REPORT TO THE CONGRESS

A Proposal For Disclosure Of Contractual And Financial Arrangements Between Hospitals And Members Of Their Governing Boards And Hospitals And Their Medical Specialists

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives

This report discusses the need for disclosing contractual and financial arrangements between hospitals and members of their governing boards and hospitals and their medical specialists.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States

Contents

ABBREVIATIONS

AHA	American Hospital Association
AMA	American Medical Association
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
JCAH	Joint Commission on Accreditation of Hospitals

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

A PROPOSAL FOR DISCLOSURE OF CONTRACTUAL AND FINANCIAL ARRANGEMENTS BETWEEN HOSPITALS AND MEMBERS OF THEIR GOVERNING BOARDS AND HOSPITALS AND THEIR MEDICAL SPECIALISTS

Department of Health, Education, and Welfare

D I G E S T

WHY THE REVIEW WAS MADE

GAO reviewed arrangements between hospitals and members of their governing and advisory boards and key employees and between hospitals and hospital-based specialists--such as radiologists and pathologists--to determine what type of information would be made public if a disclosure requirement was included in legislation.

GAO reviewed such arrangements at 19 hospitals in the Washington, D.C., metropolitan area; and in the cities or metropolitan areas of Kansas City, Springfield, and St. Louis, Missouri.

FINDINGS AND CONCLUSIONS

Many views have been expressed on public accountability of public and quasi-public organizations. This issue, as it affects the typical community nonprofit hospital, has recently received the attention of the courts, the Congress, State and local governments, the news media, and the general public.

Because overlapping interests of hospitals' governing board members or key employees may detrimentally affect hospital costs and general administration, there have been suggestions that such arrangements be made public.

The American Hospital Association has issued suggested policy statements to member hospitals, including written disclosure of possible conflicts of interest by every officer and employee with administrative responsibilities.

Outright conflict-of-interest relationships involving officials of both corporations and public nonprofit institutions are dealt with to varying extents by State legislation.

Corporation statutes of several States provide that self-dealing arrangements are voidable when interested parties participate in the transaction without making full disclosure of their interest. (See p. 2.)

In addition to making public the overlapping interests of hospitals' governing and advisory board members and employees, suggestions have been made for publicly disclosing arrangements between hospitals and their hospital-based medical specialists.

Overlapping interests of governing and advisory boards

GAO found arrangements involving overlapping interests at 17 of the 19 hospitals reviewed. The extent and nature of overlapping interests varied, although the following conditions were observed:

--The most frequent arrangement involved trustee or advisory board members who were associated with banking, investment, or legal firms serving the hospitals. At least 1 trustee at 14 of the hospitals was identified with such a firm.

GAO found little evidence that these arrangements increased hospital costs. In fact, they may have been beneficial by fostering favorable loan arrangements and expert management of hospital assets.

In some cases, individuals and/or their companies made donations to the hospital far exceeding any financial gains that could have been realized from such arrangements. (See pp. 12 to 14.)

--At 6 of 13 hospitals reviewed in Missouri, members of hospitals' governing or advisory boards included officials of local newspapers and of public utilities, such as telephone or power companies, with whom the hospital necessarily did business.

Such business relationships are practically unavoidable and there is no basis for precluding representatives from these important segments of the community from serving on hospital governing or advisory boards, providing such appointments are made public.

--At one hospital in the District of Columbia, a former employee was president of the hospital's contracted computer services firm and served as a consultant to the hospital.

There was no record of competition on the original contract and this relationship may give the firm an advantage over potential competitors in subsequent contract awards.

--Governing board members at three hospitals were associated with insurance companies doing business with the hospitals. At 1 of these hospitals, 4 of the 15 board members had this type of overlapping financial interest. (See pp. 10, 11, and 14.)

Other financial transactions between hospitals and members of their governing or advisory boards included those with construction firms; suppliers of drugs, bedding, electric and plumbing supplies, and uniforms; and financial or data processing services. Many of these procurements were competitively awarded; others involved expenditures of less than $1,000 a year.

Prohibiting the above types of overlapping interests is not practicable. However, since such arrangements are common in hospitals, public confidence in these institutions may be enhanced if the issue of overlapping interests were faced openly through public disclosure, including a statement of the extent of competition involved in acquiring goods and services.

Arrangements with hospital-based specialists

Many U.S. hospitals retain full- or part-time specialists. GAO reviewed the arrangements of radiologists and pathologists who are usually retained to direct the hospital's X-ray and laboratory departments, respectively.

Ordinarily, hospitals contract their specialists. Specific arrangements between hospitals and specialists and specialists' affiliations with firms serving the hospitals may affect the costs and quality of services the specialists provide.

GAO's review of contractual arrangements with pathologists at 17 hospitals and radiologists at 13 hospitals to identify features of the arrangements dealing with finances, control, and other issues amenable to public disclosure showed that:

--In 27 instances, hospitals provided the specialists with space, equipment, maintenance, and nonphysician personnel; in 2 instances, the specialists leased space; in the other instance, the hospital sent out its laboratory work. (See pp. 18 and 23.)

The American Hospital Association has stated that lease arrangements may result in a loss of effective administrative control over services for which the hospital's governing authority is responsible. (See p. 22.)

--In 25 instances, patient charges for the specialists' services were determined by the hospital, jointly by the hospital and specialists, or by the specialists subject to hospital approval. In the other five instances, the specialist-determined patient charges were not subject to hospital approval. (See pp. 18, 23, and 24.)

--The most common method of compensating the specialists--used in 13 instances--was to pay a percentage of the adjusted gross income of the specialists' department. Under this arrangement the pathologists and radiologists had average annual incomes of $80,100 and $60,300, respectively.

