has begun to affect the profession, and what was formerly on the fringe seems to be moving into the mainstream. More and more practitioners are seeking profits from business arrangements with hospitals, equipment manufacturers, and most recently, companies providing ambulatory health care services. Practicing physicians now have financial interests in diagnostic laboratories, radiologic imaging centers, walk-in clinics, ambulatory surgery centers, dialysis units, physical therapy centers, and other such facilities. In most of these business ventures, the investing physicians' profits depend, at least in part, on referral of patients to these facilities or on other decisions they make in the care of their patients.

A few examples will illustrate the conflicts of interest involved in such arrangements. Consider, first, the various ways some enterprising surgeons are augmenting their professional income through business connections with the facilities in which they operate on their patients. Free-standing investor-owned ambulatory surgical centers are springing up everywhere. To increase the use of their facilities, which are often in competition with similar units in the community hospitals, these companies offer local surgeons a share in the profits. Some ambulatory surgical centers are owned by the surgeons who use the facility, and they share in the profits from its use. A few investor-owned hospitals have also offered profit-sharing deals to surgeons. According to public statements made by its management, one large hospital chain substantially increased the use of its operating rooms by sharing the profits with its staff surgeons. In each of these examples, surgeons have benefited financially not only from providing professional services but from referring their patients to a facility in which they have an interest.

Free-standing radiologic imaging centers (usually featuring CAT scanners and magnetic resonance imaging units) are another recent phenomenon that is attracting increasing entrepreneurial interest from physicians. Radiologists and nonradiologists are now investing in these centers, often in partnership with venture capitalists. For the nonradiologist investors, such arrangements constitute an economic incentive to refer their own patients to the imaging center and to use radiologic procedures. The radiologist investors in such centers may have less opportunity for self-referral than their nonradiologist partners, but

since they are acting as radiologic consultants, they can recommend follow-up studies. In any case, their entrepreneurial interests in the financial success of the center may be even more compelling than their partners', because they benefit twice — once as professional supervisors and interpreters of the diagnostic procedure, and again as investors in the facility.

Another kind of business arrangement was in the news recently when a congressional committee investigating Medicare payments for cataract surgery[1] reported that some ophthalmologists accept inducements from manufacturers of intraocular lens implants, which are intended to persuade the physician to use a particular brand of lens. These include quantity discounts, cash rebates, shares of stock in the company, and a variety of gifts, such as free vacations, the use of a yacht, and expensive office equipment. The ophthalmologist makes a profit beyond the professional fee for doing the operation by charging Medicare a large markup on the implanted lens, in addition to whatever consideration he or she receives from the manufacturer for using the product.

Many other examples could be cited to demonstrate that entrepreneurialism among physicians is a widespread and rapidly growing phenomenon that is creating conflicts of interest in almost all sectors of the medical profession. Considering the manifold forces now moving medical practice in the direction of commerce,[2] this is hardly surprising. But is it in the best interests of society and the profession? And, if it is not, what if anything can be done to change the trend?

Defenders of the marketplace approach to health care say there is nothing wrong with physicians acting as entrepreneurs. They argue that fee-for-service practice is essentially a business anyway and the economic conflicts of interest that arise when physicians make financial arrangements with health care businesses are in principle not much different from those already existing in private practice.

There is something to be said for that latter point, particularly when practitioners benefit financially from special tests or procedures that they have recommended for their patients and that they themselves then supervise or carry out. However, this argument ignores the basic social role of the physician, which is to be an agent and trustee for the patient. Physicians are ethically bound to place the medical care needs of their patients before their own financial interests — an obligation that clearly sets the practice of medicine apart from business. Conflicts of interest may be inherent in the fee-for-service system, but ethical practitioners minimize them 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. Furthermore, whatever conflicts of interest may exist in the fee-for-service relation between doctor and patient are clearly visible to all concerned and have long been accepted by society. When patients have any doubts, they are free to seek other advice.

