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Ancillary Service and Self-Referral Arrangements in the Medical and Legal Professions: Do Current Ethical, Legislative, and Regulatory Policies Adequately Serve the Interests of Patients and Clinets?

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ANCILLARY SERVICE AND SELF-REFERRAL ARRANGEMENTS IN THE MEDICAL AND LEGAL PROFESSIONS: DO CURRENT ETHICAL, LEGISLATIVE, AND REGULATORY POLICIES ADEQUATELY SERVE THE INTERESTS OF PATIENTS AND CLIENTS?

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The American Inns of Court selected this Essay as the winner of its third annual Warren E. Burger Prize. The competition recognizes "significant contributions to the body of scholarship in the areas of excellence, civility, ethics and professionalism." American Inns of Court, Warren E. Burger Prize, http://www.innsofcourt.org/Content/Default.aspx?Id=309 (last visited Nov. 16, 2006). The prize "encourage[s] thoughtful consideration of the practical application of the highest principles of professionalism in the American legal community." *Id.* The *South Carolina Law Review* and the Nelson Mullins Riley & Scarborough Center on Professionalism enjoy the partnership with the American Inns of Court that allows the *Law Review* to encourage studies of legal professionalism which will contribute to enhancing the profession of law.

I. INTRODUCTION

During the last two decades, increasing numbers of physicians and lawyers have moved beyond the traditional practice of medicine and law and acquired ownership interests in facilities offering ancillary services.[1] Doctors have purchased equity in clinical laboratories, durable medical equipment suppliers, ambulatory surgery centers, nursing homes, and a host of other medically related entities.[2] Lawyers, and in particular large law firms, now offer clients non-legal (but law-related) services such as accounting, investment banking, financial consulting, and real estate development.[3] Critics of entrepreneurialism in both professions contend that professionals should be banned from owning equity in ancillary service providers, or at the very least, should be prohibited from referring patients or clients to facilities in which they have an equity interest.[4] In the medical profession, traditionalists' foremost concern is the overutilization of ancillary services,[5] whereas critics of law-related ancillary ownership have cited a broader array of ethical and professionalism concerns.[6] The debate among legal academics was lively during the early 1990s when the American Bar Association (ABA) considered a ban on ancillary ownership,[7] but has since subsided. The ABA's treatment of the issue has remained essentially constant for the last decade.[8] The ABA's Model Rules of Professional Conduct permit a lawyer to refer clients to self-owned ancillary service centers as long as the lawyer fully discloses the potential conflict of interest[9] and offers services on arms-length terms.[10] In contrast, policymakers and scholars in the medical field continue to debate the merits of different forms of regulation as new laws continue to be passed.[11] The American

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1. *E.g.*, Nancy J. Moore, *Entrepreneurial Doctors and Lawyers: Regulating Business Activities in the Medical and Legal Professions*, *in* CONFLICTS OF INTEREST IN CLINICAL PRACTICE AND RESEARCH 171, 171–72 (Roy G. Spece, Jr., David S. Shimm & Allen E. Buchanan eds., 1996) (discussing emerging entrepreneurial trends in the medical and legal professions); *see also* Dennis J. Block, Irwin H. Warren & George F. Meierhofer, Jr., *Model Rule of Professional Conduct 5.7: Its Origin and Interpretation*, 5 GEO. J. LEGAL ETHICS 739, 745–51 (1992) [hereinafter Block et al.] (tracing the long history of attorneys providing non-legal services and noting the qualitative difference in the provision of ancillary services by large firms beginning in the 1980s); Theodore N. McDowell, Jr., *Physician Self Referral Arrangements: Legitimate Business or Unethical "Entrepreneurialism,"* 15 AM. J.L. & MED. 61, 62–64 (1989) (discussing ethical considerations of ancillary businesses in the medical profession).

2. McDowell, *supra* note 1, at 62; Moore, *supra* note 1, at 171.

3. Phyllis Weiss Haserot, *Multiprofessional Mixes Are Proliferating*, NAT'L L.J., Oct. 19, 1987, at 16.

4. *See, e.g.*, Moore, *supra* note 1, at 179–80.

5. *See, e.g.*, McDowell, *supra* note 1, at 65–68.

6. *See, e.g.*, Block et al., *supra* note 1, at 757–58.

7. *See infra* notes 41–44 and accompanying text.

8. *See infra* notes 50, 57 and accompanying text.

9. MODEL RULES OF PROF'L CONDUCT R. 5.7 cmt. 1 (2006).

10. MODEL RULES OF PROF'L CONDUCT R. 1.8 (2006).

11. *See, e.g.*, Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships (Phase II), 69 Fed. Reg. 59 (Mar. 26, 2004) (containing the most recent regulations pertaining to the Stark Law); *see also* Jessica B. Applegate, *Deficit Reduction Act of 2005 Addresses*

Medical Association's (AMA's) ethical guidelines,[12] as well as state and federal statutes,[13] severely restrict physicians' ability to refer patients to facilities in which they own equity.

This Essay simultaneously examines the debates in the legal and medical professions in the hope that policymakers in each field will benefit from understanding how those in the other field have addressed the issue. Such side-by-side comparison reveals that many of the arguments generally advanced in only one profession are equally applicable to the other. Although previous authors have argued that society's focus on medical entrepreneurialism is justified,[14] this Essay contends that self-referral arrangements cause similar problems in both law and medicine, and that the current ethical, legislative, and regulatory responses of both professions are similarly misguided. Policymakers in law and medicine suffer from similar misconceptions of human cognition, insofar as they fail to take account of pertinent social psychology research. Notwithstanding abundant evidence that self-serving bias is almost always unintentional and unconscious, state and federal laws regulating physician self-referral erroneously treat the biasing effect of ownership as a matter of deliberate choice. Furthermore, promulgations by all of the groups charged with regulating the legal and medical professions rely on the idea that patients and clients can be adequately protected by mandatory disclosure of conflicts of interest. Recent social psychology studies reveal, however, that disclosure requirements may exacerbate the problem by encouraging physicians and lawyers to artificially inflate the number and forcefulness of referrals to an extent that outweighs patients' and clients' tendency to discount the advice.[15]

Ultimately, this Essay asserts that physicians and lawyers should be permitted to own equity in any business they desire but should be forbidden from advising their patients and clients to use facilities in which they possess an ownership interest. If a patient or client independently seeks out an ancillary entity in which her physician or attorney owns equity, then the relationship should be allowed. Ancillary ownership is justified because of the benefits associated with integrated services and the efficient allocation of capital that results from professionals' unique ability to identify need in the market. Such pro-competitive arguments, however, are inapplicable to self-referral arrangements, where the threat of overutilization counsels in favor of regulation. As more moderate forms of regulation are premised on a misconception of human behavior, in that they ignore the unconscious nature of self-interest bias and the failure of disclosure to sufficiently correct for such bias, a broad ban on self-referral is the proper course

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Various Health Care Issues, *Health Care Alert* (Michael Best & Friedrich, LLP), Mar. 2006, http://www.michaelbest.com/resources/publications/1812.pdf (last visited Nov. 16, 2006) (noting regulatory extensions of a Stark Law-related moratorium).

12. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, Am. Med. Ass'n.,CODE OF MEDICAL ETHICS 2006–2007 EDITION 188 (2006) [hereinafter AMA Ethical Opinion 8.032] (Ethical Opinion 8.032, Conflicts of Interest: Health Facility Ownership by a Physician).

13. *See infra* Part II.B.2.

14. Moore, *supra* note 1, at 174.

15. *See infra* Part IV.D.1.

of action. Although a narrowly drawn exception to the general ban may be warranted for professionals who serve a large percentage of the customers likely to require the ancillary service, society's interests may better be served by either selective subsidization of particular ancillary ventures, unbiased marketing of available facilities by a neutral third party, or possibly both.

Since the ancillary business activity that has prompted consternation among the ABA and legal scholars[16] is focused in large, elite law firms, this Essay focuses on the ability of large law firms, rather than solo practitioners, to offer ancillary services. If a ban on self-referral is warranted for large, corporate clients, it follows that such a ban would be desirable for the less powerful and comparatively unsophisticated clients served by small firms and solo practitioners.

Part II.A begins with a brief discussion of the growth of ancillary service facilities in medicine and law, and then Part II.B examines the ethical, legislative, and regulatory responses that have been offered by the medical and legal professions, as well as by state and federal legislators. Part II.B.1 addresses the AMA's and ABA's attempts at self-regulation, while Part II.B.2 identifies the principal legislative and regulatory approaches within the medical profession.

Part III argues that physicians and lawyers should be permitted to own equity in ancillary facilities.[17] Part III.A presents two pro-competitive benefits associated with permitting ancillary service ownership, while Part III.B refutes potential counterarguments.[18] Part III.B.1 examines the four main arguments against ancillary

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16. ABA Section of Litigation, Recommendation and Report to the House of Delegates 5–6 (June 1991) [hereinafter ABA Section of Litigation Report]. The Section of Litigation produced this report during the ABA's initial consideration of ancillary business regulation. *See infra* notes 41–45 and accompanying text. The report describes the types of non-legal services that law firms may provide to their clients in connection with their legal representation. ABA Section of Litigation Report 5–6.

17. This Essay speaks only to instances where lawyers and doctors own equity in ancillary service facilities and not the opposite, where non-professionals acquire an ownership stake in a law firm or physician group.

18. Part III.B does not address potential conflicts of interest between clients and customers of ancillary businesses, nor the application of the professions' broader ethical rules to non-clients or non-patients. Such arguments are omitted for two reasons.

First, they are only applicable to legal entrepreneurialism as opposed to medical entrepreneurialism. In the legal profession, one must be concerned whether the interests of past or current clients clash with those of a prospective client since a lawyer is expected to be a zealous advocate for *all* of her clients. In other words, the interrelatedness of clients' desires forces attorneys to tread gingerly when they take on clients who may ultimately possess interests that are adverse to one another. The same cannot be said for medicine, where one patient's interest in alleviating her symptoms generally does not conflict with another patient's interest to do the same (admittedly, psychiatry may present an exception). Furthermore, the medical profession, unlike the legal profession, generally has not worried about the application of the AMA's ethical rules to customers of ancillary businesses. Although there are several reasons for this, the most important is the fact that the medical profession is subject to significantly more governmental oversight than the legal profession. Whereas the legal profession has been historically self-regulated with minimal intervention from legislatures, physicians and ancillary providers of health care services are subject to myriad statutory requirements that stand in the place of ethical regulations.

Second, these concerns are easily addressed by ABA Model Rules 1.7(a)(2) and 5.7. According to Rule 1.7(a)(2), a lawyer may not represent a client if "there is a significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client, a

ownership, addressing the flaws of each argument in turn. Part III.B.2 speaks to one remaining—and persuasive—argument: the increased cost and decreased quality associated with inappropriate referrals to one's own ancillary facilities, a problem which I refer to as "overutilization."

In light of the significant problem overutilization presents for both medical and legal entrepreneurialism, Part IV argues that physicians and lawyers should be prohibited from referring patients and clients to ancillary facilities in which they possess an ownership interest. Part IV.A demonstrates that the pro-competitive benefits associated with ancillary ownership advanced in Part III.A do not apply to self-referral. Part IV.B argues that the AMA's policy of allowing self-referral arrangements where there is a demonstrated need in the community is both unwise in principle and unworkable in practice. Part IV.B acknowledges that a very limited exception to the general ban on self-referral may be desirable, but ultimately concludes that selective subsidization, impartial marketing of available ancillary facilities by a neutral third party, or both, are likely to be preferable.

Parts IV.C and IV.D contend that the ethical and legislative responses in both professions employ misguided mechanisms to curb overutilization and supplier-induced demand that contravene pertinent social psychology research. Part IV.C addresses the fact that legislation designed to curb physician self-referral improperly treats the biasing effect of ownership as a matter of conscious choice, when in reality overutilization is generally unintentional and subconscious. Part IV.D argues that the reliance on disclosure by legislatures, the AMA, and the ABA to curb inappropriate self-referral may not only be ineffective, but has the potential to exacerbate the problem of overutilization by increasing the number and forcefulness of referrals.

Finally, Part V offers a brief conclusion.

II. BACKGROUND

A. The Growth of Ancillary Services in Medicine and Law

Intense economic pressure precipitated the growth of ancillary service centers in both the medical and legal professions. The federal government, however, played a unique role in generating such pressure in the medical community. During the late 1970s and early 1980s, policymakers began to grow concerned with the rapidly

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former client *or a third person* or by a personal interest of the lawyer." MODEL RULES OF PROF'L CONDUCT R. 1.7(a)(2) (2006) (emphasis added). It seems evident "a third person" implicates a customer of a law firm's ancillary facilities who is not a legal client. Although it provides for some exceptions, Rule 5.7 states that the Model Rules of Professional Conduct generally apply to the provision of law-related ancillary services. *See* JAMES W. JONES, BEYOND LEGAL PRACTICE: ORGANIZING AND MANAGING ANCILLARY BUSINESSES 28–29 (2002). My point is not that Model Rules 1.7(a)(2) and 5.7 are uncontroversial or optimal, but rather that they provide a reasonable solution to the problems of (a) conflicts of interest between legal clients and customers of ancillary service providers and (b) the application of the Model Rules to non-clients who seek ancillary services. In order to keep the scope of this Essay manageable, it does not address issues that only apply to one profession and are generally considered to be less problematic.

increasing cost of medical care in the United States, and many considered hospitals to be the primary culprit.[19] Medicare traditionally had paid hospitals according to their costs but switched to the Prospective Payment System (PPS) in 1983.[20] The Social Security Amendments of 1983 stipulated that the Health Care Financial Administration (HCFA), the predecessor of the Centers for Medicare and Medicaid Services (CMS), would pay hospitals a fixed sum in advance for each type of diagnosis or Diagnostic Related Group (DRG).[21] Payment for each DRG would remain constant, regardless of the services required to treat the patient.[22] This scheme gave hospitals a financial incentive to discharge patients sooner and perform fewer tests.[23] As private insurers began to reimburse hospitals in a similar fashion, medical providers shifted the delivery of care from inpatient to outpatient settings.[24] At the same time, the focus on cost containment by public and private payers caused physicians to search for new sources of revenue.[25] The rapid

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19. *See* Randall R. Bovbjerg, *Competition Versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 VAND. L. REV. 965, 965 (1981) (identifying the provider-dominated nature of medical care decision-making as one of the causes of high-cost medical care); T. R. Marmor, Richard Boyer & Julie Greenberg, *Medical Care and Procompetitive Reform*, 34 VAND. L. REV. 1003, 1003 (1981).

> During the 1970s the focus of debate about national health policy shifted from issues of access to medical care and the distribution of the cost of care to concern about controlling the total cost of care. The rapid rate of growth of expenditures on medical care during that decade far exceeded the rate of inflation in the general economy, with the result that an increasing proportion of the gross national product (GNP) is now expended on medical care.

Id. Former President Jimmy Carter's comments on the health care crisis in his 1979 State of the Union Address also evidence this concern: "We must act now to protect all Americans from health care costs that are rising $1 million per hour, 24 hours a day, doubling every 5 years. We must take control of the largest contributor to that inflation—skyrocketing hospital costs." The State of the Union, 1 PUB. PAPERS 105 (Jan. 23, 1979).