Under the salary arrangement used in six instances, the pathologists and radiologists received annual incomes of $26,600 and $33,200, respectively. (See pp. 23 and 26.)

The American Hospital Association has stated that, because the specialist under a percentage of adjusted gross income arrangement compensates needed colleagues, the specialist is understandably reluctant to accept the reduction in personal income necessary to provide their services.

--Specialists at most hospitals were permitted to simultaneously carry on outside medical practice; however, in some cases hospital permission was required. (See pp. 18, 19, and 24.)

In nine instances, specialists' services were provided by specialists or specialists' groups who also provided similar services to other hospitals.

--One or more pathologists at 4 of the 17 hospitals were affiliated with or had an interest in firms providing services to their hospitals outside the scope of the basic agreement.

None of the radiologists at 13 hospitals were affiliated with or had an interest in firms providing services to their hospitals outside the scope of the basic agreement. (See pp. 19 and 24.)

Because hospital-based specialists enjoy a virtual monopoly regarding patient services within their specialties, hospitals should publicly disclose their contractual arrangements with these specialists regarding

--furnishing of support facilities and personnel,

--establishing of patient charges for X-ray and laboratory services,

--method of compensating specialists and amounts paid,

--any limitations on specialists' outside medical practices, and

--other financial dealings between hospitals and specialists or firms in which the specialists have financial interests.

RECOMMENDATIONS OR SUGGESTIONS

This report contains no recommendations or suggestions.

AGENCY ACTIONS AND UNRESOLVED ISSUES

The Department of Health, Education, and Welfare said that the report provided useful information and concurred with GAO's recommendation to the Congress.

The American Hospital Association said that, although the issues raised were important, existing legislation and regulations or those under development could deal with them; therefore, a public disclosure requirement was neither justified nor necessary.

The Association also stated that disclosing the types of contractual relationships with hospital-based specialists would be useful, but it felt that it was unnecessary to disclose specific amounts paid.

The American College of Radiology and the College of American Pathologists stated that neither the types of contractual relationships between hospital-based specialists and hospitals nor the amounts paid contracted specialists should be disclosed.

The American Medical Association stated that neither overlapping interests of hospitals and hospital board members nor contractual arrangements between hospitals and medical specialists should be disclosed.

Comments of the Department of Health, Education, and Welfare and others and GAO's evaluation are in chapter 4.

MATTERS FOR CONSIDERATION BY THE CONGRESS

The Congress should consider amending the Social Security Act to require hospitals, as a condition for participating in Medicare, Medicaid, and Maternal and Child Health and Crippled Childrens' Services, to make publicly available information disclosing

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--the hospitals' arrangements with hospital-based specialists.

Such a provision should also be considered for inclusion in any national health insurance program legislation.

Tear Sheet

CHAPTER 1

INTRODUCTION

Almost 50 percent of the approximately 7,700 hospitals in the United States are nongovernmental nonprofit institutions; about 31 percent are nonprofit institutions controlled by State or local governments; and about 14 percent are profitmaking institutions. The remaining 5 percent are owned and operated by the Federal Government.

Standards for hospital operations are established by the Joint Commission on Accreditation of Hospitals (JCAH), consisting of representatives of the American Medical Association (AMA), the American Hospital Association (AHA), the American College of Surgeons, and the American College of Physicians. JCAH standards apply to various aspects of hospital management and operation and encourage voluntary attainment of uniformly high standards of hospital medical care.

Compliance with the recommended standards is JCAH's primary criterion for accrediting Federal and non-Federal hospitals. Generally, non-Federal institutions accredited by JCAH are deemed to meet the eligibility requirements for participating in the federally financed Medicare program.[1] About 70 percent of the 6,750 hospitals participate in Medicare on the basis of their JCAH accreditation. Other hospitals are accredited on the basis of Medicare inspections performed by State agencies under agreements entered into with the Secretary, Department of Health, Education, and Welfare (HEW).

AHA, an organization of hospitals and related institutions, supports educational and research programs pertinent to the health care field. Recently AHA has publicized a policy requiring disclosure of overlapping interests of its trustees, officers, and employees and has encouraged member hospitals to adopt similar policies.

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[1]Hospitals must be eligible to participate in Medicare in order to participate in Medicaid.

The phrase "overlapping interest" is used throughout this report to mean the holding by a hospital board member or employee of a position or of a financial interest in any concern (1) from which a hospital secures goods or services or (2) which competes with the hospital for the delivery of medical care. A hospital board member or employee who provides consulting or other services to any outside concern doing business with the hospital is also considered to have an overlapping interest.

Overlapping interest relationships involving officials of corporations and public nonprofit institutions have been covered by some State legislation. Most States consider the trustee of either a public or private hospital a fiduciary--a person in a special position of trust and accountability--and at least one State has legislation requiring the trustees, directors, and officers of nonprofit hospitals to make public disclosure of significant business transactions between the hospital and business entities in which such persons have a financial interest. The District of Columbia has a statute prohibiting personal financial gain from transactions between charitable institutions and members of their governing boards, and corporation statutes of several States provide that self-dealing arrangements are voidable when interested parties participate in the transaction and full disclosure of an interest is not made.

The United States District Court for the District of Columbia in July 1974 held that trustees of a nonprofit hospital in the District breached their fiduciary duty to supervise the management of the hospital's investments.[1]

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[1] In David M. Stern, et al. v. Lucy Webb Hayes National Training School for Deaconesses and Missionaries, et al. 381 F. Supp. 1003 (D.C.D.C. 1974), the plaintiffs contended, among other things, that defendants maintained unnecessarily large amounts of the hospital's money on deposit with banks and savings and loan associations, drawing inadequate or no interest. The Court stated that the hospital maintained much of its liquid assets in savings and checking accounts rather than in Treasury bonds or investments and found that the defendant trustees had breached their fiduciary duty to supervise the management of the hospital's investments.