The situation is different when physicians seek income beyond fee for service and make business arrangements with other providers of services to their patients. Such arrangements introduce a new and unnecessary conflict, which strains the physician's fiduciary commitment to the patient. Unlike the conflicts of interest in the fee-for-service system, these new arrangements are usually not fully disclosed to the patient, and therefore are more difficult to control.

The new entrepreneurialism among physicians is beginning to attract legislative attention. The state of Michigan now prohibits physicians from referring their patients to any facility in which the practitioner has a financial interest. Pennsylvania has recently enacted a similar law, but it applies only to patients receiving state medical assistance. California law currently requires that physicians disclose any financial interests in free-standing diagnostic facilities to which they refer their patients, but the legislature is now considering a bill (AB 1325) that would prohibit such referrals regardless of disclosure.

State laws dealing with this issue are likely to multiply as the commercialization of our medical care system becomes ever more pervasive and public concern mounts. In my view, however, legal measures alone are not the answer. There can be no really satisfactory solution until the medical profession itself faces up to the threat of entrepreneurialism and decides to take a firm stand in defense of professional ethics. That is why I have been pleased to see the American Medical Association (AMA) debate this subject at its last few meetings and attempt to develop policy guidelines. The AMA has quite properly reminded physicians that "medicine is a profession, a calling, and not a business . . . ,"[3] and it has reaffirmed that physicians must put the needs of their patients above economic self-interest. But it has also said that physicians may ethically invest in facilities and share profits with hospitals or pharmaceutical or equipment manufacturers, provided that the arrangements are lawful, do not lead to overutilization or improper care of patients, are disclosed in advance to patients, and do not involve profit sharing with institutions being paid under the Medicare system of diagnosis-related groups (DRGs).[4,5] At its recent annual meeting, the AMA vigorously denounced a chain of investor-owned hospitals that has been sharing profits with its medical staff as a means of inducing the staff to reduce expenditures on Medicare patients.[6]

The AMA thus seems to be drawing a distinction between profit sharing in the traditional reimbursement system (ethically permissible if certain conditions are met) and profit sharing in the Medicare DRG-based prospective payment system (ipso facto unethical, a form of "kickback"). It is a distinction

that defies logic, however, and I doubt that it will withstand further reflection and discussion. If profit sharing with hospitals under a DRG system is unethical (and I agree that it is), then so is profit sharing under a charge reimbursement system, since there are possibilities for abuse and exploitation of patients in both systems and profit sharing by physicians in either system creates temptations that may be difficult to resist. Withholding or skimping on needed services (the possible abuse in the prospective payment system) is no more reprehensible than providing uneeded or inappropriate service (the possible abuse in the charge reimbursement system). Financial arrangements that tempt physicians in either direction ought to be avoided.

The AMA's present position has an even more troublesome aspect. In admitting that business deals create conflicts of interest for physicians, but arguing that we need be concerned only about arrangements that demonstrably lead to bad practice, the AMA's statements ignore the damage done to the public trust in the medical profession by even the *appearance* of conflicts of interest. That, after all, is a major problem with conflicts of interest. Full disclosure might help prevent that loss of trust, but there is already a strong popular sense that physicians are too interested in exploiting the financial advantages of their position, and disclosure is not likely to do much to change that. The continued unchecked growth of entrepreneurialism will only strengthen public suspicion and give further impetus to the kinds of legislative action now being taken in some states.

I would therefore hope that the current position of the AMA on this issue is in transition and that, after further deliberation, a stronger policy statement will emerge. The American College of Physicians, in its recently issued Ethics Manual, has taken such a position.[7] It says, "The physician must avoid any personal commercial conflict of interest that might compromise his loyalty and treatment of the patient." A similarly firm and unequivocal statement of conscience from all the important sectors of organized medicine in the United States would be salutary. Of course, we will need much more than a statement of conscience to reverse the trend, but it is a good way to begin. We cannot expect to take any practical steps in defense of our professionalism until we publicly agree that physicians serve their patients' interests best when they divorce themselves from financial interests in the medical marketplace.