20. James A. Morone & Andrew B. Dunham, *Slouching Towards National Health Insurance: The New Health Care Politics*, 2 YALE J. ON REG. 263, 276 (1985). For detailed records pertaining to the Health Care Financing Administration's (HCFA's) payments under PPS, see Nat'l Bureau of Econ. Research, Prospective Payment System Data, http://www.nber.org/data/pps.html (last visited Nov. 16, 2006).

21. Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65, 149–79 (1983) (codified at 42 U.S.C. § 1395 (2000)).

22. Morone & Dunham, *supra* note 20, at 263 n.3.

23. For a more thorough discussion of the PPS system, see Regina E. Herzlinger, *Financing of the U.S. Health Care Sector*, Harvard Business School Note No. 9-304-039, at 30 (2006). *See also* David M. Frankford, *The Medicare DRGs: Efficiency and Organizational Rationality*, 10 YALE J. ON REG. 273 (1993) (discussing the goals of the PPS system and the flaws in its framework); Centers for Medicare and Medicaid Services, Prospective Payment Systems-General Information, http://www.cms.hhs.gov/prospmedicarefeesvcpmtgen/ (last visited Nov. 16, 2006).

24. McDowell, *supra* note 1, at 64; OFFICE OF INSPECTOR GEN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., OAI-12-88-01410, FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES: REPORT TO CONGRESS 1–2 (1989) [hereinafter OIG REPORT]. The implementation of prospective payment systems was not solely responsible for this shift from inpatient to outpatient services. Both public and private payers implemented several cost containment strategies that drove this transition. *See generally* Moore, *supra* note 1, at 172.

25. McDowell, *supra* note 1, at 64; Moore, *supra* note 1, at 172; OIG Report, supra note 24, at 1–2.

development of therapeutic and diagnostic technology[26] led many physicians to embrace the shift toward outpatient care by investing in ancillary service businesses.[27] Doctors purchased equity interests in ambulatory surgery centers, outpatient imaging centers, laboratories, and other non-hospital facilities.[28]

The provision of ancillary, law-related services by law firms similarly crept onto policymakers' radar screens during the early and mid-1980s.[29] Economic pressures generated by the growth of corporate in-house counsel, an increase in the number of law firms, and the reduced level of corporate activity led large law firms to experiment with such offerings.[30] Arnold & Porter of Washington, D.C. was the first large law firm to offer ancillary services when it established APCO, a public affairs and legislative services subsidiary, in 1984.[31] Other firms immediately followed suit, and by 1987, major firms were engaged in a wide variety of law-related ancillary services such as investment banking, energy consulting, management services, employee benefits consulting, advertising, labor relations consulting, real estate brokerage and development, and office support services.[32] By 1991, approximately eighty-five major law firms offered ancillary services of some kind.[33]

B. Ethical, Legislative, and Regulatory Responses to Ancillary Services

1. Efforts at Self-Regulation

Although the AMA and ABA have ultimately settled on very different rules governing professional self-referral, both organizations experienced position shifts and indecisiveness over the years. In December 1991, the AMA formally announced its view that physicians should generally not engage in self-referral.[34] In June 1992, however, the AMA's House of Delegates reversed its vote, concluding that "self-referrals are ethical as long as patients are 'fully informed' of a physician's ownership interest and as long as they are notified of any alternative facilities."[35] The change in position was prompted by dozens of outspoken

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26. Arnold S. Relman, *The Future of Medical Practice*, 2 HEALTH AFF. 5, 9 (1983).

27. McDowell, *supra* note 1, at 64; Moore, *supra* note 1, at 172.

28. McDowell, *supra* note 1, at 64.

29. JONES, *supra* note 18, at 4.

30. James F. Fitzpatrick, *Legal Future Shock: The Role of Large Law Firms by the End of the Century*, 64 IND. L.J. 461, 461–67 (1989); James W. Jones, *The Challenge of Change: The Practice of Law in the Year 2000*, 41 VAND. L. REV. 683, 685–88 (1988); Moore, *supra* note 1, at 172–73; ABA Section of Litigation Report, *supra* note 16, at 5.

31. JONES, *supra* note 18, at 4.

32. Haserot, *supra* note 3, at 18.

33. Stephanie B. Goldberg, *More than the Law: Ancillary Business Growth Continues*, A.B.A. J., Mar. 1992, at 55 (discussing a 1991 survey conducted by Phyllis Weiss Haserot regarding ancillary businesses operated by law firms).

34. Moore, *supra* note 1, at 173 (citing Michael Abramowitz, *AMA Votes to Ease New Curbs on Physician 'Self-Referral,'* WASH. POST, June 24, 1992, at A20).

35. Abramowitz, *supra* note 34, at A20; David Albertson, *Self-Referral Controversy Boils Anew*, MED. LABORATORY OBSERVER, Aug. 1992, at 21, 21.

delegates who objected to the implication that *all* physicians with ownership interests in ancillary facilities will improperly act on the conflict of interest.[36] The insurgents argued that a ban on self-referral is unduly restrictive when only a few bad apples are the problem.[37] Six months later, in December 1992, the AMA reversed itself yet again, this time holding that self-referral arrangements are unethical unless (a) such behavior is necessary to meet a special medical need for a community, or (b) but for the ability to refer one's own patients, the physician would not have created the center.[38] The AMA returned to its original position because of mounting evidence that physicians were overutilizing self-owned facilities and consequently threatening the profession's legitimacy.[39] Although the AMA has tinkered slightly with its stance on this issue since 1992, the substance remains largely the same. Under the AMA's most recent promulgation, physicians may own equity in ancillary service centers but generally should not refer their patients to such centers unless "there is a demonstrated need in the community for the facility and alternative financing is not available."[40]

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36. Abramowitz, *supra* note 34, at A20; Albertson, *supra* note 35, at 21.

37. This argument is a paradigmatic expression of the fundamental attribution error, which is discussed *infra* at note 149, and again at notes 188–89 and accompanying text. The insurgent physicians erroneously believed that physicians' dispositions would determine whether they acted on conflicts of interest, rather than exogenous situational pressures. Like those responsible for the policies discussed *infra* in Part IV.C, the insurgents failed to understand that the biasing effect of ownership is subconscious.

38. *AMA Rules Against Self-Referrals*, CHI. TRIB., Dec. 9, 1992, at N20. If taken literally, point (b) is highly problematic since it fails to recognize that medical providers may invest in an ancillary center only because they are able to artificially create demand for its services by referring their patients to the center. Such a situation would fall within the letter of exception (b), notwithstanding the fact that it embodies the very instances where physician ownership of ancillary centers is likely to be most problematic. The AMA's most recent promulgation addresses this problem. *See infra* note 40 and accompanying text.

39. Jean M. Mitchell & Elton Scott, *Physician Ownership of Physical Therapy Services: Effects on Charges, Utilization, Profits, and Service Characteristics*, 268 JAMA 2055, 2057 (1992).

40. AMA Ethical Opinion 8.032, *supra* note 12, at 189. According to the AMA, when there is a demonstrated need in the community, the following guidelines should also be met:

> (1) Physicians should disclose their investment interest to their patients when making a referral, provide a list of effective alternative facilities if they are available, inform their patients that they have free choice to obtain the medical services elsewhere, and assure their patients that they will not be treated differently if they do not choose the physician-owned facility;
> (2) Individuals not in a position to refer patients to the facility should be given a bona fide opportunity to invest in the facility on the same terms that are offered to referring physicians;
> (3) The opportunity to invest and the terms of investment should not be related to the past or expected volume of referrals or other business generated by the physician investor or owner;
> (4) There should be no requirement that a physician investor make referrals to the entity or otherwise generate business as a condition for remaining an investor;
> (5) The return on the physician's investment should be tied to the physician's equity in the facility rather than to the volume of referrals;
> (6) The entity should not loan funds or guarantee a loan for physicians in a position to refer to the entity;

The ABA's path to its final position was similarly tortuous. In July 1989, in response to the proliferation of ancillary businesses, the ABA Special Coordinating Committee on Professionalism (SCCOP) appointed a Working Group on Ancillary Business Activities to investigate whether changes to the Model Rules of Professional Conduct were necessary.[41] After two years of research, the Working Group ultimately determined that the benefits of ancillary services outweighed the potential for harm and therefore recommended a revised ethics rule that would regulate rather than ban ancillary activities.[42] The ABA Standing Committee on Ethics and Professional Responsibility (CEPR) agreed with the recommendation from the Working Group and prepared a revised Rule 5.7 for consideration by the ABA House of Delegates.[43] Meanwhile, the ABA's Section of Litigation appointed its own Task Force on Ancillary Business Activities that created a very different draft Rule 5.7, one that sought to completely prevent lawyers from owning or operating businesses that provided law-related ancillary services.[44]

In August 1991, the ABA House of Delegates voted to adopt the Litigation Section's version of the rule, which sought to forbid the provision of ancillary services to individuals who are not clients of the law firm and to strictly regulate

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(7) Investment contracts should not include "noncompetition clauses" that prevent physicians from investing in other facilities;
(8) The physician's ownership interest should be disclosed to third party payers upon request;
(9) An internal utilization review program should be established to ensure that investing physicians do not exploit their patients in any way, as by inappropriate or unnecessary utilization;
(10) When a physician's commercial interest conflicts to the detriment of the patient, the physician should make alternative arrangements for the care of the patient.

Id. at 189–90.

41. JONES, *supra* note 18, at 5; Ted Schneyer, *Policymaking and the Perils of Professionalism: The ABA's Ancillary Business Debate as a Case Study*, 35 ARIZ. L. REV. 363, 370 (1993). The Working Group's conclusion was based on ethical concerns alone, without any consideration of professionalism. Block et al., *supra* note 1, at 780–81. For a further discussion of the difference between "ethical concerns" and "professionalism concerns," see Block et al., *supra* note 1, at 757–58, 764.

42. JONES, *supra* note 18, at 5 (citing WORKING GROUP OF THE SPECIAL COORDINATING COMM. ON PROFESSIONALISM, ABA FINAL REPORT ON ANCILLARY BUSINESS ACTIVITIES OF LAWYERS AND LAW FIRMS 11–12 (1990)).

43. *Id.* The CEPR draft included three key provisions. First, it stipulated that whenever a law firm provided in-house ancillary services (not in a separate establishment), the clients of the ancillary businesses would be treated no differently from legal clients insofar as they would receive the full protection of the rules of practice. Second, it mandated disclosure. Lawyers would be responsible for fully informing all clients about the relationship between the law firm and the ancillary service providers. Finally, the draft rule made it clear that all ethical protections available to legal clients would be available to the clients of ancillary businesses unless the ancillary services were entirely unrelated to legal representation and the lawyer told the client ex ante that the attorney-client privilege did not attach to the non-legal transactions. *Id.*

44. *Id.* at 5–6; Block et al., *supra* note 1, at 792–800; Henry J. Reske & Don J. DeBenedictus, *Ethics Proposals Draw Fire: House Restricts Ancillary Businesses, Rejects Confidentiality Change*, A.B.A. J., Oct. 1991, at 34; Schneyer, *supra* note 41, at 370. Dennis Block was appointed chair of the Litigation Section's task force and was a dissenting member of the SCCOP Working Group. Block et al., *supra* note 1, at 781, 792.

such activity for clients.[45] As no state adopted the rule in the year following its passage, it became clear that there was little public support for such stringent regulation.[46] Many viewed the regulations as unnecessarily restrictive since they prohibited common practices such as lawyers serving as agents of title insurance companies or trust administrators.[47] The Litigation Section's version of the rule also raised First Amendment and antitrust concerns.[48] In August 1992, the House of Delegates met again and, after extensive debate, rescinded Rule 5.7.[49] As this left the ABA exactly where it started, without any rule regulating the provision of ancillary, law-related services, the House of Delegates considered a third approach at its meeting in February 1994.[50] This meeting spawned the current version of Rule 5.7, which makes all ancillary activities subject to the full range of restrictions set out in the Model Rules of Professional Conduct unless (1) the ancillary activity is distinct from the lawyer's legal practice and (2) the lawyer informs the client that,

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45. JONES, *supra* note 18, at 6; Moore, *supra* note 1, at 187 n.29; Gary A. Munneke, *Dances with Nonlawyers: A New Perspective on Law Firm Diversification*, 61 FORDHAM L. REV. 559, 583 (1992). Rule 5.7, as adopted by the House of Delegates in August 1991, appeared as follows:

> RULE 5.7 Provision of Ancillary Services
>
> (a) A lawyer shall not practice in a law firm which owns a controlling interest in, or operates, an entity which provides non-legal services which are ancillary to the practice of law, or otherwise provide such ancillary non-legal services, except as provided in paragraph (b).
>
> (b) A lawyer may practice law in a law firm which provides non-legal services which are ancillary to the practice of law if:
>
> (1) The ancillary services are provided solely to clients of the law firm and are incidental to, in connection with and concurrent to, the provision of legal services by the law firm to such clients;
>
> (2) Such ancillary services are provided solely by employees of the law firm itself and not by a subsidiary or other affiliate of the law firm;
>
> (3) The law firm makes appropriate disclosure in writing to its clients; and
>
> (4) The law firm does not hold itself out as engaging in any non-legal activities except in conjunction with the provision of legal services, as provided in this rule.
>
> (c) One or more lawyers who engage in the practice of law in a law firm shall neither own a controlling interest in, nor operate, an entity which provides non-legal services which are ancillary to the practice of law, nor otherwise provide such ancillary non-legal services, except that their firms may provide such services as provided in paragraph (b).
>
> (d) Two or more lawyers who engage in the practice of law in separate law firms shall neither own a controlling interest in, nor operate, an entity which provides non-legal services which are ancillary to the practice of law, nor otherwise provide such ancillary non-legal services.

MODEL RULES OF PROF'L CONDUCT R. 5.7 (repealed 1992). For a thorough discussion of the legislative history associated with Rule 5.7, see CENTER FOR PROF'L RESPONSIBILITY, A LEGISLATIVE HISTORY: THE DEVELOPMENT OF THE ABA MODEL RULES OF PROFESSIONAL CONDUCT, 1982–1998, at 245–69 (1999).

46. *See* JONES, *supra* note 18, at 6.

47. *Id.*

48. *Id.* (citing Munneke, *supra* note 45, at 585–614).

49. JONES, *supra* note 18, at 6; Moore, *supra* note 1, at 187 n.29.

50. JONES, *supra* note 18, at 6.

since no legal services are being provided, the attorney-client relationship does not attach to the provision of ancillary services.[51]

There are several other Model Rules of which attorneys seeking to offer ancillary, law-related services must take account.[52] For purposes of this Essay, however, the most important is Rule 1.8(a).[53] Rule 1.8(a) speaks to circumstances in which an attorney wishes to enter into a business transaction with a client. When a lawyer or law firm refers a client to an ancillary service center, the provisions of Rule 1.8(a) are implicated because this is, in effect, a "business transaction."[54] In order to comply with this rule, attorneys may not refer the client unless three requirements have been met: (1) the terms of the agreement relating to the provision of ancillary services are (a) "fair and reasonable" and (b) fully disclosed to the client in writing and in a manner that the client can understand; (2) "[t]he client is advised in writing of the desirability of seeking and is given a reasonable opportunity to seek the advice of independent legal counsel"; and (3) the client provides written, informed consent to the agreement's terms, including the relationship between the attorney and the ancillary service provider.[55]

2. *Legislative and Regulatory Responses to Ancillary Services*

Regulation of lawyers' ability to offer law-related ancillary services has taken place entirely through the legal profession's self-regulating procedures.[56] When integrating their legal work with ancillary services, attorneys and law firms need only consider the ethical requirements adopted by the states in which they

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51. *Id.*; MODEL RULES OF PROF'L CONDUCT R. 5.7 (2006).