The Court ordered that each hospital trustee shall disclose in writing to the full board of trustees his or her affiliations, if any, with any bank, savings and loan association, investment firm, or other financial institution presently doing business with the hospital and shall thereafter quarterly amend such writing to reflect any changes.

The Court also ordered that the auditors of the hospital shall, for a period of 5 years, incorporate into each annual audit a written summary of all business conducted during the preceding fiscal year between the hospital and any bank, savings and loan association, investment firm, or other financial institution with which any hospital officer or trustee is affiliated as a trustee, director, partner, general manager, principal officer, or substantial stockholder and shall make a copy of the audit reports available on request for inspection by any patient of the hospital at the hospital's offices during business hours.

The Congress has expressed concern over the public disclosure of financial arrangements between hospitals and their boards of trustees and hospitals and their medical specialists. For example, in March 1973 a Member of Congress suggested that the Congress could require administrators of any hospital providing services under a Federal program to disclose, among other things:

--The name of every hospital trustee, his business, and any amount paid to him or firms in which he has a financial interest for goods or services provided to the hospital during the past year.

--Evidence that goods or services were purchased by the hospital on the basis of competitive bids.

--The details of the current financial arrangements between the hospital and its medical specialists.

SCOPE OF REVIEW

This review included 5 nonprofit hospitals and 1 profitmaking hospital in the Washington, D.C., metropolitan area and 13 nonprofit hospitals in the cities or metropolitan areas of Kansas City, St. Louis, and Springfield,

Missouri. We (1) identified areas where overlapping interests existed between hospitals and members of their governing and advisory boards and (2) determined what compensation arrangements existed between the hospitals and certain hospital-based medical specialists. At the Washington area hospitals, we also identified overlapping relationships between hospitals and key employees.

We did not attempt to evaluate the propriety or reasonableness of a particular overlapping arrangement. We have identified and described the type of information that would be publicly disclosed were a disclosure requirement established.

Selection of hospitals

The Washington area hospitals were selected on the basis of (1) the request of one hospital official for us to review its activities and (2) an attempt to obtain a cross section by type of control--e.g., university affiliated, local government, church, and proprietary. In Missouri the hospitals were selected to coincide with an earlier congressional request for information on hospital laboratories where the selection was made in consultation with the requestor.

CHAPTER 2

OVERLAPPING INTERESTS EXIST IN MOST HOSPITALS

Arrangements involving overlapping interests existed at 17 of the 19 hospitals. The type and extent of overlapping interest varied at each hospital; however, governing or advisory board members associated with banks or investment or legal firms doing business with the hospital occurred most frequently. Some of these relationships probably benefited the hospitals by fostering favorable loans and expert management of hospital assets. In other instances, members of governing or advisory boards included officials of local newspapers or of public utilities with whom the hospital necessarily did business. In following sections we discuss (1) the composition of hospital governing and advisory boards and (2) the overlapping interests at the 17 hospitals.

GOVERNING AND ADVISORY BOARDS

One of the JCAH standards provides that the hospital governing function be carried out by a designated body of trustees or directors who are responsible for insuring that high quality patient care is provided. The hospital may also establish an advisory body to assist in the decision-making process, but generally advisory board members do not have voting authority.

JCAH recommends that the hospital governing and advisory body include a broad representation of the community served by the hospital and that membership be based on the member's ability to participate effectively in fulfilling the governing body's responsibilities. Specific background criteria for board members are not stated.

The boards of the nonprofit hospitals we reviewed generally were composed of community business leaders who had expressed an interest in the hospital's welfare. The hospitals' nomination and election procedures varied as did the professional background of board members. Most hospitals judged each nominee's background individually, and did not possess specific criteria for board qualification.

At the profitmaking hospital we reviewed, the board was generally composed of medical staff members who brought with them substantial patient business.

In February 1973 the American Protestant Hospital Association issued a statement recognizing the need for its members to appraise potential conflict-of-interest situations and urging them to consider possible conflicts of the governing board, administration, medical staff, and department heads. The Association noted that, in instances of overlapping relationships involving the purchase of any service or product, there should be at least a full record of open bidding.

On February 6, 1974, AHA approved Guidelines for Resolution of Conflicts of Interest in Health Care Institutions. These guidelines were developed at the request of health care institutions for guidance in developing policies and procedures for identifying and resolving potential conflicts of interest on the part of persons who make or influence institutional decisions.

At all of the Washington area hospitals reviewed, evidence exists that their governing boards have considered overlapping relationships, and hospital officials expressed awareness of this as a potential problem if such relationships were not disclosed. However, only two of the six boards had passed resolutions requesting board members to submit questionnaires disclosing overlapping relationships to an executive committee of the board. Board members at both hospitals had reported their overlapping relationships.

OVERLAPPING INTERESTS

In determining the extent of overlapping interests in Washington area hospitals, we examined the business interests of key hospital employees as well as members of hospital governing and advisory boards. At the Missouri hospitals we examined only the interests of governing and advisory board members. At both locations we compared the identified business interests with firms providing commodities and services to the member's hospital to determine where overlapping relationships existed.

Of 17 hospitals with overlapping interests, 14 had at least 1 board member associated with a bank or investment or legal firm serving the hospital. Board members at 3 hospitals had associations with insurance companies; 14 hospitals had board members associated with various other firms doing business with the hospital.

Six hospitals where 25 percent or more of the board membership had overlapping interests are discussed below. Appendixes VII and VIII summarize these relationships as well as those at the remaining 13 hospitals we reviewed.