ARNOLD S. RELMAN, M.D.

REFERENCES

1. Cataract surgery: fraud, waste, and abuse: a report by the Chairman of the Subcommittee on Health and Long-Term Care of the Select Committee on Aging of the House of Representatives. Ninety-Ninth Congress, July 19, 1985. Washington, D.C.: Government Printing Office, 1985. (Committee publication no. 99-506).
2. Relman AS. The future of medical practice. Health Affairs 1983; 2(2):5-19.
3. House of Delegates of the American Medical Association. Commercialism in the practice of medicine: report of the Board of Trustees of the American Medical Association, June 1983.
4. House of Delegates of the American Medical Association. Conflict of interest — guidelines: report of the Judicial Council of the American Medical Association, December 1984.
5. House of Delegates of the American Medical Association. Ethical implications of hospital-physician risk-sharing arrangements under DRGs: report of the Judicial Council of the American Medical Association, December 1984.
6. Kickback plan by hospital hit. American Medical News. June 28-July 5, 1985:1, 34.
7. Ad Hoc Committee on Medical Ethics of the American College of Physicians. American College of Physicians ethics manual. Part I. History of medical ethics, the physician and the patient, the physician's relationship to other physicians, the physician and society. Ann Intern Med 1984; 101:129-37.

VASCULAR DISEASE AND HOMOCYSTEINE METABOLISM

ELSEWHERE in this issue, Boers and co-workers[1] present evidence that among 50 patients with early occlusive peripheral arterial or cerebrovascular disease, far more heterozygotes for deficiency of the enzyme cystathionine synthase were detected than would be expected in a random sample of the general population. This finding lends important support to the emerging hypothesis that there may be an association between premature vascular disease and mild impairments of homocysteine metabolism.

Homocysteine is an amino acid formed during the metabolism of methionine. Several genetic diseases of human beings are now known to interfere with the further use of homocysteine, affecting either its conversion to cystathionine (cystathionine synthase deficiency) or its reconversion to methionine by a pathway that requires the formation of methylated derivatives of both vitamin B_{12} and folic acid.[2,3] In each of these diseases, homocysteine accumulates abnormally in body fluids, chiefly as the disulfide homocystine (homocysteine–homocysteine), and spills into the urine.[2] In cystathionine synthase deficiency, methionine also accumulates abnormally; in the other diseases, the methionine level is low or normal. The association of cystathionine synthase deficiency with premature thromboembolic disease has been demonstrated in studies of more than 600 patients.[3] Among the few patients with the other forms of severe homocystinuria whose tissues have been examined pathologically, most had severe atherosclerotic changes, one as early as the age of 7½ weeks.[2] In some but not all studies, the administration of homocystine or its derivatives caused atherosclerotic changes in laboratory animals.[1,2] Together, these findings have led to the general acceptance of the notion that severe homocystinemia leads to early vascular disease.

Is the same true for milder homocysteinemia and less drastic impairments of homocysteine metabolism? Until very recently, the search for cases of mild homocysteinemia, with or without methionine load-

State of Kansas

Office of Judicial Administration

Kansas Judicial Center
301 West 10th
Topeka, Kansas 66612

(913) 296-2256

March 5, 1986

House Judiciary Committee
Testimony of Marjorie J. Van Buren

House Bill 2825

The 30th Judicial District is a five-county district, with the heaviest caseload in Sumner and Pratt counties. Currently, Pratt County has a district judge and a district magistrate judge. House Bill 2825 provides for converting the district magistrate judge position in Pratt County to a district judge, since the district is experiencing difficulty with caseload outside the jurisdiction of a district magistrate judge. The conversion would be effective at such time as the district magistrate position becomes vacant.

The 30th District had the largest year-to-year percentage increase in case filings of any district in the State. Major civil (regular Chapter 60, domestic relations, and limited actions) and criminal case filings were up 24% in '85 over '84. Over half of this increase occurred in Pratt and Barber counties. The number of pending cases in these areas also had increased sharply--up 30% in FY 85 over FY 84, reflecting the fact that the district had difficulty coping with the increase in filings.