52. Consider, for example, the following rules: (1) Rule 5.4 prohibits non-lawyers from owning equity in law firms or exercising control over attorneys; (2) Rule 5.5 prohibits a lawyer from assisting laypersons engaged in the unauthorized practice of law; (3) Rule 1.6 pertains to the maintenance of client confidences and secrets; (4) Rule 1.7 discusses the avoidance of conflicts of interest between past and current clients; (5) Rule 5.3 delineates special considerations for "in-house" businesses (lawyers must ensure that the behavior of non-lawyers conforms to the Model Rules); (6) Rule 1.8 regulates business transactions with clients and is implicated when a lawyer refers a client to an ancillary service center; and (7) Rules 7.1, 7.2, and 7.3 cover advertising and solicitation. MODEL RULES OF PROF'L CONDUCT (2006). See *infra* note 127 for a discussion of the solicitation concerns that the provision of ancillary services may produce.

53. MODEL RULES OF PROF'L CONDUCT R. 1.8(a) (2006). This rule expressly deals with the problem of overutilization and supplier-induced demand, which I argue is the strongest objection to self-referral arrangements.

54. MODEL RULES OF PROF'L CONDUCT R. 5.7, cmt. n.5 (2006); JONES, *supra* note 18, at 31 (citing State Bar of Cal., Standing Comm. on Prof'l Responsibility and Conduct, Formal Ops. 1995-140 & 1995-141 (1995); PA. RULES OF PROF'L CONDUCT R. 5.7 cmt. 11 (2005); S.C. Bar Ethics Advisory Comm. Ops. 99-07 (1999), 93-05 (1993), & 90-16 (1990)) (demonstrating that this is true even in jurisdictions that have adopted the safe-harbor approach set out in Model Rule 5.7)).

55. MODEL RULES OF PROF'L CONDUCT R. 1.8(a). James Jones suggests that all of these items can be covered in the retainer agreement between the client and the ancillary business. *See* JONES, *supra* note 18, at 31–32. He provides sample language for such an agreement. *Id.* app. D.

56. *See* Schneyer, *supra* note 41, at 363–64.

practice.[57] Physicians, on the other hand, are governed by a host of complicated federal and state statutes that limit the extent to which self-referral arrangements are permissible.[58] This section discusses federal law first and then summarizes the various types of state legislation that physicians must consider.

i. The Stark Law

a. A Brief History of the Governing Statutes and Regulations

The Federal Stark Law, which is divided into two parts, is the principal federal statute governing self-referral arrangements in the medical profession. The initial proposal for federal regulation of the practice of physician self-referral originated in 1988 with Congressman Pete Stark, a Democrat from California.[59] Congress passed the legislation, which became known as "Stark I," in 1989.[60] Stark I, which became effective on January 1, 1992, prohibits physicians from referring Medicare patients to clinical laboratories with which they have a financial relationship.[61] In 1993, Congress expanded Stark I to cover other ancillary service centers besides clinical laboratories. These amendments, collectively known as "Stark II," became effective on January 1, 1995.[62] The Health Care Financing Administration (HCFA) opened the notice and comment period by issuing proposed regulations for Stark II in 1998,[63] which met with strong opposition from the medical community.[64] The complexity of the issue led HCFA to bifurcate the final Stark II regulations into two phases. HCFA issued Phase I of the Stark II regulations on January 4, 2001, which

57. E-mail from James W. Jones, Director of the Hildenbrant Institute, to author (May 5, 2006) (on file with author).

58. *See generally* THOMAS WM. MAYO, STATE ILLEGAL-REMUNERATION AND SELF-REFERRAL LAWS 9–13 (1996) (discussing and categorizing various state approaches to regulating physician self-referral); Philip H. Lebowitz & John W. Jones, *An Overview of the Stark Law*, AM. CLINICAL LABORATORY, Aug. 2001, at 31 (addressing the federal prohibition on physician self-referrals and exceptions to the prohibition).

59. *See* AM. ACAD. OF PHYSICAL MED. & REHAB., STARK II ANALYSIS AND SUMMARY, http://www.aapmr.org/hpl/pracguide/pmrprac/starkb.htm (last visited Nov. 4, 2006) [hereinafter STARK II ANALYSIS AND SUMMARY].

60. Congress passed Stark I under the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2236 (effective Jan. 1, 1992) (codified at 42 U.S.C. § 1395nn (2000)).

61. 42 U.S.C. § 1395nn. The statute provided several exceptions. In August 1995, the Health Care Financing Administration (HCFA) codified regulations for Stark I. 42 C.F.R. § 411.350–.360 (1995).

62. STARK II ANALYSIS AND SUMMARY, *supra* note 59. Like the AMA and ABA, Congress apparently had second thoughts about regulating professional self-referral. The House Ways and Means Committee initiated legislation in 1995 to scale back Stark II. *Id.* The bill passed the House and Senate but was vetoed by President Clinton. *Id.*

63. Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships, 63 Fed. Reg. 1659, 1659 (Jan. 9, 1998).

64. STARK II ANALYSIS AND SUMMARY, *supra* note 59. Industry representatives managed to introduce legislation that, like the bill initiated by the House Ways & Means Committee in 1995, *see supra* note 62, would have significantly blunted the force of Stark II. This legislation, however, was never acted upon by the House or Senate. *Id.*

became effective exactly one year later.[65] Phase I deals extensively with regulatory treatment of group practices and the general exceptions that protect both ownership and compensation relationships.[66] On March 26, 2004, the U.S. Centers for Medicare and Medicaid Services (CMS, formerly HCFA) issued Phase II of the Stark II regulations in the form of an interim final rule.[67] Phase II includes regulations that were not addressed in Phase I, including several of the statute's exceptions and the reporting requirements.[68]

b. The Stark Law Today

The Stark Law, as it exists today, prohibits a physician from referring Medicare patients for certain "designated health care services" (DHS)[69] to a facility with which the physician (or her immediate family member) has a financial relationship through ownership or compensation.[70] If the physician is not requesting reimbursement from Medicare, or the referral is for something other than a DHS, then the Stark Law does not apply.[71] Moreover, several exceptions within the law exempt certain types of self-referral arrangements. For example, physicians are exempted from the prohibitions if the services are (1) provided by the physician herself, (2) provided by another physician in the same practice group, (3) provided under the supervision of a physician in the same practice group, (4) provided as in-office ancillary services (not in a separate facility), (5) provided as "clinical laboratory services . . . in an ambulatory center," (6) "performed by an academic medical center," or (7) considered "preventive screening, tests, immunizations and vaccines."[72] The Stark Law also does not apply if the applicable financial interest is an equity interest in a publicly traded security purchased in the open market.[73] Finally, if a physician has a financial interest in an entire hospital, she may refer patients for services at that facility without violating the statute.[74]

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65. Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships (Phase I), 66 Fed. Reg. 856, 856, 952 (Jan. 4, 2001) (codified at 42 C.F.R. pts. 411 & 424).

66. STARK II ANALYSIS AND SUMMARY, *supra* note 59. Phase I also adds several new compensation exceptions. 66 Fed. Reg. 856.

67. Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships (Phase II), 69 Fed. Reg. 16,054, 16,054, 16,126 (Mar. 26, 2004) (codified at 42 C.F.R. pts. 411 & 424).

68. *CMS Issues Long-Awaited Phase II Stark Regulations*, ON THE SUBJECT (McDermott, Will & Emery Publications), Mar. 30, 2004, http://www.mwe.com/index.cfm/fuseaction/publications.nldetail/object_id/9258ae7c-0018-4fb5-93fa-e986de5f16b9.cfm.

69. DHSs include, inter alia, clinical laboratory services, physical therapy, occupational therapy, certain imaging services, and home health services. 42 C.F.R. § 411.351 (2004).

70. 42 U.S.C. § 1395nn (2000).

71. *Id.* Under a companion provision of the Medicaid statute, federal matching funds for state Medicaid expenditures may not be paid to physicians who are in violation of the Stark Law. *Id.*

72. Rebecca Berthard, *Physician Self-Referral: Beyond Stark II*, 43 BRANDEIS L.J. 465, 470 (2005) (summarizing 42 C.F.R. § 411.355 (2001)). These exemptions are only some of the many within the statute. *Id.*

73. 42 C.F.R. § 411.356 (2004).

74. *Id.*

ii. State Laws Regulating Physician Self-Referral

Many state legislatures and regulatory bodies have also promulgated statutes and regulations that restrict the extent to which physicians can legally refer patients to their own ancillary facilities.[75] Approximately half of the states regulate the referral of privately insured or uninsured patients in addition to individuals who receive governmental benefits.[76] Many others make use of legislation that essentially mirrors the federal Stark Law, banning the referral of governmentally insured patients for certain designated health care services.[77] In almost all cases, the pertinent state statutes and regulations, like the federal Stark Law, are replete with exceptions.[78]

Many states permit physicians to refer patients to an entity with which they have a financial relationship, but they require disclosure of the relationship to the patient.[79] Physicians generally must inform patients that (a) "the physician has an ownership interest in the facility," (b) the patient may choose an alternative facility, and (c) "the physician-patient relationship will not be affected" if the patient seeks care elsewhere.[80] States typically do not require physicians to disclose information that identifies alternative providers.[81] The required disclosure usually must be in writing, but sometimes can be satisfied with a wall sign.[82] The laws of these "disclosure states" resemble Rule 1.8(a) of the Model Rules of Professional Conduct, but do not follow it exactly.[83] Unlike Rule 1.8(a), state laws and regulations governing physician self-referral generally do not mandate that the transaction take place on terms that are "fair and reasonable," nor do such laws stipulate that patients be given a chance to consult an outside advisor.[84]

Finally, under the assumption that small equity interests are unlikely to influence physicians' judgment, some states make use of percentage of ownership limitations.[85] For instance, Colorado regulations limit physicians' ownership

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75. For a very thorough discussion of the state laws regulating physician self-referral arrangements, see MAYO, *supra* note 58, at 9–13. For a relatively up-to-date chart that briefly summarizes the physician self-referral laws and regulations of each state, see Berthard, *supra* note 72, at 479 app. A.

76. Twenty-six states regulate, to some degree, the self-referral by physicians of patients who do not receive health benefits through the government. *See* Berthard, *supra* note 72, at 479 app. A (identifying all of the states that regulate private patients).

77. MAYO, *supra* note 58, at 12–13; Berthard, *supra* note 72, at 475.

78. MAYO, *supra* note 58, at 10.

79. *Id.* at 11; Berthard, *supra* note 72, at 475.

80. Berthard, *supra* note 72, at 475 (citing ROBERT FABRIKANT, PAUL E. KALB, MARK D. HOPSON & PAMELA H. BUCY, HEALTH CARE FRAUD: ENFORCEMENT AND COMPLIANCE § 2 (2001)).

81. MAYO, *supra* note 58, at 11 & n.91 and accompanying text (listing only seven states which do require disclosure of alternate providers).

82. *Id.* at 11 & nn.88–89 and accompanying text.

83. For a discussion of the applicability of Model Rule 1.8(a) to law-related ancillary businesses, *see supra* notes 53–55 and accompanying text.

84. *See* MAYO, *supra* note 58, at 11.

85. For a general discussion of percentage of ownership limitations as a tool to combat inappropriate physician self-referral, see McDowell, *supra* note 1, at 88–90.

interest in pharmacies to 10%.[86] Rather than capping investment, some states use percentage of ownership levels as a "threshold to trigger more extensive protective mechanisms."[87] In Florida, for example, equity interests greater than 10% activate disclosure requirements.[88] Similarly, in California, any physician with a "significant beneficial interest" in the ancillary service center to which she refers a patient must disclose such interest to the patient.[89] A "significant beneficial interest" is defined as 5% or more of the total equity in the ancillary entity or a $5,000 investment.[90]

In essence, policymakers in law and medicine have devised three different mechanisms for regulating professional self-referral arrangements. The AMA has taken the strictest stance insofar as it has declared all self-referral to be unethical unless there is a demonstrated need in the community and alternative financing is unavailable. The federal Stark Law and several state laws ban only large equity interests in medical ancillary service centers. Finally, the ABA and many of the state laws regulating physicians take the view that disclosure requirements can sufficiently protect patients and clients by alerting them to potential conflicts of interest. Part IV of the Essay examines each of these forms of regulation and ultimately concludes that they do not adequately address the problems associated with self-referral.

III. PHYSICIANS AND LAWYERS SHOULD BE PERMITTED TO OWN EQUITY IN ANCILLARY SERVICE CENTERS

A. Benefits Associated with Ancillary Service Ownership

Before deciding whether self-referral should be permitted, the first consideration must be whether physicians and lawyers should be permitted to own equity in ancillary services at all. This section addresses the two principal benefits associated with ancillary service ownership: (1) enhanced quality and reduced cost of professional services and (2) professionals' unique position to identify need. As these benefits are widely recognized and largely uncontroversial, they are given only cursory treatment. Part III.B provides a much more extensive analysis of the counterarguments advanced by critics of ancillary ownership.

1. Enhanced Quality and Reduced Cost of Professional Services

There are two reasons why allowing physicians and lawyers to own equity in ancillary service centers may enhance the quality and reduce the cost of professional services. First, permitting such ownership allows professionals to develop a better working relationship with the ancillary entities and provide patients

86. 3 COLO. CODE REGS. § 719-1.00.15 (2006).

87. McDowell, *supra* note 1, at 88–89.

88. FLA. STAT. ANN. §§ 458.327(2)(c) (2005) & 459.013(3)(b) (2001) (governing medical doctors and osteopaths, respectively).

89. CAL. BUS. & PROF. CODE § 654.2(a) (West 2003).

90. CAL. BUS. & PROF. CODE § 654.2(d)(2) (West 2003).

and clients with integrated, rather than piecemeal, services.[91] In the medical field, the expanding number of diagnostic and therapeutic procedures available to individuals make it increasingly important that patients receive coordinated care.[92] The same argument can be made in the context of law-related ancillary services—the complex corporate clients of today are well served by a seamless, interdisciplinary approach to problem solving.[93]

Second, ancillary ownership allows quality to rise while costs decline solely because of the increased competition associated with lower barriers to entry.[94] Permitting physicians and lawyers to own and manage ancillary facilities increases supply but does not affect demand as long as self-referral is prohibited.[95] Competition generated by the absence of governmental regulations restricting ancillary ownership could spur substantial innovation. Pressure to keep up with the competition leads firms to create new and desirable bundles of services and adopt technology at a faster rate.[96] In a world that banned ancillary ownership, the high volume of customers might lead an MRI center to forgo purchasing new capital equipment until its old machines become obsolete. Lifting the restriction on ancillary ownership increases the potential number of suppliers, making it more difficult for any given center to attract patients. In the face of increased competition, management might be prompted to invest in updated computer equipment, purchase "open MRIs," or hire more personable technicians.