Hospital A

This Washington area hospital was governed by a 42-member board of trustees (including emeritus members). The hospital also had three honorary trustees with no voting authority. Twelve board members and all honorary trustees, or 33 percent, had overlapping interests. The primary overlapping interest involved banks servicing the hospital, although board members were also identified with legal, investment, and three other types of firms.

Seven board members were associated with a bank which maintained a hospital savings account; checking account; and custody of hospital investment property, such as stocks and bonds, for a fee of 3 percent of the income collected. At December 31, 1972, the checking account balance was $5,000; the savings account balance was about $46,659, earning 4.5-percent interest. As of December 31, 1972, the hospital's investments totaled about $4.6 million, yielding an annual income of about $7,700.

Two members were associated with two other banks where the hospital maintained various checking and savings accounts. At one bank, savings account balances at December 31, 1972, totaled about $941,500, earning 4.5-percent interest, and balances in eight checking accounts, according to yearend confirmations, totaled about $678,000.

Three board members were associated with two firms providing legal services to the hospital. The hospital reimbursed one firm on an hourly basis with a guaranteed minimum of $15,000 and, for the year ended September 30,

1972, paid this firm approximately $89,000. The hospital was charged only for expenses on the services the other firm provided.

One member was associated with a group of eight radiologists providing radiology services to the hospital. The group's net income from the hospital in 1972 was about $496,000.

In addition to the 15 board of trustees members we identified 2 nontrustee officers of the hospital, 3 action committee[1] members, and 3 administrative employees with overlapping business interests. One officer owned stock in a bank that serviced the hospital; an employee owned stock in two firms doing business with the hospital; and another employee received half of his salary from the company which provided food service to the hospital.

Overlapping interests of the other nontrustee hospital personnel involved stock ownership in, or association with, the firm which had provided the hospital with computer services. The firm's services were based on a May 1970 agreement between hospital officials and the computer services firm president, who was also the hospital's assistant administrator-controller from 1967 to 1972. No record of competitive bidding was available at the hospital to indicate that other firms had been considered. The computer services cost the hospital about $680,000 in 1972.

The arrangement for computer services was presented for hospital board approval in April 1972--2 years after the agreement was made. At that time, 10 hospital employees, including the hospital administrator and 3 assistant administrators, had purchased stock in the computer firm. As a result of a 1972 hospital board resolution, most of them disposed of their stock.

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[1]Action committees perform functions such as making investment decisions and revising by-laws and may include persons who are not voting board members. According to the hospital administrator, committee members identified herein with overlapping interests serve only a staff liaison function.

At the time of our review, however, we identified the following relationships with the computer services firm:

--One nontrustee officer, two nontrustee action committee members, relatives of one nontrustee action committee member, and a hospital assistant administrator owned stock in the computer firm.

--A physician, employed by the hospital under an employment agreement, provided consultant services to the firm.

--The firm's president, the former hospital assistant administrator-controller, was a hospital consultant and an action committee member.

In mid-1973 the hospital requested competitive bids for computer services. However, according to the hospital administrator, the bids received generally provided for additional equipment and services which hindered their comparability with the services currently being provided. Therefore, early in 1974 the hospital decided to retain the present supplier for 12 to 18 months during which time a more specific request for bids would be developed. We believe the overlapping relationships with the present supplier may give that firm an advantage over potential competitors.

This hospital has passed a resolution requiring board members, management employees, medical staff officers, and auxiliary officers to submit disclosure questionnaires. We verified compliance with this resolution for board members and management employees.

Hospital F

This profitmaking hospital in the Washington area was a wholly owned subsidiary of a corporation which also owned a pharmacy and a medical supply company. The parent corporation was also a partner in a partnership which owned and operated a nursing home in property subsequently converted to a hotel and other business properties.

We noted that 22, or 82 percent, of the hospital's 27-member board of directors had overlapping business relationships. Directors with overlapping interests included parent

corporation stockholders, governing board members of another subsidiary of the parent corporation, and partners in the nursing home. Five stockholders, together owning more than 50 percent of the parent corporation stock, were also members of a partnership owning a parcel of land near the hospital. The parent corporation plans to build a replacement hospital and had approved purchase of the partnership's land as a relocation site.

One director, besides being a member of the above-mentioned partnership and the largest stockholder in the parent corporation, was president of the hospital's board of directors and chairman of the parent corporation's board. He was also the director of the laboratory which provided pathology services to the hospital. The overlapping relationships of this director had been questioned by other directors and in November 1973 were unsuccessfully challenged by a stockholders committee of the parent corporation.

Other overlapping interests of the board of directors involved:

--Two directors who were former officers of two banks which were serving the hospital.

--One director who was an officer in a prospective competitive hospital.

A resolution requesting directors to disclose their overlapping relationships to the board of directors was complied with by August 1973.

Hospital I

This Kansas City hospital was governed by a 13-member board of trustees. Four of the trustees, or 31 percent, had overlapping interests.

The primary overlapping interest involved three trustees associated with an insurance company which furnished various types of insurance to the hospital. Annual premiums for this coverage amounted to $36,582. One of the three trustees, who was the insurance company president, said that he and the two other trustees associated with his company

divided a commission of 7-1/2 percent of the premiums as compensation for this service. He explained that general liability insurance was extremely difficult to get for the hospital and considerable time and effort was expended in obtaining this coverage.

The fourth board member with an overlapping interest was an attorney associated with a legal firm serving the hospital. During a 10-month period ended June 30, 1972, the hospital paid this firm about $8,335.

Hospital N

This hospital, located in Springfield, Missouri, was governed by a 36-member board of directors. Fourteen of the directors, or 39 percent, had overlapping interests with a total of 16 different companies. We examined the business relationships of eight of the directors.