Caseload in Pratt County is of sufficient size to require two judges, thus the main question is whether the second judge is a district magistrate judge or a district judge. The conversion would permit a needed broadening of judicial resources in Pratt County. Additionally, the district judge position is needed to assist in handling the caseload in Barber County which falls outside a district magistrate judge's jurisdiction. Currently, most of these cases in three counties--Barber, Harper, and Kingman--are heard by the associate district judge from Harper County. The district has experienced difficulty, because of the caseload demands, in keeping the dockets current in these three counties, but in particular in Barber County.

The conversion, if approved, would give Pratt County the same judicial staffing pattern now present in Sumner County, but the difference would allow some use of the district judge in other counties of the district, especially Barber County.

MJVB:myb
Attachments

Attachment 5
House Judiciary
March 5, 1986

30th Judicial District
FILINGS

	FY 84	FY 85	% of Change
Barber County			
Chapter 60	96	114	+18.9
Chapter 61	67	150	+124.0
Domestic Relations	49	74	+51.0
Felonies	23	40	+73.9
Misdemeanors	43	45	+4.7
TOTAL	278	423	+52.2
Harper County			
Chapter 60	42	63	+50.0
Chapter 61	23	25	+8.7
Domestic Relations	55	50	-9.0
Felonies	27	24	-11.1
Misdemeanors	34	68	+100.0
TOTAL	181	230	+27.1
Kingman County			
Chapter 60	52	63	+21.2
Chapter 61	36	29	-19.4
Domestic Relations	54	66	+22.2
Felonies	17	12	-29.4
Misdemeanors	43	36	-16.3
TOTAL	202	206	+2.0
Pratt County			
Chapter 60	116	143	+23.3
Chapter 61	128	184	+43.8
Domestic Relations	100	96	-4.0
Felonies	117	86	-26.5
Misdemeanors	140	236	+68.6
TOTAL	601	745	+24.0
Sumner County			
Chapter 60	146	204	+39.7
Chapter 61	145	189	+30.3
Domestic Relations	151	187	+23.8
Felonies	89	81	-9.0
Misdemeanors	170	173	+1.8
TOTAL	701	834	+19.0
DISTRICT TOTALS	1,963	2,438	+24.2

State of Kansas

Office of Judicial Administration

Kansas Judicial Center
301 West 10th
Topeka, Kansas 66612-1507

(913) 296-2256

February 10, 1986

To: Gary Stotts, Acting Director of the Budget

From: Jerry Sloan, Budget and Fiscal Officer

Re: House Bill 2825

This bill would change the position district magistrate judge in Pratt County to a district judge upon a vacancy in the district magistrate judgeship.

Currently, the cost of a district judgeship including fringe benefits is $63,208. The cost of a district magistrate judgeship is $30,083. Thus, the total annual fiscal impact of this bill would be $33,125. However, this cost would not begin to accrue until there was a vacancy in the district magistrate judgeship.

JS:myb

TESTIMONY OF THE KANSAS HOSPITAL ASSOCIATION

BEFORE THE HOUSE JUDICIARY COMMITTEE

CONCERNING HOUSE BILL 2672

MARCH 5, 1986

The Kansas Hospital Association appreciates the opportunity to comment briefly on House Bill 2672, which removes the workers' compensation exemption from K.S.A. 65-406, the hospital lien. Presently, the law provides that every hospital which furnishes emergency, medical or other services to any patient injured by reason of an accident shall have a lien of up to $5,000 upon a patient's claim against another for damages on account of such injuries. The present law, however, also states that if recovery is made under the Workers' Compensation Act, such a lien is not valid. H.B. 2672 would make claims under the Workers' Compensation Act subject to such a lien.