2. *Professionals' Unique Position to Identify Need*

The second pro-competitive benefit associated with ancillary ownership pertains not to the quality of services, but to assurance that needed facilities are constructed in the first place. In a letter advancing the potential pro-competitive effects of ancillary ownership in the medical field, the FTC argued that physicians may be uniquely situated to identify and respond to community health care needs.[97]

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91. For the argument in the context of the medical profession, see McDowell, *supra* note 1, at 71–73 (summarizing the Federal Trade Commission's (FTC) position set forth in two letters responding to requests for comments). For the argument in the context of the legal profession, see Fitzpatrick, *supra* note 30, at 470–71 (describing the pioneering experience of a large law firm in developing a real estate consulting firm).

92. *See* McDowell, *supra* note 1, at 64.

93. Fitzpatrick, *supra* note 30, at 471. Still, the benefits of integration do not necessarily depend on professionals' ability to self-refer patients and clients. Consumers may independently decide to use a physician's or lawyer's self-owned facility.

94. *See* McDowell, *supra* note 1, at 72–73 (describing potential to reduce costs for medical services).

95. See *infra* Part III.B.2 for a discussion of how permitting self-referral may manipulate demand for ancillary services.

96. *See* McDowell, *supra* note 1, at 64.

97. BUREAUS OF COMPETITION PROTECTION & ECON., FED. TRADE COMM'N, COMMENTS CONCERNING THE DEVELOPMENT OF REGULATIONS PURSUANT TO THE MEDICARE AND MEDICAID ANTI-KICKBACK STATUTE 15 (1987), *available at* http://www.ftc.gov/be/healthcare/docs/AF%2033.pdf (last visited Nov. 17, 2006) [hereinafter FTC Comments to HHS] (responding to request for comments from U.S. Department of Health and Human Services); McDowell, *supra* note 1, at 71–72 (summarizing the

For example, the FTC suggested that doctors are likely to be the first to recognize that a specific type of medical laboratory would benefit a given area.[98] Thus, prohibiting doctors from owning equity in ancillary centers would remove the most important source of capital from the health care market. Venture capital and private equity funding might be available, but the "smart money" would be lost. Preventing physicians who know and understand the particular needs of the community from investing would lead to an inefficient allocation of resources—a system where undesirable ventures can obtain funding but innovative and highly needed providers of ancillary services are left without access to capital.

Although this argument has not been made as forcefully for lawyers, the point appears equally applicable to the legal profession. For example, lawyers may be best equipped to identify when particular clients could benefit from a unique form of management consulting or focused real estate development advice. Preventing attorneys from investing in such novel businesses might shun innovation and dry up much-needed capital.

B. Potential Arguments Against Ancillary Ownership: Rebutting the Critics

Critics of entrepreneurialism in the medical and legal professions advance several arguments for why the harm caused by ancillary service ownership outweighs the benefits discussed in Part III.A. Part III.B demonstrates that only one of these arguments—the threat of overutilization—is persuasive.

1. Unpersuasive Arguments

i. Decreased Focus on Serving Society

Critics of ancillary ownership in both medicine and law point to the decline in professionalism that may flow from increased entrepreneurial opportunities and focus on the bottom line.[99] They argue that the ability to generate revenue by referring patients and clients to ancillary services will detract from the ideal that professionals have a duty to advance society and ultimately will influence professionals to choose financial gain over serving the public.[100] This position,

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FTC position set forth in its responsive comments).

98. FTC Comments to HHS, *supra* note 97.

99. *See* Block et al., *supra* note 1, at 764–69; McDowell, *supra* note 1, at 68–69; Moore, *supra* note 1, at 176; Schneyer, *supra* note 41, at 383. Other authors have used the phrase "professionalism concerns" to implicate a much broader set of problems that may be caused by the provision of law-related ancillary services. *See* Block et al., *supra* note 1, at 764–69; Moore, *supra* note 1, at 176. I use the term much more narrowly (in a fashion similar to McDowell) to signify a shift in professionals' focus from humanitarian goals to the prospect of financial gain.

100. *See* Block et al., *supra* note 1, at 765–66; McDowell, *supra* note 1, at 68–70; Arnold S. Relman, Editorial, *Practicing Medicine in the New Business Climate*, 316 NEW ENG. J. MED. 1150, 1150 (1987). This claim is made much more forcefully in the context of medical self-referral than it is by critics of ancillary services in law (compare McDowell's direct discussion to Block et al.'s tangential treatment). Although it is unclear why this concern appears more pronounced in medicine than in law,

however, is rather unpersuasive. Traditionalists who make such an argument assume that profit motives are fundamentally at odds with an orientation toward public service when this need not be the case.[101] In fact, increased revenues may provide physicians and lawyers with the financial cushion necessary to devote greater resources to uncompensated care or pro bono work.[102] In any event, professionals' motives are largely irrelevant to the policy debate over ancillary businesses; the costs and benefits of regulation should be the only considerations.[103]

A system in which professionals serve the public out of altruism is not necessarily superior to one in which they are financially motivated to do so. Although the former system may generate a greater sense of pride within the professions, the latter system may be less vulnerable to seemingly unpredictable changes in cultural mores. Consider, for example, a situation where physicians of later generations exhibit a desire for a better work-life balance and therefore become less driven toward advancing science or serving the indigent. If physicians were motivated by financial concerns to serve the public in the first place, then policymakers should be able to mitigate the harm associated with the profession's changing attitudes by ensuring greater reimbursement for certain activities or procedures. The less the current generation of medical providers is driven by financial concerns, however, the more difficult it will be to ameliorate the adverse effects of shifting professional goals. If physicians remain relatively unresponsive to enhanced reimbursement, then policymakers must search (potentially in vain) for creative ways to refocus the profession on scientific advancement and uncompensated care.

ii. Decline in the Quality or Availability of Professional Services

The second argument advanced by critics is similar to the first insofar as it relates to the decreased quality of professional services caused by the lure of extraprofessional profits. Those who are opposed to the provision of ancillary services in the legal profession argue that the quality of legal work may suffer if attorneys are permitted to spend significant time and effort solving their clients' non-legal problems.[104] This point is arguably more applicable in the medical field

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the disparate treatment may be due to the fact that, for whatever reason, society expects lawyers to be more focused on remuneration than physicians. For example, the public might view a physician who refuses to provide uncompensated care as less respectable than a lawyer who fails to perform pro bono work.

101. Schneyer, *supra* note 41, at 383.

102. *See* RICHARD L. ABEL, AMERICAN LAWYERS (1989) (discussing survey results which suggest that the extent to which attorneys perform pro bono work is directly correlated with income).

103. Schneyer, *supra* note 41, at 384. Motives should be considered only as an intermediate step in the calculation. It may be the case that, if professionals are motivated to provide for society as a whole, then they will ultimately generate greater social welfare by performing uncompensated work. The question to ask, however, is not whether professionals will be desirably motivated, but whether the cost-benefit ratio associated with generating such a system is superior to the cost-benefit ratio of another system in which professionals are motivated more by financial concerns.

104. Block et al., *supra* note 1, at 767–68; Schneyer, *supra* note 41, at 373–75.

where significant research has demonstrated that physicians and institutions that perform a high volume of procedures are more likely to obtain successful outcomes.[105] In both professions, however, the argument suffers from two principal flaws.

First, the proper distinction to draw is between part-time work and full-time commitments. If evidence suggests that high-volume professionals generally provide superior services, then policymakers should consider imposing mandatory time commitments, rather than prohibiting alternative activities.[106] It is hard to imagine how ancillary business activities reduce a professional's ability to provide legal or medical services more than any other endeavor.

Second, it is questionable whether additional legal or medical work always enhances a practitioner's skills to a greater extent than work relating to an ancillary service. This is especially true when a professional exhausts all of the cases in which she specializes and still has time remaining. For instance, consider a neurosurgeon that specializes in spinal surgery. She lives in a relatively small suburb where she sees only 100 patients per year who require spinal surgery. With the remainder of her time, the neurosurgeon could take on a few patients that require cranial surgery, a procedure with which she is not particularly comfortable, or she can open an MRI center. In such a scenario, opening and managing the MRI center may be preferable because it will allow her to gain a better understanding of a process that the vast majority of her patients must undergo. Encouraging this physician to broaden her practice into an area in which she is not comfortable is likely to have an adverse impact on the quality of care. Similarly, it may be preferable for an attorney to perform some consulting work in an area that is substantively related to her legal work, rather than motivating her to take cases that are entirely unrelated to her specialty.[107]

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105. R. Adams Dudley et al., *Selective Referral to High-Volume Hospitals: Estimating Potentially Avoidable Deaths*, 283 JAMA 1159, 1163 (2000); Harold S. Luft et al., *Should Operations Be Regionalized? The Empirical Relation Between Surgical Volume and Mortality*, 301 NEW ENG. J. MED. 1364, 1365–66 (1979); David R. Thiemann et al., *The Association Between Hospital Volume and Survival After Acute Myocardial Infarction in Elderly Patients*, 340 NEW ENG. J. MED. 1640, 1642–44 (1999). Studies analyzing the relationship between the volume of legal work one provides and the quality of such work do not appear to exist.

106. Schneyer, *supra* note 41, at 374, briefly addresses this concern:

> In any event, ancillary work poses no greater risk of diminishing one's legal skills than practicing part-time for family reasons, having a side line unrelated to law, managing a law firm, or participating as house counsel in a client's business affairs. Yet the Litigation Section expressed no concern on these scores.

Id.

107. *See id.* at 373–74

> Moreover, an environmental lawyer whose firm operates an environmental consulting business may find it easier, not harder, to concentrate on the legal side of her clients' problems. Even if she does become active in running the consulting unit, she seems more likely to enhance her true legal expertise by doing so than by rounding out her environmental practice with some divorce cases, as the Litigation Section would apparently prefer.

Id. (footnotes omitted).

iii. Threats to the Reputation of the Profession

The third argument against ancillary ownership relates to the potential damage that such financial relationships might do to the reputations of the medical and legal professions. During the late 1980s and 1990s (when, because of the ABA's consideration of the subject, the debate was most lively), traditionalists opposed to the provision of law-related ancillary services argued that business scandals are an inevitable result of entrepreneurial activity and the negative publicity associated with such scandals brings the legal profession into disrepute.[108] Although this argument has not been advanced for the medical field, it seems equally applicable. Indeed, the social and political power that physicians and attorneys enjoy, combined with the vulnerability of many patients and clients, makes an element of trust critical to the success of both professions. If the public suspects that lawyers and doctors are willing to sacrifice their patients' and clients' interests for the sake of financial gain, individuals will be less likely to seek out health care and legal counsel or, when an individual does see her physician or lawyer, discussions are likely to be guarded and unproductive.

The concern about the reputations of the professions is largely unfounded. Despite conclusive data that physicians' ownership of ancillary service centers increases referrals (and often decreases the quality of care),[109] the majority of patients firmly believe that their own physician could never be swayed by financial interest.[110] In other words, patients' faith in medical providers is remarkably unshakable.[111] In the legal profession, the traditionalists' warning has been disproved by the test of time. Law-related ancillary services have been popular among major law firms for approximately a decade and a half,[112] yet there is no evidence that firms engaging in such practices are any more likely to be criminally

108. ABA Section of Litigation Report, *supra* note 16, at 13–16.

109. *See* Steven D. Wales, *The Stark Law: Boon or Boondoggle? An Analysis of the Prohibition on Physician Self-Referrals*, 27 LAW & PSYCHOL. REV. 1, 5–7 (2003) (discussing several studies that indicate self-referral results in higher utilization of ancillary services). See *infra* Part III.B.2 for a fuller discussion of this point.

110. Jason Dana & George Loewenstein, Commentary, *A Social Science Perspective on Gifts to Physicians from Industry*, 290 JAMA 252, 254 (2003).

111. *See, e.g.*, Elizabeth Dugan, Felicia Trachtenberg & Mark A. Hall, *Development of Abbreviated Measures to Assess Patient Trust in a Physician, a Health Insurer, and the Medical Profession*, 5 BMC HEALTH SERVICES RES. 2005 art. 64 (reporting that, where responses could equal between 5 and 25, and 5 indicated the greatest trust in physicians, the average score reported by the patients surveyed was 20.43); David H. Thom, Mark A. Hall & L. Gregory Pawlson, *Measuring Patients' Trust in Physicians When Assessing Quality of Care*, 23 HEALTH AFF. 123, 126 (2004) ("Focus groups with patients reveal that trust is often a defining characteristic of their relationships with physicians and other care providers."). Although patients as a whole possess remarkable faith in their physicians' decisions, the degree of such faith is not constant across groups. Minority racial and ethnic groups tend to exhibit lower levels of trust in their medical providers than do whites. Thom, Hall & Pawlson, *supra*, at 126–27 (discussing the literature regarding the effects of racial and ethnic differences on trust).

112. *See supra* notes 29–33 and accompanying text.

prosecuted or held civilly liable for fraudulent behavior.[113] Perhaps, as Ted Schneyer predicted, "the law firms considering whether to set up ancillary businesses [are able] to weigh [the risk of scandals] to their own reputations, which are far more directly at stake than the reputations of other lawyers."[114]

iv. Patient and Client Confusion

Traditionalists argue that the provision of law-related ancillary services may confuse clients about which of the law firm's employees are attorneys and may lead to the unauthorized practice of law by non-lawyers.[115] This point is arguably more persuasive in medicine where physicians often face uneducated patients who may confuse an MRI technician or physical therapist for a doctor. On the other hand, the representatives of large, corporate legal clients seem more likely to understand when they are dealing with an accountant and when they are speaking to an attorney. In either profession, however, it is questionable whether the provision of ancillary services increases the chance of confusion. Physicians and lawyers utilize a host of non-physician and non-lawyer personnel who interact with patients and clients on a regular basis. A patient seems more likely to erroneously believe that a nurse, who wears a white coat and records the patient's vital signs in the same room in which the physician examines the patient, is a medical doctor, than to believe the same of the MRI technician or physical therapist who see patients in an entirely different location. Similarly, paralegals and student interns (e.g., summer associates) seem at least as likely to confuse a client as an accountant or business consultant.[116]

Furthermore, there is no evidence to suggest that law firms that offer ancillary services are more likely to be investigated—or sued—for violations of Model Rule 5.5.[117] Indeed, the provision of such services may help to prevent violations of the Code since law firms with ancillary departments are likely to be "on guard" for any activity which might be construed as the unauthorized practice of law.[118]

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113. E-mail from James W. Jones, Director of the Hildenbrant Institute, to author (May 5, 2006) (on file with author).

114. Schneyer, *supra* note 41, at 377–78.

115. Block et al., *supra* note 1, at 762–63. Rule 5.5 of the Model Rules of Professional Conduct prohibits the unauthorized practice of law. MODEL RULES OF PROFESSIONAL CONDUCT R. 5.5 (2006). During the late 1980s and early 1990s, one of the most popular arguments advanced by critics was the idea that clients may not know when state rules of professional conduct apply to the law firm employee assisting them. Block et al., *supra* note 1, at 762–63. As discussed in Part I, however, this point is beyond the scope of this Essay since the issue does not apply to the medical profession and Model Rule 5.7 provides a reasonable solution.

116. Although paralegals and student interns are used to provide legal services, it would certainly be problematic for a client to confuse them with attorneys. Given the lack of legal experience of many paralegals and all student interns, clients may be harmed less by believing their seasoned management consultant is a lawyer than by erroneously thinking the paralegal or student is authorized to practice law.