Four directors were associated with two banks providing financial services to the hospital. One of these directors was the chairman of the board, and one was the president of a bank where the hospital had been doing business for 40 years and where it maintained three checking accounts, a savings account, and three certificates of deposit. One of the checking accounts, from which few disbursements were made, had a balance of $79,580 on February 28, 1973. A hospital official said that this account was treated as an additional cash reserve and that the amount was small relative to their total operation. Investment of some of these funds was being planned.

Balances in the savings account ranged from about $1,100 to over $400,000 during a 3-month period ended March 21, 1973, and earned interest at 4.5 percent. The hospital's certificates of deposit were valued at $183,000 at an interest rate of 5.5 percent.

The two remaining directors with bank relationships were board members of a bank which maintained a checking account for payment of construction contractors. At the time of our survey the balance in this account was about $214,000, representing less than 2 months' disbursements.

Printing, tractor and implement, airline, and motor supply firms provided about $10,000 in supplies and services to the hospital during the year ended September 30, 1972. One hospital director was president of three of the firms and chairman of the board of another. In addition to the above business, the hospital was the beneficiary of a trust holding 500,000 shares of the airline stock and a residuary legatee of an estate holding 497,576 shares of this stock. Donations to the hospital by this director or his business firms had amounted to more than $25,000 since December 1971.

Another director was vice president of an electrical and plumbing supply firm which sold the hospital supplies during the fiscal year ended September 30, 1972, amounting to $23,000. A hospital engineer said that informal bid quotations were normally received before plumbing supplies were purchased.

Hospital R

This St. Louis hospital was governed by a five-member board of directors. Each director was a member of a religious order and we were advised that none had any overlapping financial interests. The hospital also had a 15-member advisory council which served in a management consulting capacity but had no decisionmaking authority. Two of the advisory council members were associated with firms doing business directly with the hospital.

One member was chairman of the board of a bank where the hospital maintained a checking account with an average balance of about $3,000 for the 3-month period ending February 1973. This member had donated about $23,000 in stock to the hospital. Another advisory council member was a partner in a law firm serving the hospital. During 1972 the hospital paid about $12,000 to the law firm.

Four advisory council members (one of the above and three others) were associated with firms not directly doing business with the hospital. Three members were officers of a firm supplying frozen egg products to a purchasing association of several hospitals. The hospital purchased $4,516 in frozen egg products from the association during

the 7-month period ended December 31, 1972. One council member was vice president of a national corporation. The hospital received data processing services from a subsidiary of this corporation. The agreement to provide these services was between the subsidiary and the religious organization sponsoring this hospital. The agreement also provided for similar services to six other hospitals. This hospital's estimated cost for these services was $15,000 to $20,000 monthly. An official of the sponsoring organization said that proposals were submitted by three firms and the firm selected was competitive in both price and quality.

We believe any opportunity to influence the procurement of frozen egg products and data processing services was extremely remote.

Hospital S

This St. Louis hospital was governed by a 15-member board of trustees. Ten members, or 67 percent, had overlapping interests with 12 different companies.

Seven trustees were also directors at three banks providing financial services to the hospital. One board member was a director of a bank which maintained three checking and two savings accounts for the hospital as well as certificates of deposit. Balances in the checking accounts totaled $559,522 on January 31, 1973; savings account balances earning 4.5-percent interest totaled about $189,000 at that date. The hospital had invested about $2.9 million in certificates of deposit at this bank earning interest from 5.25 to 5.625 percent. The bank had pledged about $160,000 to the hospital and had paid half of this amount. The board member had personally donated about $200,000 in stock and $27,000 in cash to the hospital since 1968.

Two board members were directors of another bank which managed a pension plan for the hospital. The bank received about $3,000 during 1972 for managing about $329,000 in contributions. The hospital also owned certificates of deposit at this bank amounting to about $2.1 million at interest rates from 5.125 to 5.625 percent; a small hospital checking account; and a savings account of about $42,000 earning 4.5-percent interest. The bank had pledged $54,600

to the hospital; half had been paid. Pledges or contributions attributable to the two board members totaled $130,000.

Three other board members were directors of still another bank which handled temporary fund investments, estates, an endowment fund, and a certificate of deposit for the hospital. Investment funds consisted of treasury bills valued at $425,000 and an additional $9,460 which was not invested. The bank received $255 for managing the fund during 1972. The endowment fund consisted of stock and bond investments valued at about $4.2 million. The bank received about $4,400 for handling this fund during 1972. In addition, the bank received about $30,000 for managing two estates with a total value of $15,258,666. A $147,836 bank certificate of deposit was earning 5.5-percent interest. The bank had pledged about $200,000 to the hospital, of which half had been paid. Another board member was a director of another bank not doing business with the hospital but which was in the same banking corporation as the preceding bank. These four board members had contributed a total of $35,454 to the hospital.

According to the hospital's comptroller, the interest rates received from these banks on savings accounts and certificates of deposit were competitive.

Four members were directors of a life insurance company which handled an optional hospital employee retirement plan. The company received 4.75 percent of current contributions for managing the plan. During 1972 employee contributions amounted to $61,000 and the resulting fee was about $2,900. Contributions of these members, not previously discussed, totaled $14,000.

Other types of overlapping business firms included utilities, a conglomerate, and manufacturing firms. The hospital did business with these firms totaling about $934,000 during 1972--about $913,000 was with utilities. These firms had pledged cash and real estate valued at about $1,907,000 to the hospital, of which about $1,400,000 had been donated at the time of our review.

CHAPTER 3

ARRANGEMENTS WITH HOSPITAL-BASED SPECIALISTS

Many U.S. hospitals retain full- or part-time specialists, including pathologists, anesthesiologists, and radiologists. We reviewed the arrangements of radiologists and pathologists who are frequently retained to direct a hospital's X-ray and laboratory departments, respectively.