The Kansas Hospital Association supports House Bill 2672 because it would provide a means for reimbursement for services rendered not presently allowed. Under current law, a claimant under the Workers' Compensation Act is able to reach a lump sum settlement and after the cash is received, fail to take care of the medical expenses incurred without fear of the imposition of the hospital lien. The only recourse then left to the hospital is to file a law suit against the person for recovery of the amount of hospital expenses. Besides court costs and the time involved, there is no assurance of recovery of anything by such a method.

Attachment 6
House Judiciary
March 5, 1986

The amount of uncompensated care provided by hospitals in Kansas continues to grow at an alarming rate. These increases are occurring during an era of decreasing hospital operating revenues. Kansans will not tolerate anyone being turned away from a hospital door because of his or her inability to pay for those services. In some instances, however, individuals who are able to make such payments neglect to do so. House Bill 2672 helps to insure that those who do have the money to pay their medical bills are required to do so.

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LEE HAMM
REPRESENTATIVE, 108TH DISTRICT
CLARK, COMANCHE, KIOWA,
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R.R. 1
PRATT, KANSAS 67124

COMMITTEE ASSIGNMENTS
RANKING MINORITY MEMBER:
AGRICULTURE AND LIVESTOCK
MEMBER: WAYS AND MEANS

The 30th Judicial District is a five-county district, with the heaviest caseload in Sumner and Pratt counties. Currently, Pratt County has a district judge and a magistrate judge. The immediate proposal is to convert the magistrate judge position in Pratt County to a law judge, since the district is experiencing difficulty with caseload outside the jurisdiction of a magistrate judge. The conversion would be effective at such time as the district magistrate position becomes vacant.

The 30th District had the largest year-to-year percentage increase in case filings of any district in the State. Civil and criminal case filings were up 24% in '85 over '84. Over half of this increase occurred in Pratt and Barber counties. The number of pending cases also had increased sharply--up 30% in FY 85 over FY 84, which is a reflection of the fact that the district had difficulty coping with the increase in filings.

Caseload in Pratt County is of sufficient size to require two judges, thus the main question is whether the second judge is a magistrate or law judge. The conversion would permit a needed upgrading of judicial resources in Pratt County. Additionally, the law-judge position is needed to assist in handling the major caseload in Barber County. Currently, major cases in three counties--Barber, Harper, and Kingman--are heard predominantly by the associate district judge from Harper County. The district has experienced difficulty, because of caseload demands, in keeping the dockets current in these three counties, but in particular in Barber County.

The conversion, if approved, would give Pratt County the same judicial staffing pattern now present in Sumner County. Caseload in Pratt is only slightly smaller than Sumner, but the difference would allow some use of the law judge in other counties of the district, especially Barber County.

Attachment

30th Judicial District
FILINGS

	FY 84	FY 85	% of Change
Barber County			
Chapter 60	96	114	+18.9
Chapter 61	67	150	+124.0
Domestic Relations	49	74	+51.0
Felonies	23	40	+73.9
Misdemeanors	43	45	+4.7
TOTAL	278	423	+52.2
Harper County			
Chapter 60	42	63	+50.0
Chapter 61	23	25	+8.7
Domestic Relations	55	50	-9.0
Felonies	27	24	-11.1
Misdemeanors	34	68	+100.0
TOTAL	181	230	+27.1
Kingman County			
Chapter 60	52	63	+21.2
Chapter 61	36	29	-19.4
Domestic Relations	54	66	+22.2
Felonies	17	12	-29.4
Misdemeanors	43	36	-36.3
TOTAL	202	206	+2.0
Pratt County			
Chapter 60	116	143	+23.3
Chapter 61	128	184	+43.8
Domestic Relations	100	96	-4.0
Felonies	117	86	-26.5
Misdemeanors	140	236	+68.6
TOTAL	601	745	+24.0
Sumner County			
Chapter 60	146	204	+39.7
Chapter 61	145	189	+30.3
Domestic Relations	151	187	+23.8
Felonies	89	81	-9.0
Misdemeanors	170	173	+1.8
TOTAL	701	834	+19.0
DISTRICT TOTALS	1,963	2,438	+24.2