117. E-mail from James W. Jones, Director of the Hildenbrant Institute, to author (May 5, 2006) (on file with author).

118. *See* JONES, *supra* note 18, at 27 (discussing issues firms should consider in structuring their operations so as to avoid the unauthorized practice of law).

Compliance protocols established in the wake of expansion into ancillary services are likely to help not only the employees of the ancillary entities avoid a violation of Rule 5.5, but also other non-lawyer law firm employees such as paralegals and student interns. Although critics of physician self-referral seem relatively unconcerned with the potential for the unauthorized practice of medicine, the same argument can be made for the medical profession.

2. *The One Persuasive Argument: Increased Cost and Decreased Quality Associated with Overutilization and Supplier-Induced Demand*

This section examines the only persuasive reason for regulating professionals' ownership of ancillary services: the threat of overutilization. Part IV argues that, since overutilization is the only real concern, the solution is not to restrict ownership per se, but rather to ban self-referral.

The threat of overutilization is not limited to ancillary service facilities. Any time an expert is paid on a fee-for-service basis, she has a financial incentive to recommend and provide more services than a fully informed patient, client, or customer would desire.[119] This phenomenon, however, is largely unavoidable. Switching to alternative forms of compensation, such as capitation[120] or contingency fee agreements,[121] arguably creates a more perverse environment since professionals have an incentive to render too few services.[122] In essence, society has

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119. In law, fee-for-service payment would be an hourly fee. In medicine, fee-for-service compensation might be an hourly fee or a set price per procedure.

120. Capitation contracts are often used to reimburse medical providers. Under a capitation agreement, a physician or group of physicians agrees to provide specified types of care to the patients in question for a given amount of time. STEDMAN'S MEDICAL DICTIONARY 280 (27th ed. 2000). For example, a physician group might agree to accept $500,000 to provide all medically necessary care for 100 patients for one year. Capitation agreements transfer actuarial risk from first party insurers to physicians.

121. Under a contingency fee agreement, a lawyer receives a certain percentage (often one-third) of the ultimate recovery.

122. Research demonstrates that physicians drastically alter their treatment decisions depending upon the applicable reimbursement method. Generally speaking, salary (fixed payment per year regardless of patients treated or procedures performed) and capitation arrangements reduce the provision of care while fee-for-service contracts increase it. *See* T. Gosden et al., *How Should We Pay Doctors? A Systematic Review of Salary Payments and Their Effect on Doctor Behaviour*, 92 Q. J. MED. 47, 53 (1999). Hospital admissions and Medicaid expenses are both significantly lower under capitated than fee-for-service reimbursement. *See* Nicole Lurie et al., *The Effects of Capitation on Health and Functional Status of the Medicaid Elderly: A Randomized Trial*, 120 ANNALS INTERNAL MED. 506, 508 (1994). According to one recent study, patients suffering from major depression were over 4 times less likely to receive a selective serotonin reuptake inhibitor (SSRI) antidepressant if they belonged to an HMO with capitated visits. *See* Betsy Sleath & Ya-Chen Tina Shih, *Sociological Influences on Antidepressant Prescribing*, 56 SOC. SCI. & MED. 1335, 1342 (2003). Another study found that physicians in fee-for-service practices ordered 40% more chest radiographs and 50% more electrocardiograms than doctors in prepaid groups. *See* Arnold M. Epstein et al., *The Use of Ambulatory Testing in Prepaid and Fee-for-Service Group Practices: Relation to Perceived Profitability*, 314 NEW ENG. J. MED. 1089, 1092 (1986). Capitation is also associated with a decrease in the amount of time physicians spend with their patients and an increased receipt of *preventive* and health counseling services. Rajesh Balkrishnan et al., *Capitation Payment, Length of Visit, and Preventive Services:*

no choice but to accept a regime that permits some opportunistic gaming of compensation arrangements.[123] Problems begin to arise, however, when professionals increase the likelihood of gaming by expanding the services for which they collect fee-for-service payment.

Research suggests that physicians make significantly greater use of ancillary services if they have a financial stake in such referrals via an ownership interest.[124] For example, one study found that utilization, charges per patient, and profits are higher when referring physicians have an ownership interest in physical therapy and rehabilitation facilities.[125] Since the decision of whether the patient is in need of ancillary services is uniquely within the purview of the treating physician, medical providers are able to fill excess capacity by increasing referrals.[126] Overutilization[127]

Evidence from a National Sample of Outpatient Physicians, 8 AM. J. MANAGED CARE 332, 338 (2002).

Lawyers operating on contingency fees exhibit similar incentives to capitated physicians. It is generally believed that plaintiffs' attorneys calculate the proper investment based on their expected payout. *See* David Rosenberg, *The Causal Connection in Mass Exposure Cases: A "Public Law" Vision of the Tort System*, 97 HARV. L. REV. 851, 890 (1984). Assuming a one-third contingency fee structure, an attorney will continue investing time and money into a trial as long as the expected judgment increases by more than 3 times the amount required to produce it. A fully rational pro se litigant, however, would continue to invest time and money far beyond this point, stopping only when the expected judgment no longer increases by an amount that is commensurate with the resources required to generate the increase. *See id.*

123. *See* Andrew Stark, *Why Are (Some) Conflicts of Interest in Medicine so Uniquely Vexing?*, *in* CONFLICTS OF INTEREST: CHALLENGES AND SOLUTIONS IN BUSINESS, LAW, MEDICINE, AND PUBLIC POLICY 152, 154–55 (Don A. Moore, Daylian M. Cain, George Loewenstein & Max H. Bazerman eds., 2005). Andrew Stark (no relation to Congressman Pete Stark who sponsored the Stark Law) argues that "internal" conflicts of interest, which are inherent and unavoidable in the medical profession, must be distinguished from "external" conflicts of interest. *Id.* at 153–54. According to Stark, conflicts are internal to the profession if (a) they originate within the professional relationship between the physician and her patient (i.e., no external third party is needed to initiate the conflicts, unlike the case with pharmaceutical gifts to industry), and (b) "they advance interests that the . . . physician enjoys internal to, and only because she occupies, her professional role: interests in professional remuneration or status." *Id.* at 154.

124. *E.g.*, Wales, *supra* note 109, at 5–7.

125. Mitchell & Scott, *supra* note 39, at 2058.

126. It has been known for some time that the availability of resources has a dramatic effect on physicians' utilization of those resources. *See generally* John E. Wennberg, Jean L. Freeman & William J. Culp, *Are Hospital Services Rationed in New Haven or Over-Utilised in Boston?*, 854 3 LANCET 1185, 1186–87 (1987) (noting that the availability of resources has a dramatic effect on physicians' utilization of those resources). The fact that bed vacancy in hospitals drives admission rates is so well recognized "that it has become enshrined as 'Romer's' Law; a bed built is a bed filled." Richard Bohmer, *Changing Physician Behavior*, Harvard Business School Note No. 9-699-124, at 11 (2000); *see also* Elliott S. Fisher, John E. Wennberg, Therese A. Stukel, Jonathan S. Skinner, Sandra M. Sharp, Jean L. Freeman & Alan M. Gittelsohn, *Associations Among Hospital Capacity, Utilization, and Mortality of U.S. Medicare Beneficiaries, Controlling for Sociodemographic Factors*, 34 HEALTH SERVICES RES. 1351, 1358–59 (2000). It has also been shown that cardiologists are more likely to recommend cardiac catheterization when there is ready access to the facilities required to perform the procedure. *See* Richard A. Lange & L. David Hillis, Editorial, *Use and Overuse of Angiography and Revascularization for Acute Coronary Syndromes*, 338 NEW ENG. J. MED. 1838, 1838, 1839 (1998).

127. It is important to distinguish between overutilization and supplier-induced demand. Supplier-induced demand is a type of overutilization that occurs when a patient or legal client is referred to an ancillary facility even though there is no need for the patient or client to obtain such ancillary services.

of physician-owned ancillary facilities insulates the facilities from the competitive

See, e.g., David M. Frankford, *Creating and Dividing the Fruits of Collective Economic Activity: Referrals Among Health Care Providers*, 89 COLUM. L. REV. 1861, 1885 n.80 (1989) (discussing the theoretical underpinnings of supplier-induced demand and the lively debate regarding its existence). The term "overutilization" can be used much more broadly, insofar as it also describes a circumstance where a physician or attorney inappropriately refers a patient or client to a self-owned ancillary center, and the patient or client switches from another facility so that she may receive the services at the physician- or lawyer-owned facility. In such a scenario, there is no supplier-induced demand since the patient or client experienced demand for the ancillary services even before the referral was made.

There are two arguments advanced by critics of medical and legal entrepreneurialism that, although persuasive, ultimately boil down to the problem of overutilization and supplier-induced demand: (1) improper solicitation, and (2) the loss of independent professional judgment. For a detailed discussion of these arguments, see Block et al., *supra* note 1, at 761–62, 765–67. Such a realization indicates that policymakers addressing the issue need only be concerned with overutilization.

As discussed *supra* in Part III.B.2, physicians' and lawyers' referrals to ancillary centers are problematic because the professional is uniquely qualified to recommend such services. Improper solicitation is merely a referral in the opposite direction, from the ancillary service to the professional. If the lawyer or doctor herself is making the referral, then the issue is comparable to the threat of overutilization. One must be concerned that lay clients and patients will defer to the physician's or lawyer's ostensibly sound, professional judgment. This concern may also be true to a lesser extent if the ancillary service employees are themselves "professionals" with expert opinions on health or legal issues (e.g., accountants or physical therapists). If ancillary providers who do not profess to offer expert opinions about clients' and patients' physical or legal health (e.g., massage therapists or non-lawyer management consultants) refer patients to the professionals who own their facilities, then there is simply no risk of harm. If the recommendations of such individuals create an irrational demand for legal or medical services, then it is no different than the heightened demand created by advertising or a friend's suggestion that one seek professional advice. Comment 1 to Model Rule 7.3, which addresses improper solicitation by attorneys, seems to endorse this point: "These [direct] forms of contact between a lawyer and a prospective client subject the layperson to the private importuning of the *trained advocate* in a direct interpersonal encounter." MODEL RULES OF PROF'L CONDUCT R. 7.3 cmt. 1 (2006) (emphasis added).

Traditionalists in the legal profession also contend that ancillary services can jeopardize lawyers' independent, professional judgment in two principal ways. First, attorneys may be reluctant to provide their clients with honest assessments of their affiliated businesses' performance. *See* Block et al., *supra* note 1, at 765; L. Harold Levinson, *Making Society's Legal System Accessible to Society: The Lawyer's Role and Its Implications*, 41 VAND. L. REV. 789, 804 (1988). This argument can easily be applied to the medical community and appears rather persuasive for both professions. Physicians are likely to be hesitant to criticize the angiogram performed at a center in which they have an equity interest, just as lawyers may be hesitant to provide honest feedback about an affiliated management consulting firm. This reluctance to speak poorly about one's own ancillary services is problematic because it may lead patients and clients to continue using the affiliate when better quality services are available elsewhere (or perhaps the most desirable option would be forgoing the ancillary service altogether). In this sense, the problem can be conceptualized as a type of overutilization or supplier-induced demand. In the traditional case, there is an error of *commission*—a physician or lawyer improperly refers a patient to an ancillary service center. Here, the result is the same but there is an error of *omission*—the professional improperly fails to terminate the original referral.

Second, if an ancillary entity brings in substantial revenue for attorneys, then its non-lawyer managers may be able to exert significant influence over the law firm's policies. *See* Block et al., *supra* note 1, at 766–67; Schneyer, *supra* note 41, at 375. Even if the non-lawyers do not hold an equity interest in the law firm, they may be able to persuade the attorneys to generate additional referrals to the ancillary entity by threatening disbandment. Similar issues may arise in medicine. A physician-owned physical therapy office, for example, may be able to pressure the owners for more business. As long as we assume, however, that the non-lawyers and non-physicians do not have an ownership interest in the law firm or medical practice, the problem is, once again, nothing more than overutilization and supplier-induced demand.

marketplace, thereby increasing costs and decreasing quality.[128]

This issue has not been empirically tested for lawyers.[129] It is currently unknown whether attorneys are more likely to suggest that their clients should seek out consulting services, accountants, or real estate development advisors if their own firms provide such services. Given the similarities between lawyers' representation of clients and physicians' treatment of patients, however, it seems likely that lawyers act on the incentive to overutilize ancillary services.[130] As is the case with medical providers, lawyers' understanding of the law leaves them exclusively qualified to determine whether a client will be more thoroughly protected by making use of the firm's ancillary offerings. Lawyers, like physicians, therefore may be able to create demand for their law-related services by over-representing the synergies associated with one-stop shopping or generally suggesting that the use of such services would be good for the client's "legal health."[131]

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128. *See* Mitchell & Scott, *supra* note 39, at 2058.

129. E-mail from James W. Jones, Director of the Hildenbrant Institute, to author (May 5, 2006) (on file with author).

130. Interestingly, virtually all of the writing on the ethical conflicts of interest associated with the provision of law-related ancillary services either completely ignores or cursorily addresses the potential problem of overutilization and lawyer-induced demand. *See, e.g.*, TASK FORCE ON THE INDEP. LAWYER, AMER. BAR ASSOC., LAWYERS DOING BUSINESS WITH THEIR CLIENTS: IDENTIFYING AND AVOIDING LEGAL AND ETHICAL DANGERS 68 (2001) (citing RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 10 cmt. g (2000)), *available at* http://www.abanet.org/litigation/ethics/ethicsreport.html (last visited Nov. 5, 2006) (noting only that the Restatement prohibits a lawyer from allowing self-interest to distort the lawyer's judgment, though not addressing overutilization or supplier induced demand); Block et al., *supra* note 1, at 765–66 (touching on the ability to offer objective advice, without discussing overutilization). Such writing tends to focus on concerns of client confidentiality. It is unclear why commentators expressly recognize the problem in medicine but ubiquitously overlook it in law; it may be because most legal writing focuses on the provision of ancillary services by large law firms, where commentators assume clients are sufficiently sophisticated to combat supplier-induced demand. As discussed in the next three paragraphs of the text, however, this assumption is questionable.

131. Notwithstanding the lack of empirical data, there are three reasons why overutilization of ancillary services may be more prevalent and deleterious in law than in medicine. First, in the medical field, patients' insurance companies may be able to serve as medical experts who can determine when it is appropriate to make use of ancillary service centers in which the referring physician possesses an equity interest. In theory, both patients and their insurers have an interest in forming a contract that combats overutilization by closely monitoring referrals. By agreeing ex ante to such oversight, insurers are able to contain costs and thereby lower premiums. In essence, insurers may be able to serve a role that is comparable to that performed by in-house corporate counsel, insofar as both can advise the principal (patient or corporate client) whether its agent (physician or lawyer) is acting in the agent's own self interest. According to this model, non-corporate clients without legal expertise would be analogous to uninsured patients since neither party is well equipped to determine whether the self-referral is in her best interests. But see *infra* notes 132 and 142 for a discussion of how insurers, unlike corporate in-house counsel, often have an incentive to act in ways that are not in their insureds' best interests.

Second, as discussed later in this section, companies may have difficulty finding an agent who will impartially represent the interests of the organization as a whole.