Ordinarily, hospitals contract their specialists. AHA has adopted certain principles for contractual arrangements between hospitals and physician specialists and has stated that it approves of any arrangement between a hospital and a physician that is (1) fair to the parties involved, (2) conducive to high quality medical care, and (3) supportive of the interest of the patients and the community served by the hospital.[1] Physician groups--AMA, the American College of Radiology, and the College of American Pathologists--do not necessarily subscribe to AHA's principles. The American College of Radiology said its policy is that radiologists have no contractual basis for practice in hospitals. The College and AMA support the right of radiologists to practice in hospitals on the same terms as other members of the medical staff; that is, to separate their professional fees from hospital charges and present their own bills to patients.

In discussing lease arrangements for specialists' services, AHA stated that hospitals increasingly are being held responsible for whatever happens within their walls, including the professional acts of members of their medical staffs. AHA has adopted certain principles for arrangements between hospitals and physician specialists. Regarding the hospital's responsibilities for acts of specialists, furnishing of facilities and personnel to support such specialists, and financial aspects of such arrangements, AHA principles include the following statements:

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[1]AHA stated that it was in the process of issuing a revised document entitled "Contractual Relationships Between Hospitals and Physicians."

--"The governing authority of the hospital is responsible to the community for assuring availability of laboratory determinations, radiological examinations, and certain other services at the hospital. Though these determinations, examinations, and services necessarily involve competent professional personnel, the governing authority cannot abdicate its responsibility regarding availability, quality, and cost.

--"A hospital must provide the attending physician what he needs for diagnosis and treatment in the care of his patient. As such, it must provide space, facilities, and trained personnel not only in the operating rooms, delivery rooms, medical and surgical wards, but in laboratory, x-ray, and other diagnostic areas as well.

The professional services provided in a hospital shall be determined by its governing body, medical staff, and administration.

--"Hospitals have the responsibility for charges to patients for hospital services.

Whenever an in-hospital monopoly situation is created, someone besides the purveyor of the service must approve the charges to patients since total costs for hospital facilities and services are of concern to the governing body and the public.

Since it is the responsibility of hospitals to determine which hospital services will be provided, it also becomes the responsibility of the hospital, through its governing body, to determine the charges for these hospital services.

--"The physician specialist is entitled to fair remuneration for his services considering his training and experience and the level of compensation prevailing in the locality for physicians of comparable qualifications."

AHA recognizes a variety of compensation arrangements including (1) salary, (2) a percentage of the net income of the specialist's department, (3) a percentage of gross departmental income, (4) the specialist's leasing of hospital facilities, (5) the direct billing of patients for the specialist's professional services, (6) fee for service (fee schedules), or (7) some modifications or combination of these methods.

AHA also suggests that the parties may find it desirable to regulate or limit the specialists' professional activities outside the hospital.

In recognition of these principles, we reviewed the contractual arrangements with pathologists at 17 hospitals and with radiologists at 13 hospitals to identify those features dealing with finances, control, and other issues which could be subject to public disclosure. Those features, along with reasons why the public may want to know about them, are listed below.

--How space, equipment, maintenance, and nonphysician personnel are provided. The public may believe that the hospital is responsible for all aspects of patient care and should be informed when there are other arrangements.

--How patient charges for X-ray and laboratory services are determined. In view of concern over high medical costs and the monopoly position of pathologists and radiologists at many hospitals, the public should be informed of methods used to determine patient charges for X-ray and laboratory services and the extent that specialists can determine their own income.

--The method of compensating these specialists and the amounts earned. The public should be informed of how the specialist is compensated because certain methods may deter the specialists from incurring expenses needed to improve patient care.

--The limitations, if any, on outside medical practice. Because a specialist's outside practice could prevent him from devoting the time and attention necessary

to assure quality hospital laboratory services, the public should be informed of the specialist's outside medical practice.

Because specialists' affiliations with other firms serving the hospitals may affect the costs and quality of services, we also reviewed the extent that such specialists may be affiliated with, or have interests in, firms serving the hospital outside the scope of the basic agreements.

ARRANGEMENTS WITH PATHOLOGISTS

Arrangements with pathologists at the 17 hospitals are summarized below:

--Sixteen hospitals provided the pathologists with space, equipment, maintenance, and nonphysician personnel; at one hospital, there was no formal agreement for pathology services but the hospital's parent corporation leased office space to the pathologist group which provided nearly all of the hospital's pathology services.

--At 3 hospitals, the pathologist, subject to hospital approval, determined patient charges for pathology services; at 12 hospitals, the hospital determined patient charges; at 1 hospital, the pathologists established patient charges; and at 1 hospital, the hospital and pathologists jointly established patient charges.

--Pathologists were compensated by (1) salaries at four hospitals; (2) a percentage of net income received by the pathology department at one hospital; (3) a percentage of adjusted gross income by the pathology department at nine hospitals; (4) amounts based on fee schedules at one hospital; and (5) direct billing by the pathologist at two hospitals. Pathologists' average income by type of compensation is shown on page 23.

--Pathologists at 3 hospitals were not permitted simultaneous outside medical practice; at 1 hospital they were permitted to have outside practice as long as it

did not compete with the hospital; at 2 hospitals pathologists could have outside practice only with hospital permission; and pathologists at 11 hospitals were permitted to have outside practice with no restrictions. (At 7 of the 13 hospitals permitting outside practice, pathology services were provided by pathologists or pathology groups who provided similar services to other hospitals.)