The third reason why overutilization may be more harmful in the legal profession than in the medical profession relates to the idea that patients generally do not unilaterally decide to make use of laboratories or surgery centers, whereas clients of large law firms often seek out law-related services without the advice of outside attorneys. This difference suggests that law-related overutilization may

Overutilization is not a problem if the patient or client is able and has the incentive to determine, independent of the professional, the soundness of the offered advice. A patient or client must expend resources to make such a determination and must act on discoveries of impropriety to moot the overutilization problem. If the consumer patient or client conducts a de novo investigation into the propriety of the referral, then she need not take the professional's word that a referral is necessary. It seems plausible that large corporate clients have the expertise necessary to determine for themselves whether a referral to a professional-owned ancillary facility is appropriate. It is questionable, however, whether they have adequate incentives to expend the resources necessary to make such investigations and act on discoveries of overutilization.[132]

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result in significantly more competitive harm than does the same phenomenon in medicine. If physicians are generating new demand for ancillary services, then they are only harming the consumer, who ultimately pays higher insurance premiums as a result of inappropriate referrals. If lawyers, however, are not only creating demand but shifting demand away from freestanding providers of law-related services, then they are also inflicting injury on competitors. Several authors have suggested that the injuries to competition caused by physician self-referral could be dealt with under the antitrust laws. *See, e.g.*, E. Haavi Morreim, *Conflicts of Interest for Physician Entrepreneurs*, *in* CONFLICTS OF INTEREST IN CLINICAL PRACTICE AND RESEARCH, *supra* note 1, at 251, 262–71 (discussing the applicability of antitrust law to self-referral); Julie E. Mathews, *The Physician Self-Referral Dilemma:* Enforcing *Antitrust Law as a Solution*, 19 AM. J.L. & MED. 523, 545–46 (1993). Given that the competitive harm associated with ancillary services may be greater in law than in medicine, the argument seems applicable to the law as well.

132. The same point can be made for health insurance companies. Notwithstanding the cost savings associated with avoiding overutilization, health insurers may be poorly motivated to design and implement policies that combat inappropriate self-referral. The political backlash against managed care has demonstrated that physicians and health care consumers desire empowerment. *See, e.g.*, Regina E. Herzlinger, *The Frayed Safety Net*, *in* CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS AND POLICYMAKERS 28, 46 (Regina E. Herzlinger ed., 2004) ("The managed care movement has hit a brick wall of consumer, employer, and political resistance . . . ."). Patients want to play an integral role in their own care, and doctors do not want to be second-guessed by corporate bureaucrats. Insurance companies have an incentive to please their customers so that they continue supplying the company with business. An insurance company that attempts to wage war against consumers' belief that *their own* physician would never refer inappropriately may lose business to competitors who cater to the insureds' irrational requests. *See, e.g.*, Dana & Loewenstein, *supra* note 110, at 254 (concluding that even if patients recognize that some doctors may be inappropriately swayed by financial incentives, most believe that their own doctor would never be biased). Refusals to pay for a recommended ancillary service pit the insurance company against the doctor. Patients are likely to see the insurer's coverage refusals as self-serving, profit-maximizing actions and, if given a choice by their employer, may seek alternative health insurance.

Collective action and free-rider problems may also inhibit insurers from implementing educational initiatives to combat overutilization and provider-induced demand. Since consumers frequently change insurance companies, each company individually lacks the incentive to educate its enrollees on the cost savings (via premium reductions) associated with collectively agreeing to forgo inappropriate referrals. *See* Herzlinger, *supra*, at 44 (stating that, in any given year, 20% of the average insurer's client base consists of new enrollees). If insurer *A* invests in combating its customers' irrational demand, insurer *B*, who later insures these newly enlightened individuals, benefits from *A*'s investment in cultivating rational customers without expending its own resources. The money insurer *B* saves by not educating its enrollees allows it to offer lower premiums that attract more customers. The result may be that no insurance companies are willing to combat their customers' irrational demands with education. For a similar argument in the context of consumers' irrational demand for brand name drugs, see Benjamin

Large corporate clients may have difficulty finding an agent who will selflessly represent the company's interests—the interests of the organization as a whole, rather than the representative's personal interests—when negotiating with a law firm. Although the corporate client may suffer significant financial impact if it uses a law firm's ancillary services unnecessarily, such negative effect on the company's representative is likely to be negligible. However, the personal advantages that flow to the representative from agreeing to use a law firm's ancillary services may be substantial, regardless of whether the law firm's ancillary services are necessary or whether alternative ancillary providers offer superior value. Telling lawyers with whom one has regular contact that one's company has selected alternative consultants or real estate developers might strain business and personal relationships that were painstakingly cultivated over many years. In such a circumstance, it seems likely that, at least at the margins, company representatives may agree to make use of ancillary services when it is in the client's best interest (the best interest of the organization as a whole) to pursue other options.

Even if an impartial agent can be found, a "law firm's client may feel impelled to use the firm's ancillary business . . . for fear of insulting a firm's attorneys and becoming a second-class citizen on legal matters."[133] Competition between firms for clients may be insufficient to eliminate this phenomenon since, after working with a particular client for an extended period, a law firm develops in-depth knowledge of the client's affairs that is indispensable to optimal representation and extremely costly to reproduce in another firm.[134] Finally, although a corporate client may have the requisite sophistication, the financial and opportunity costs associated with immersing itself in the legal affairs handled by outside counsel and evaluating the merits of a referral might be prohibitive.

P. Falit, Curbing Industry Sponsors' Incentive to Design Post-Approval Trials that Are Suboptimal for Informing Prescribers but More Likely than Optimal Designs to Yield Favorable Results (2006) (unpublished manuscript, on file with author).

133. ABA Section of Litigation Report, *supra* note 16, at 11 (cited and criticized in Moore, *supra* note 1, at 181).

134. The same can be said for patients who have seen the same physician for years, but the argument is more powerful in the legal context since patients are generally presumed to be unsophisticated anyway.

IV. PHYSICIANS AND LAWYERS SHOULD BE PROHIBITED FROM REFERRING PATIENTS AND CLIENTS TO ANCILLARY FACILITIES IN WHICH THEY POSSESS AN OWNERSHIP INTEREST

The problem of overutilization discussed in Part III.B.2 demonstrates that professionals' ability to refer patients and clients to self-owned ancillary centers must be regulated in some fashion. Policymakers have adopted three general mechanisms for addressing the problem.[135] First, the AMA has stated that physicians should not refer patients to entities in which they possess an ownership interest unless "there is a demonstrated need in the community for the facility and alternative financing is not available."[136] This model is a partial ban. A second possible approach, reflected in federal and state legislation regulating the medical profession, imposes percentage of ownership limitations, which stipulate that self-referral is improper only if the physician owns more than a predetermined amount of equity in the ancillary facility. Finally, all of the ethical guidelines, legislation, and regulations discussed in Part II use disclosure of conflicts of interest as a protective mechanism designed to alert customers to the potential for bias. Part IV argues that all three types of self-referral regulation are inadequate for preventing the problem of overutilization, and therefore policymakers should ban professional self-referral.

A. The Pro-Competitive Arguments Advanced for Ancillary Ownership Are Not Applicable to Self-Referral

Part III.A examined two persuasive arguments for allowing physicians and lawyers to own equity in ancillary service facilities. Specifically, permitting ancillary ownership would (a) enhance the quality and reduce the cost of professional services, and (b) encourage efficient allocation of capital. This Part demonstrates that those arguments do not support permitting professionals to refer patients to self-owned entities.

As discussed *supra* in Part III.A.1, the argument that ancillary ownership by professionals will enhance quality and reduce costs has two components. Permissive ownership rules (1) provide consumers with integrated services and (2) increase competition by lowering barriers to entry. Advocates of legal entrepreneurialism advance a third point in the context of self-referral (rather than mere ownership of ancillary facilities). They contend that the ability of lawyers to refer their clients to competent ancillary providers will reduce the cost of finding non-legal experts.[137] Once again, the same could be said for patients who, without

135. *See supra* Part.II.

136. AMA Ethical Opinion 8.032, *supra* note 12.

137. Moore, *supra* note 1, at 175 (citing Fitzpatrick, *supra* note 30, at 465, as originating the one-stop-shopping argument).

a referral from their physicians, might be forced to spend significant time and energy finding a rehabilitation clinic or a qualified dietician.[138]

The first of these points—the gestalt theory that the combination of legal or medical services and their ancillary offerings is equal to more than the sum of its parts—does not support the argument that professionals should be permitted to self-refer patients and clients. If physicians and lawyers merely invested in ancillary entities but allowed the consumer to make an unencumbered choice regarding the selection of a facility, then the advantages should still be available.[139] If integration is as beneficial to patients and clients as proponents of self-referral suggest, then clients and insurance companies (and possibly patients themselves) should be able to identify that value and seek out physicians and lawyers who work closely with ancillary entities. Health insurance companies might even provide patients with additional motivation to select entrepreneurial physicians by offering higher reimbursement for integrated networks. Although informational asymmetries may exist,[140] and the incentives of health insurance companies may not be perfectly aligned with the interests of their enrollees,[141] such a problem can be remedied with broadly applied marketing. Physician groups and law firms might advertise to the

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138. This result is especially true in medicine where there is a lack of information about the cost and quality of medical providers. *See, e.g.*, Regina E. Herzlinger, *A Health Care SEC: The Truth, the Whole Truth, and Nothing but the Truth*, *in* CONSUMER-DRIVEN HEALTH CARE, *supra* note 132, at 797, 799–800 (advocating the formation of a medical information regulatory body); David Lansky, *Providing Information to Consumers*, *in* CONSUMER-DRIVEN HEALTH CARE, *supra* note 132, at 419, 422–23 (describing public demand for health care information); J.D. Power III, *The Role of Information: J.D. Power's Paradigm Lessons from the Automotive Industry*, *in* CONSUMER-DRIVEN HEALTH CARE, *supra* note 132, at 410, 414–15 (discussing the public's desire for more information in the context of a warning to the industry of the need to become more consumer focused); Regina E. Herzlinger, *Let's Put Consumers in Charge of Health Care*, HARV. BUS. REV., July 2002, at 50 (advocating a more market-driven approach to health care, which requires greater availability of information regarding the health care system) .

139. The physician or lawyer might offer the patient or client a list of ancillary service providers that she considers to be of high quality and allow the consumer to make the ultimate choice without undue influence.

140. Significant literature suggests that the lack of information pertaining to the quality of health care providers is one of the principal drivers of medical inflation. *See supra* note 138.

141. As mentioned *supra* at note 132, the interests of health insurers and patients are not always aligned. Consider also the fact that, since consumers frequently change employers (and thus often change insurers) insurance companies have little incentive to design innovative plans which encourage beneficiaries to seek high-quality care that is cost-effective over the *long term*. Instead, each firm has a perverse incentive to minimize short-term costs (the cost of care during the period in which a patient is likely to remain insured by the company). If the focus on short-term expenditures increases the overall cost to the system because more expensive care is needed later in life, then it is of little concern to the company since the later costs are borne by the patient's subsequent insurer. In other words, individual insurance companies desire an imperfect market for health care services in which patients have neither the knowledge nor the incentive to make rational purchasing decisions. Insurers prefer to implement supply-side techniques that actively manage overuse but fail to correct for underuse that does not result in *short-term* cost increases. They may therefore refrain from encouraging the selection of physicians who work closely with ancillary providers, even if such integrated networks offer long-term health benefits to the patient. If, however, the short-term benefit outweighs the cost associated with designing and implementing the reimbursement policy, insurers will likely sculpt enrollees' choice.

public generally—rather than a specific patient or client—that integrated services *may* provide certain benefits.[142] While such advertisements present a small risk of overutilization, the threat of overreaching is far less than that associated with self-referral. Broad-based advertisements, unlike personal references, would not provide a professional opinion that using self-owned ancillary facilities would best remedy a particular patient's or client's issues.

The second of these points—that lower barriers to entry will increase competition and decrease costs for patients and clients—is similarly not relevant to self-referral arrangements. Permitting physicians and lawyers to advise their patients or clients to utilize their own ancillary entities may, in fact, inhibit competition and therefore increase prices. By narrowing the options consumers consider, professionals may be able to secure business for their ancillary providers even though an informed patient or client making an unencumbered choice would have preferred an alternative facility.[143] Furthermore, regulatory hurdles that inhibit market entry logically decrease competition and increase price, but may be necessary to ensure quality goods and services. Consider the drug development process, for example. Eliminating the requirement that pharmaceutical manufacturers obtain approval from the Food and Drug Administration before marketing a drug would likely increase competition and reduce the cost of drugs, but such a reform would wreak havoc on quality. In the context of medical and legal entrepreneurialism, the proper question is not whether permitting professionals to refer patients and clients to their own centers will increase competition and decrease prices, but whether the reduction in price outweighs any potential diminution in quality.

The final point—the idea that integrated networks will reduce the cost associated with finding ancillary providers—is also flawed. Any given physician or lawyer is likely to know several different MRI centers, physical therapy offices, accounting firms, or management consultants. The cost associated with referring to an entity in which the professional does not hold an equity interest would likely be no greater than the cost associated with referring to one's own ancillary center. Cost savings would result only in those rare cases where a professional knows of no other qualified providers of ancillary services besides her own. Moreover, the appropriate inquiry is not whether a physician or lawyer can help a patient or client locate *any* ancillary service provider more cheaply, but whether she can help the consumer to secure a *qualified* provider. The argument seems to put the cart before

142. Policymakers should ensure that the advertisements appropriately qualify the claims of benefit. For instance, law firms and physician groups should be prohibited from flatly asserting that integrated services are always better for the patient or client.

143. The argument resembles an antitrust tying claim, where a seller ties the sale of a second product to the sale of the product over which the seller has substantial market power. *See* Morreim, *Conflicts of Interest for Physician Entrepreneurs*, *in* CONFLICTS OF INTEREST IN CLINICAL PRACTICE AND RESEARCH, *supra* note 1, at 263–67. It may be possible to use the Sherman and Clayton Acts' prohibitions on tying arrangements to curb self-referral in the medical profession. *See id.* As discussed *supra* at note 131, the anticompetitive harm may be greater in law than in medicine since lawyers may have greater ability to shift demand away from freestanding providers of ancillary services.

the horse when it assumes that the professional's ancillary offerings are of equal quality to the entities that the patient or consumer could find on her own (or with the help of the insurance company). Although there may be benefits associated with an integrated approach, it is also plausible that the professionals' ability to generate demand will relax the discipline of the market, thereby reducing the quality of their ancillary services. The lack of market-based discipline may decrease the quality of the self-owned entity to an extent that outweighs any benefits conferred by integration.

The second pro-competitive argument advanced for ancillary ownership—that professionals' unique ability to identify market needs will allow the most promising ventures to secure funding—also fails to support self-referral arrangements. The ability to advise one's patients or clients that they should utilize self-owned ancillary providers is generally unnecessary to promote the efficient allocation of capital. If professionals have a unique ability to identify need in the market, then there should be sufficient incentive to invest wisely, regardless of policymakers' view of self-referral. Surely, as the FTC points out, prohibiting self-referral will reduce the extent to which professionals "invest time, money and experience" in ancillary service centers.[144] Additional investment, however, is undesirable if it is prompted by the ability to overutilize ancillary centers and artificially create demand. If a professional has identified a true need in the market, then the business venture should produce a favorable return even without the ability to self-refer.[145]

There is one exception to this general principle that should not be overlooked. If a physician or lawyer cannot refer her patients or clients to self-owned facilities, then she will only seek to satisfy the demand created by the patients or clients of other professionals. As long as the entrepreneur's customers do not comprise a large percentage of the individuals who will require the ancillary service in question, her incentives will be only minimally skewed. If, however, the physician or law firm serves a large percentage of the people who will legitimately make use of the ancillary service, an exception to the ban on self-referral may be warranted. Consider, for example, a physician who believes that all of the MRI centers in his locale are of poor quality and wants to open a new facility that will provide superior service. Suppose that his experiences as a medical provider have left him uniquely situated to identify the need for better quality services. Imagine first that this physician works in New York City and treats less than 0.01% of the population who would benefit from the new MRI center. In this case, the physician has an incentive to open up the facility, regardless of whether he is permitted to refer his own

144. McDowell, *supra* note 1, at 72 (citing FTC Comments to HHS, *supra* note 97).

145. Policymakers should attempt to promote the socially optimum level of investment. If self-referral offers advantages of which this Essay has failed to take account, then policymakers ideally should permit some amount of self-referral. Given the harm that can flow from overutilization and supplier-induced demand, however, it is unlikely that permitting unrestrained and unregulated referral of one's own patients and clients will achieve the optimum level of investment.

patients.[146] Either way, there will be plenty of business. Now imagine that the physician lives in rural Nebraska and treats 60% of the population who would benefit from the new MRI center. In this scenario, the inability to refer her own patients to the new facility might inappropriately deter the physician from building the center in the first place.

This analysis suggests that the need-based exception to the AMA's ban on physician self-referral is overly broad and therefore may prompt overutilization and encourage supra-optimal investment. The next section examines this point in detail.

B. The Need-Based Exception to the AMA's Ban on Self-Referral Is Overly Broad

As discussed in the introduction to Part IV, policymakers have adopted three general mechanisms for addressing the problem of overutilization: (a) the AMA's general ban with a need-based exception, (b) percentage of ownership limitations, and (c) disclosure requirements. This section addresses the first of the three solutions and concludes that it does not adequately protect patients and clients from professionals' conflicts of interest.

The AMA's ethical guidelines state:

> Physicians may invest in and refer to an outside facility, whether or not they provide direct care or services at the facility, if there is a demonstrated need in the community for the facility and alternative financing is not available. Need might exist when there is no facility of reasonable quality in the community or when use of existing facilities is onerous for patients.[147]

A return to the hypothetical case presented in Part IV.A helps to illuminate the flaws in the AMA's policy. In the case of the New York City physician treating 0.01% of the market, self-referral would be permitted since the poorer quality of the existing MRI centers creates a "demonstrated need in the community." Thus, notwithstanding the fact that the ability to self-refer is entirely unnecessary to catalyze investment, the physician entrepreneur would be given the ability to overutilize the self-owned facility.

Even in instances where a physician or lawyer serves a significant percentage of the market likely to use the ancillary service, it is questionable whether the benefits of allowing self-referral outweigh the disadvantages. Unless 100% of the entrepreneur's patients or clients justifiably need the ancillary service and there are no other providers of the service, some risk of overutilization will always exist. One

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146. A physician or lawyer entrepreneur need not worry about losing patients or clients because of her inability to refer customers to superior ancillary facilities. Patients and clients should be permitted to use whatever ancillary entities they desire, even if their physicians or lawyers own equity in the facilities. I merely suggest that professionals should be prohibited from recommending to their patients and clients that a self-owned facility is preferable to an alternative provider.

147. AMA Ethical Opinion 8.032, *supra* note 12, at 189.

must ask whether the harm associated with not meeting the ancillary service needs of consumers outweighs the harm associated with any overutilization of new facilities. Even if a cost-benefit analysis reveals that self-referral is desirable, it may be possible to encourage investment in the facility without permitting the overutilization that inevitably follows from the ability to self-refer. Governmental subsidies in the form of tax exemptions or direct disbursements might achieve the best of both worlds, insofar as they have the power to prompt optimal investment and to reduce the extent of overutilization. The government, or a third party acting on behalf of the government, might ensure that physicians and lawyers provide their patients and clients with impartial information pertaining to the available ancillary centers. If physicians and lawyers fail to provide this information, potential patients or clients might vastly underutilize the new ancillary center because of the investing professional's inability to refer patients or clients to the facility. Indeed, if the provision of unbiased information were perfect, the socially optimal number of patients would use the ancillary facility regardless of the physician or lawyer's ability to self-refer, and there would be no need for governmental subsidization.

In any case, a policy that requires technocrats to determine when there is a "demonstrated need in the community," and therefore whether self-referral is permissible, is unworkable. If an interventional cardiologist contends that her locale is in dire need of a more efficient cardiac catheterization lab, it is doubtful that anyone at the AMA (or anyone else for that matter) will be able to say for sure whether the physician's assertion is correct. It therefore seems preferable to have a much narrower exception to the general ban on self-referral that does not require "experts" to determine whether an entrepreneur's identification of need is legitimate. A limited exception for instances in which a professional treats a sufficiently large percentage of the patients or clients likely to need the ancillary service may be justifiable, but even in such cases, targeted subsidization, or unbiased marketing by neutral third parties, or both, may be preferable because of their capacity to prompt optimal investment without any threat of overutilization.

C. Percentage-of-Ownership Limitations Erroneously Treat the Biasing Effect of Ownership as a Matter of Deliberate Choice

The second mechanism that policymakers employ to curb overutilization, limitation on percentage-of-ownership, also fails to adequately correct the problem. Unlike the ethical promulgations of the ABA[148] and AMA, federal and state laws regulating physician self-referral are premised on the idea that the biasing effect of ownership is a matter of deliberate choice. In other words, the Stark Law and the state statutes and regulations discussed in Part II.B.2 implicitly embrace the notion

148. The ABA seems to have based other ethical promulgations, which have nothing to do with ancillary services, on an erroneous belief that bias is a matter of deliberate choice. Consider, for example, the ABA's stance on gifts to lawyers. MODEL RULES OF PROF'L CONDUCT R. 1.8 cmts. 6–8 (2006). Comment 6, like the legislation regulating physician self-referral, suggests that nominal gifts are not likely to alter lawyers' behavior. *Id.* at R. 1.8 cmt. 6.

that a physician who overutilizes ancillary services in which she owns equity chooses to do something unethical.[149] Consider, for example, the Stark Law's exceptions for referrals to (a) a publicly traded company in which the physician's equity was purchased in the open market and (b) a hospital where the physician possesses an ownership interest in the entire facility.[150] These exceptions assume that some ownership interests will not be large enough to influence individuals' judgment, as if a physician is making a trade-off between the financial benefit of referral and the cost to the patient.[151] The same is true of state statutes and regulations that condition penalties or additional protective mechanisms on the acquisition of a certain percentage of the ancillary facility.[152]

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149. People have a natural tendency to attribute human action to disposition (i.e., conscious choice based on internal, stable preferences), when in reality a host of situational factors interact to produce the behavioral response. This error is so common that social psychologists have named it the "fundamental attribution error." Thus, it is not surprising that federal and state law also succumbs to this erroneous belief. For a thorough discussion of the fundamental attribution error and the policy implications that stem from it, see generally Jon Hanson & David Yosifon, *The Situational Character: A Critical Realist Perspective on the Human Animal*, 93 GEO. L.J. 1 (2004) [hereinafter Hanson & Yosifon, *The Situational Character*] (asserting the important role both internal and external situational influence exert with regard to perceived cognitions, attitudes, will, and behavior); Jon Hanson & David Yosifon, *The Situation: An Introduction to the Situational Character, Critical Realism, Power Economics, and Deep Capture*, 152 U. PA. L. REV. 129 (2003) [hereinafter Hanson & Yosifon, *The Situation*] (discussing the prevalence of the situational character in law and economics, as well as the broader implications of the situational character). Part IV.D.1 discusses how the fundamental attribution error may make disclosure an inadequate remedy to the problem of professional self-referral.

150. 42 U.S.C. § 1395nn(d)(3) (2000 & Supp. 2003).

151. For a similar argument in the context of industry gifts to physicians, see Dana & Loewenstein, *supra* note 110, at 252. Dana and Loewenstein argue that the pertinent ethical guidelines implicitly rely on the assumption that physicians consciously and intentionally make the choice to alter their prescribing behavior, which leads to the erroneous assumption that small gifts will not influence physicians' decision-making. *Id.*

152. *See supra* notes 85–90 and accompanying text (discussing such state laws and regulations) and notes 35–37 and accompanying text (demonstrating that physicians succumb to the same cognitive errors as lawmakers).

Scholars analyzing the problem of self-referral in both medicine and the law have also fallen into the trap of believing that biased decisions (i.e., decisions to inappropriately refer patients) are primarily a matter of conscious choice. Consider the following quote from Nancy Moore:

> [W]hat must be avoided is the essentially circular reasoning used by some traditionalists, in which these important *ethical* concerns are thought to be supported by unsubstantiated presumptions about *professionalism*: that is the apparent belief that doctors and lawyers who are involved in ancillary businesses are less likely than their more "professional" peers to fulfill their fiduciary duties. Thus, physicians who voted to reverse their original vote banning self-referrals apparently did so because they were angered by the implication that they could not be trusted to act professionally in caring for their patients. These physicians understand that it is unethical to recommend unnecessary procedures or to refer patients to inappropriate facilities; however, they "object to the implication that every physician that [sic] is involved in investing in some kind of facility is guilty of a violation of ethics."

Moore, *supra* note 1, at 178–79 (citations omitted). Part IV.C of this Essay seeks to demonstrate that doctors (and lawyers) who own equity in ancillary businesses are, in fact, more likely than their non-conflicted peers to unintentionally and unconsciously refer patients to ancillary providers when there

A substantial body of literature in the field of social psychology suggests that, contrary to the implicit assumption in much of the federal and state self-referral law, small equity stakes may influence physicians as much as large ownership interests.[153] The relevant literature conveys three principal messages.[154]

First, studies have shown that even when individuals are motivated to be objective they have difficulty remaining impartial, suggesting that self-serving bias is unintentional.[155] Loewenstein, Issacharoff, Camerer, and Babcock performed a series of experiments that tested the notion of self-serving bias.[156] In these studies, subjects were presented with identical materials from an actual lawsuit and were randomly assigned the role of plaintiff or defendant.[157] Researchers paired the subjects and asked them to negotiate a settlement in the form of a payment from defendant to plaintiff.[158] The defendant was provided with money to fund the settlement.[159] Both parties suffered financial penalties for dilatory negotiations.[160] If the subjects failed to reach an agreement, a neutral third party determined the amount of the settlement.[161] Prior to negotiating, researchers asked the subjects to predict how a judge would rule in the case and compensated the subjects in accordance with their accuracy.[162] Notwithstanding a financial incentive to remain impartial and predict accurately (the predictions had no effect on the outcome of the settlement), plaintiffs' predictions of the amount the judge would likely award them were substantially higher than those of defendants.[163]

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is no genuine need. Contrary to physicians' assertions, no matter how good one's intentions are, it is likely impossible for a physician or lawyer to remain uninfluenced by financial conflicts of interest. To be fair, Nancy Moore does recognize this somewhat when she writes: "Similarly, at a minimum, disclosure should also be required whenever a self-referring physician has a *significant* economic stake in the facility in question, since there is unquestionably a substantial risk that the decision to refer will be affected—either consciously *or unconsciously*—by the physician's own financial interest." Moore, *supra* note 1, at 179–80 (emphasis added). Professor Moore mentions that the bias may be unconscious and hence unintentional, but her focus on the substantiality of the ownership interest cuts against this realization. *See* Moore, *supra* note 1, at 179–80 & 192 n.98.

153. Dana and Loewenstein, *supra* note 110, at 253, summarize some of the most applicable research. Although their paper is focused on industry gift-giving, the conceptual framework is equally as applicable to professional self-referral.

154. *Id.*

155. *Id.*

156. Linda Babcock & George Loewenstein, *Explaining Bargaining Impasse: The Role of Self-Serving Biases*, 11 J. ECON. PERSP. 109, 111–12 (1997); Linda Babcock, George Loewenstein, Samuel Issacharoff & Colin Camerer, *Biased Judgments of Fairness in Bargaining*, 85 AM. ECON. REV. 1337, 1338 (1995); George Loewenstein, Samuel Issacharoff, Colin Camerer & Linda Babcock, *Self-Serving Assessments of Fairness and Pretrial Bargaining*, 22 J. LEGAL STUD. 135, 145 (1993) [collectively hereinafter *Bargaining Studies*].

157. Dana & Loewenstein, *supra* note 110, at 253 (discussing *Bargaining Studies*, *supra* note 156).

158. *Id.*

159. *Id.*

160. *Id.*

161. *Id.*

162. *Id.*

163. *Id.*

This result suggests that physicians and lawyers who overutilize ancillary facilities in which they have an ownership interest are likely doing so unintentionally. In other words, like the litigant who erroneously estimates the amount that she is likely to recover or pay out during negotiations, the professional who improperly refers a patient or client to her ancillary provider likely believes that her judgment is sound—that the referral is nothing less than entirely proper.

The second key insight from the social psychology literature is the idea that it is impossible for people to avoid succumbing to bias.[164] Even when the financial incentive associated with bias is minimal (as in small equity interests in ancillary facilities) and individuals are instructed to be aware of partiality, they still have tremendous difficulty behaving objectively. In follow-up research to the study just discussed, researchers attempted to reduce partiality by educating the subjects.[165] They described the tendency for self-serving bias in detail and tested subjects to ensure comprehension.[166] Although the subjects became convinced that their negotiating opponents would exhibit bias, the subjects believed that they themselves would not.[167] The minority of subjects who admitted that they might exhibit bias during the experiment drastically underestimated the extent of such bias.[168] This research suggests that educational initiatives designed to inform physicians and lawyers that even small equity stakes in ancillary facilities can promote bias are unlikely to actually reduce the extent of overutilization. Regardless of the amount of debate surrounding the propriety of ancillary service ownership and self-referral, physicians and attorneys are unlikely to recognize that they are unintentionally overutilizing their own facilities.

Finally, social science research suggests that "self-interest affects choices indirectly, changing the way individuals seek out and weigh the information on which they later base their choices when they have a stake in the outcomes."[169] When subjects were assigned the role of plaintiff or defendant after reading the case materials (thereby preventing any bias during the actual processing of the materials) bias was reduced and settlement rates increased.[170] Like the subjects reading the case materials, physicians and lawyers are likely to unintentionally and unconsciously construe the medical and legal "evidence" they collect from their patients and clients in ways that ultimately lead them to believe that their patients and clients are in need of ancillary services. The inability to interpret evidence in an unbiased fashion is likely the reason why people find it so difficult to remain impartial, even if they have a financial incentive to do so. Once the subject has read

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164. *Id.*

165. Linda Babcock, George Loewenstein & Samuel Issacharoff, *Creating Convergence: Debasing Biased Litigants*, 22 LAW & SOC. INQUIRY 913, 917–18 (1997) [hereinafter *Debiasing Biased Litigants*].

166. Dana & Loewenstein, *supra* note 110, at 253 (discussing *Debiasing Biased Litigants*, *supra* note 165, at 917–18).