--One or more pathologists at 4 of the 17 hospitals were affiliated with, or had an interest in, laboratories that provided laboratory services to their hospitals outside the scope of the basic agreements. Also, the chairman of the pathology department at one hospital that did not have a formal agreement for pathology services was a partner and director of the laboratory which provided nearly all of the hospital's pathology services.

Arrangements with pathologists at some of the hospitals are discussed in more detail below.

Hospital A

The pathologist at this hospital was paid a percentage of net department income. He was an independent contractor responsible for operating and administering the pathology department in a manner acceptable to the hospital administrator, the medical staff, and the board of trustees. The hospital supplied space, equipment, maintenance, and nonphysician personnel. The pathologist was not permitted to have a simultaneous outside medical practice and was responsible for hiring and compensating any associate pathologists. Pathology department rates were determined by the pathologist subject to hospital approval. The pathologist received 28 percent of the department's adjusted net income to compensate himself and the pathology associates. The average income during 1972 was about $67,000 for each full-time equivalent pathologist.

AHA points out that some hospitals are concerned that specialists might be influenced, perhaps subconsciously, by the percentage of net income arrangement to fail to recommend hospital expenditures that would improve patient

care because the expenditures would reduce the net departmental income on which his income is based.

Hospital D

The pathologist at this hospital was compensated according to a percentage of adjusted gross laboratory income. The pathologist was responsible for directing and retaining all department personnel. The hospital furnished space, equipment, maintenance, and nonphysician personnel. The pathologist hired and compensated associate pathologists. The hospital determined the laboratory fees (including professional charges), but gave much consideration to the pathologist's recommendations. It also billed and collected the fees. The pathologist received 19 percent of the first $100,000 of laboratory billings and 5 percent of the amount above $100,000. The average income during 1972 was about $91,000 for each full-time equivalent pathologist. Pathologists could have outside medical practices as long as the practice was not competitive with the hospital's.

AHA has stated that, as the volume of work increases and additional professional personnel become necessary, the specialist under a percentage of gross arrangement often is understandably reluctant to reduce his personal income in order to compensate an additional colleague; thus, a busy department may be understaffed to the detriment of the patient.

Hospital G

The pathologists at this hospital were paid a percentage of gross laboratory billings to patients. In addition, the pathologist group was affiliated with an independent laboratory which performed most of the work done outside the hospital's laboratory. Hospital laboratory personnel were employed by the hospital but selection and retention of such personnel were subject to the pathologist's approval. The hospital furnished space, equipment, and maintenance and established patient charges for the pathology department's services.

The hospital paid the independent laboratory associated with the hospital's pathologists for tests performed in the independent laboratory for hospital patients and the

pathologists received 25 percent of the hospital charges to patients for the same tests--an arrangement which could be considered double reimbursement. A hospital official estimated that over a 6-year period this practice had increased pathologists' income by about $131,000.

For example, during fiscal year ended June 30, 1972, these pathologists received about $183,500 for personal services, or about $73,400 for each full-time equivalent pathologist. This amount was based on 25 percent of the hospital's adjusted gross laboratory charges of about $734,000. The laboratory charges included about $100,000 for services performed in the hospital's pathologists' independent laboratory plus about $5,000 for services performed by another laboratory. We believe this charge base should have excluded these amounts. Had this been done, the pathologists would have received about $157,200 (25 percent of $628,800), or $26,300 less, in fiscal year 1972.

After we discussed this matter with officials of Hospital G and its Medicare intermediary, the payment method to the pathologists was changed as of July 1, 1973, to exclude the percentage reimbursement of hospital charges for tests performed in the independent laboratory. Also, the hospital and the Medicare intermediary determined that $33,169 had been overpaid by the Government on behalf of Medicare patients. The hospital is reimbursing Medicare according to a mutually agreeable payment schedule.

Hospital F

This hospital had no formal agreement for pathology services but the hospital's parent corporation leased office space at the hospital to the pathologist group which, according to the hospital administrator, provided 90 to 95 percent of the hospital's pathology services. Maintenance of the premises was provided by the parent corporation. The pathology group provided equipment and nonphysician personnel, established its own charges, and billed directly for its services through a billing and collection service operated by the hospital's parent corporation at a cost to the group of 15 percent of the gross charges. Group members were compensated according to percentage arrangements decided by the group and received no

compensation from the hospital for pathology services. Based on information provided by the group's director, average income for the pathologists during 1972 was about $65,000 for each full-time equivalent pathologist. The director was chairman of the hospital's pathology department and was a major stockholder in both the hospital's parent corporation and the laboratory which provided pathology services.

AHA believes that a lease arrangement may result in a loss of effective administrative control over services for which the hospital's governing authority is responsible and that the hospital's responsibility for the actions of a hospital department can probably not be legally negated by the hospital's claim that the department is under a lease arrangement. In contrast, the College of American Pathologists advised us that a hospital and its board of trustees cannot be medically responsible for medical services provided within the hospital under a lease arrangement. The American College of Radiology advised us that the hospital would be more responsible for radiology services provided in the hospital if the radiologist was a hospital employee than if he was a fully independent member of the medical staff.

Hospital N

This hospital had entered into an agreement with a pathologist and separate agreements with four associate pathologists. Each agreement included the same fee schedule which was used to pay the pathologists for their laboratory services. Except for cost of living increases, no fee changes could be made without prior approval of the hospital's administration. We were informed that the hospital also must approve changes in patient charges for laboratory services. Patient charges included the pathologists' fees plus an amount to cover the hospital's costs applicable to the services. The pathologists were responsible for operating the laboratory and for a teaching program in an associated school of medical technology. The hospital furnished facilities, personnel, equipment, and maintenance. The pathologists had formerly been retained under a percentage of gross arrangement; however, we were informed that the hospital initiated the fee schedule arrangement so that increases in hospital charges would not automatically provide

additional income for the pathologists. The average income during the year ended September 30, 1972, was about $90,600 for each full-time equivalent pathologist.