167. *Id.*

168. *Id.*

169. *Id.*

170. *Id.*

the materials while wearing her plaintiff's or defendant's hat, the damage is done; unintentional, unconscious bias will persist, regardless of the ameliorative efforts undertaken by others. The damage is similarly irreversible once a physician or lawyer—subconsciously understanding that referrals to ancillary facilities generate additional revenue—has interviewed a patient or client. As the professional is entirely unaware and is unlikely ever to be made fully aware of the biased nature of her decision-making, regulatory policies based on a framework of deliberate choice seem misguided.

Disclosure requirements, the third and final mechanism that policymakers employ to curtail overutilization, also fail to adequately correct the problem. Like percentage-of-ownership limitations, disclosure requirements fail to take account of pertinent social psychology literature and rely on a fundamental misconception of human behavior.

D. Disclosure Requirements May Be Counterproductive

All of the ethical, legislative, and regulatory responses to self-referral examined in Part II rely, at least in part, on the assumption that professionals' disclosures of their conflicts of interest can significantly mitigate, if not entirely eliminate, the problem of overutilization. Model Rule 1.8(a) states that business relationships between lawyers and clients (such as a referral to a self-owned ancillary center) are acceptable only if the lawyer fully discloses the details of the transaction (e.g., the nature of the financial conflict of interest) and the client provides written, informed consent.[171] Similarly, the AMA's Ethical Opinion 8.032 argues that, when a medical need that otherwise would go unfilled justifies self-referral arrangements, disclosure will help to prevent overutilization.[172] Finally, the physician self-referral laws in about a dozen states use disclosure to patients as a way of curbing inappropriate referrals.[173]

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171. MODEL RULES OF PROF'L CONDUCT R. 1.8(a) (2006).

172. *See* AMA Ethical Opinion 8.032, *supra* note 12, at 189.

> Physicians should disclose their investment interest to their patients when making a referral, provide a list of effective alternative facilities if they are available, inform their patients that they have free choice to obtain the medical services elsewhere, and assure their patients that they will not be treated differently if they do not choose the physician-owned facility . . . .

Id.

173. *See* Berthard, *supra* note 72, at 479 app. A (summarizing state legislative approaches to physician self-referral). Many scholars also suggest that, at least for the legal profession, disclosure is an adequate solution. *See, e.g.*, Moore, *supra* note 1, at 180–81 (arguing that disclosure is likely sufficient in law but not in medicine since the presence of first party insurance in the latter but not in the former renders patients less value conscious than legal clients); Schneyer, *supra* note 41, at 377 (contending that, in the legal profession, disclosure is sufficient to protect sophisticated corporate clients).

A large body of social science research demonstrates that disclosure may be an ineffective solution to professionals' conflicts of interest.[174] This conclusion is true for two principal reasons. First, disclosure can only be effective if patients and clients understand the extent to which they should discount the advice of their doctors and lawyers when told that the professionals have a financial incentive to make referrals to a particular ancillary facility.[175] Evidence suggests, however, that individuals fail to sufficiently discount the advice they receive from partial advisors.[176] Second, research suggests that mandatory disclosure of conflicts of interest may increase the extent to which conflicted individuals offer biased advice.[177] Thus, not only may disclosure requirements for professionals fail to curb overutilization, the requirements may exacerbate the problem as doctors and lawyers inappropriately refer more patients and clients than they would in a system in which disclosure was not mandated.

1. The Effect of Disclosure on the Receivers of Advice

The receivers of professional advice may have trouble sufficiently discounting the advice they receive from conflicted physicians and lawyers because of three psychological phenomena: "(1) [the] difficulty of judgmental correction, (2) [the] failure of evidentiary discreditation," and (3) the fundamental attribution error.[178]

The first phenomenon speaks to the idea that it is difficult to quantify the extent of an advisor's partiality, and when in doubt, people tend to err on the side of less bias. Cain, Loewenstein, and Moore conducted a study in which subjects answered questions on a variety of topics such as the population of the United States.[179] Participants increased their chances of receiving additional remuneration by answering the questions correctly. The researchers provided the subjects with an "anchor value" that was either 50% higher or 50% lower than the actual population

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174. Daylian M. Cain, George Loewenstein & Don A. Moore, *Coming Clean but Playing Dirtier: The Shortcomings of Disclosure as a Solution to Conflicts of Interest, in* CONFLICTS OF INTEREST: CHALLENGES AND SOLUTIONS IN BUSINESS, LAW, MEDICINE, AND PUBLIC POLICY, *supra* note 123, at 104, 108–19 [hereinafter Cain et al., *Coming Clean*] (presenting evidence from social science studies that demonstrates the potential inadequacy of disclosure as a solution to conflicts of interest). The present section of this Essay applies the work of Cain, Loewenstein, and Moore to the specific context of ancillary services in law and medicine.

175. *See id.* at 109.

176. *Id.* at 108–14.

177. *Id.* at 114–16.

178. *Id.* at 108. Part IV.D assumes arguendo that the act of disclosure causes the advisee to discount the advisor's recommendations *to some extent.* Although researchers have never empirically examined the issue, it is questionable whether it is, in fact, true that physicians' and lawyers' disclosures actually serve as a warning that increases patients' and clients' scrutiny of the referral. It seems equally plausible that disclosure engenders trust by demonstrating the professional's desire to be honest and up front with the patient or client. If this is true, then disclosure may actually reduce the scrutiny that patients and clients give to referrals, thereby increasing the likelihood of overutilization and supplier-induced demand. *See id.* at 117.

179. *See* Cain et al., *Coming Clean*, *supra* note 174, at 111 (summarizing the study's results).

of the United States.[180] Researchers told the subjects who received the high anchor that someone who had an interest in getting them to provide an answer that is artificially high created the anchor value.[181] Similarly, researchers told those who received the low anchor that the individual who created the anchor wanted them to provide an answer that is artificially low.[182] The results showed that, notwithstanding full disclosure that a biased party created the anchors, subjects failed to sufficiently discount the extent of the bias.[183] Individuals in the high anchor group provided significantly higher estimates than those in the low anchor group.[184] This result suggests that patients and clients may systematically underestimate the extent to which a referral to an ancillary facility is based on improper financial motives. The two psychological processes described next help to shed light on why individuals may be prone to such systematic error.

The second phenomenon relates to the idea that people have difficulty discrediting or "unlearning" false or misleading information, even when they are fully convinced that discrediting such information is in their best interests.[185] Moreover, over time people may increasingly believe in the truth of something they previously knew was false as their memory of the unreliability of the source of the information fades.[186] This research has significant implications for the ability of patients and clients to make informed choices about the extent of a professional's bias. It will likely be difficult for patients and clients to unlearn all of the information that their physician or lawyer conveyed when the patient or client was not aware of the conflict of interest. For instance, imagine that two weeks before suggesting to a client that she seek an opinion from the law firm's chief management consultant, an attorney mentioned some of the potential synergies that can flow from combining legal analysis and management consulting under one roof. When the attorney later tells the client of her ownership interest in the consulting firm to which she is referring the client (as Model Rule 1.8 demands),[187] the client will have difficulty discrediting her previous conversations with the lawyer. Imagine now that the general conversation surrounding synergies took place several years earlier, and that the client doubted the attorney's statements at the time because of her own experience in management consulting. Given the amount of time that has elapsed since the conversation about synergies, the attorney's referral may bring back the memory of the discussion without the associated disbelief the client experienced at that time.

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180. *Id.* at 111.

181. *Id.*

182. *Id.*

183. *Id.* at 111–12.

184. *Id.*

185. *See, e.g.*, Amos Tversky & Daniel Kahneman, *Judgment Under Uncertainty: Heuristics and Biases*, 185 SCIENCE 1124, 1126 (1974) (discussing the "illusion of validity" which occurs when there is a close "fit between [the] predicted outcome and the input information").

186. Anthony R. Pratkanis, Anthony G. Greenwald, Michael R. Leippe & Michael H. Baumgardner, *In Search of Reliable Persuasion Effects: III. The Sleeper Effect is Dead. Long Live the Sleeper Effect.*, 54 J. PERSONALITY & SOC. PSYCHOL. 203, 205, 216 (1988) (citations omitted).

187. MODEL RULES OF PROF'L CONDUCT R. 1.8 (2006).

The final psychological phenomenon is one that appears elsewhere in this Essay—the fundamental attribution error.[188] People generally presume that conscious choice based on internal, stable preferences directs human actions, but research indicates that a variety of situational factors influence human behavior.[189] In other words, people have a tendency to erroneously believe that others act in ways that are consistent with their "true selves" and not according to situational pressure. Since patients and clients generally view their physicians and attorneys as "good people" (otherwise they would seek out new ones), they likely have trouble attaching biased motives to referrals by their physicians and attorneys. The fundamental attribution error makes it difficult to see that lawyers and doctors attempting to overutilize their ancillary facilities are not manipulating patients and clients based on pure greed, but rather are subconsciously swayed by financial conflicts of interest that surreptitiously sneak into the psyche.

2. *The Effect of Disclosure on the Providers of Advice*

Although proponents of disclosure often assume that it will either have no effect on the advice given or will improve the quality of advice by alerting the advisor to the fact that others are watching,[190] evidence from the social psychology literature suggests otherwise. Cain, Loewenstein and Moore conducted an experiment in which subjects were randomly assigned to the roles of estimator and advisor.[191] Estimators were responsible for estimating how much money was in several jars of coins that they saw briefly and from a distance and were compensated in relation to their accuracy.[192] Advisors were able to examine the jars closely and were responsible for recommending values to estimators.[193] Researchers gave some of the advisors a conflict of interest by paying them in accordance with how high above the actual value each estimator guessed.[194] When these advisors were forced to disclose their incentives, their advice was higher than when no disclosure of incentives was required.[195] More importantly, disclosure of the advisors' conflicts of interest caused estimators to make significantly more errors.[196] In other words, the degree to which the estimators discounted advice because of the

188. *See supra* notes 37 and 149 and accompanying text. Cain, Loewenstein, and Moore refer to this phenomenon as the "representative heuristic" and "lay dispositionism," but the point is the same. *See* Cain et al., *Coming Clean*, *supra* note 174, at 113–14.

189. For a detailed discussion of the fundamental attribution error, see generally Hanson & Yosifon, *The Situational Character*, *supra* note 149; Hanson & Yosifon, *The Situation*, *supra* note 149.

190. *See* Stark, *supra* note 123, at 155–56 (noting that disclosure merely invites the patient or client to judge the professional's character).

191. Daylian M. Cain, George Loewenstein & Don A. Moore, *The Dirt on Coming Clean: Perverse Effects of Disclosing Conflicts of Interest*, 34 J. LEG. STUD. 1, 8 (2005) [hereinafter Cain et al., *The Dirt on Coming Clean*].

192. *Id.* at 8–10.

193. *Id.* at 8–9.

194. *Id.* at 8.

195. *Id.* at 13–14.

196. *Id.* at 17.

disclosure (which, as demonstrated in Part IV.D.1, is likely to be insufficient) was outweighed by the advisors' tendencies to alter their recommendations.

There are three reasons why disclosure requirements may cause professionals to offer more biased recommendations than they would in a system without such requirements. First, physicians and lawyers referring patients to ancillary services in which they own equity may engage in "strategic exaggeration."[197] If professionals fear that disclosure will cause patients and clients to question whether a referral is in their best interests, they may consciously or subconsciously try to counteract this affect by further skewing their advice. As Cain, Loewenstein, and Moore aptly put it, "disclosure might warn an audience to cover its ears, [but] it also may encourage advisors to yell even louder."[198]

Second, physicians and lawyers may be upset by the tacit implication of disclosure requirements—that professionals are prone to pursuing their own interests before those of their patients or clients—and therefore "feel entitled to behave in ways that [their] personal ethical code might otherwise have prohibited."[199] Even with factual proof, it is extraordinarily difficult to convince someone that she has exhibited, or will exhibit, unconscious bias.[200] Many physicians and lawyers therefore view disclosure requirements as unfair to the vast majority of professionals who behave ethically, and perhaps some even see it as an insult to their profession.[201] Given this sense of betrayal, it is reasonable to hypothesize that physicians and lawyers feel entitled to engage in a certain amount of overutilization.[202]

The final reason why disclosure may render more biased advice involves a psychological phenomenon called "moral licensing."[203] If physicians and lawyers believe that disclosure adequately looks out for patients' and clients' interests, then they may be less vigilant in ensuring that they can justify their referrals. In moral licensing, the concern is not that professionals feel cheated by a system that requires disclosure, as was the case in the previous paragraph, but that disclosure requirements may lull physicians and lawyers into complacency, falsely convincing them that external checks will protect against overutilization.

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197. Cain et al., *Coming Clean*, *supra* note 174, at 115.

198. *Id.*

199. Dale T. Miller, *Psychologically Naive Assumptions About the Perils of Conflicts of Interest*, *in* CONFLICTS OF INTEREST: CHALLENGES AND SOLUTIONS IN BUSINESS, LAW, MEDICINE, AND PUBLIC POLICY, *supra* note 123, at 126, 128.

200. *See supra* Part IV.C.

201. *See supra* notes 35–37 and accompanying text. It is likely that the policies discussed in Part IV.C, as well as scholars' general belief that the biasing effect of ownership is a matter of conscious choice, contribute to professionals' indignation. Since the bias is seen as willful, an allegation of overutilization is an implicit accusation of misconduct. See Dana & Loewenstein, *supra* note 110, at 252, for a similar argument in the context of industry gift-giving to physicians.

202. It is important to note that there is no empirical literature to support the idea that physicians and lawyers will consciously alter their advice because they are disgruntled with the implications of disclosure requirements. This idea is merely one explanation for the results of the coin jar experiments discussed *supra* at notes 191–96 and accompanying text.

203. Cain et al., *Coming Clean*, *supra* note 174, at 115–16.

V. CONCLUSION

Although traditionalists have marshaled many arguments against medical and legal entrepreneurialism, only one of them—overutilization—should be of significant concern to policymakers. Advocates of physician- and lawyer-owned ancillary facilities have similarly offered a number of reasons why entrepreneurialism should be embraced rather than regulated and shunned. None of these arguments, however, speak to the actual process of referring patients to one's own facilities. A system that bans self-referral entirely can fully realize all of the pro-competitive benefits.

The ethical bodies regulating the medical and legal professions, as well as federal and state legislatures, have tried to create a compromise which permits self-referral but subjects it to strict ownership limitations and disclosure requirements. Social psychology research, however, suggests that such restrictions are unlikely to reduce overutilization, and may even exacerbate the problem. As bias induced by monetary interests is unconscious and unintentional, ethical guidelines and laws are unlikely to have much of an impact on the extent to which professionals inappropriately refer patients. This probable result suggests that all self-referral arrangements in both medicine and law should be flatly prohibited. The AMA's policy comes closest to doing this, but errs in its exemption of facilities for which there is a "demonstrated need in the community." Such an exemption is generally not needed to encourage optimal investment and is unworkable because of its reliance on technocratic expertise that regulators are unlikely to possess.

Physicians and lawyers should be permitted to own equity in any business they desire, but they should be forbidden from advising their patients and clients to use ancillary services in which they possess an ownership interest. If a patient or client independently seeks out an ancillary entity in which her physician or attorney owns equity, one can assume the professional has not artificially generated the demand for such services, and the relationship should be permitted. Although a narrowly drawn exception to the general ban may be warranted for professionals who serve a large percentage of the customers likely to require the ancillary service, targeted subsidization, impartial marketing of available ancillary facilities, or both may better serve society's dual interests of promoting efficient investment and limiting overutilization.