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The average income of pathologists at the 17 hospitals for annual periods ended between April and December 1972 was as follows:

Arrangement	Number of hospitals	Pathologists' average income
Percentage of adjusted gross income	9	$ 80,100
Percentage of net income	1	67,100
Direct billing (one with a lease arrangement)	2	70,600
Salary	4	26,600
Fee schedule	1	90,600
Total	17	

ARRANGEMENTS WITH RADIOLOGISTS

The arrangements with radiologists at the 13 hospitals are summarized below:

--11 hospitals provided the radiologists with space, equipment, maintenance, and nonphysician personnel; at 1 hospital the radiologist, who leased space from the hospital, furnished equipment, maintenance, and personnel; and at 1 hospital radiology work was sent outside.

--At four hospitals patient charges for radiology services were determined by the radiologist, subject to hospital approval; at four hospitals charges were determined by the hospital; at four hospitals charges

were established by the radiologists; and at one hospital charges were established jointly by the radiologist and the hospital.

--The radiologists were compensated by salary at two hospitals; a percentage of adjusted gross income at four hospitals; fee schedules at two hospitals; and direct billing by the radiologists at five hospitals.

--Radiologists at nine hospitals were permitted to have outside medical practice; radiologists at two hospitals were permitted to have outside practice only with hospital permission; and radiologists at two hospitals were not permitted to have outside practice. (Radiology services at two of the hospitals were provided by a radiologist group which also provided radiology services to other hospitals.)

--None of the radiologists were affiliated with, or had an interest in, firms providing services to their hospitals outside the scope of the basic agreement.

Arrangements with radiologists at some of the hospitals are discussed in more detail below.

Hospital E

The radiologist at this hospital was compensated with 30 percent of the adjusted gross income of the radiology department. The radiologist was the administrative and professional head of the radiology department. The hospital provided him with needed equipment, space, maintenance, and nonphysician personnel. He was responsible for retaining and compensating any needed additional radiologists. The radiologist was to confine his practice to the hospital unless additional practice was approved by the hospital governing board. Fees for radiology services were established jointly by the radiologist and the hospital. The hospital billed and collected the radiology department's charges. The average income during 1972 was about $79,200 for each full-time equivalent radiologist.

Hospital F

This hospital operated on an "open staff" arrangement whereby any qualified radiologist could perform radiology services in the hospital. However, according to the hospital administrator, a corporation of radiologists, which leased space from the hospital and provided its own equipment, maintenance, and personnel, provided 90 to 95 percent of the radiology services. The corporation determined its own charges for professional services, operated its own billing and collection system, and compensated its members according to corporate salaries plus a share of yearly corporate profits. The average income during 1972 was about $62,500 for each full-time equivalent radiologist.

Hospital A

This hospital had contracted a radiologist corporation to provide radiological services. The corporation was compensated according to a mutually agreeable fee schedule and was responsible for providing radiologists acceptable to the hospital. The hospital provided the radiologists with space, equipment, maintenance, and most types of nonphysican personnel. The fees for professional services were determined by the radiologists' corporation subject to hospital approval. The hospital billed and collected the radiology department's fees. The radiologists were allowed to have outside medical practice. The agreement provided that periodic adjustments would be made in the radiologists' compensation to allow the hospital's recovery of departmental operating costs, allowances, bad debts, and a factor for growth and development. The average income during 1972 was about $69,900 for each full-time equivalent radiologist.

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The average income of radiologists at 8 of the 13 hospitals where we obtained such information for annual periods ended between April and December 1972 was as follows:

Arrangement	Number of hospitals	Radiologists' average income
Percentage of adjusted gross	4	$60,300
Direct billing (one with a lease arrangement)	2	64,000
Salary	1	33,200
Fee schedule	1	69,900
Total	8	

CHAPTER 4

CONCLUSIONS, RECOMMENDATION, AGENCY AND OTHER COMMENTS, AND OUR EVALUATION

CONCLUSIONS

Since one important function of a hospital's governing board is to provide for the control and use of the hospital's physical and financial resources, and since advisory boards may assist in and influence the decisionmaking process, overlapping interests of board members or employees with firms serving the hospital could result in self-serving arrangements. This would be particularly true regarding goods and services acquired without adequate competition.

We identified governing and advisory board members with overlapping interests at 17 of the 19 hospitals reviewed but found little evidence that these arrangements increased hospital costs. In some instances, the arrangements may have benefited the hospitals through favorable loan arrangements and expert management of hospital assets. We believe that prohibiting these types of overlapping interests is not practicable. However, we believe that public confidence in these institutions would be enhanced if the issue of overlapping interests was faced openly through public disclosure, including a statement of the extent of competition involved in acquiring goods or services.

Although hospital-based specialists may be considered private practitioners similar to other physicians serving the general public, they enjoy a virtual monopoly regarding services rendered to hospital patients. As with most hospital services, patients have a negligible voice in determining the services provided, the physician providing them, or the amounts paid by them or on their behalf for such services. Further, patients may not realize that the arrangements between hospitals and hospital-based specialists may have some impact on patient care.

Because of the monopoly enjoyed by hospital-based specialists, we believe that hospitals should publicly disclose their contractual arrangements with these specialists regarding (1) the furnishing of supporting facilities and

personnel, (2) the establishing of patient charges for X-ray and laboratory services, (3) the method of compensating specialists and amounts paid, (4) limitations on the specialists' outside medical practice, and (5) other financial dealings between hospitals and specialists or firms in which the specialists have financial interest.

RECOMMENDATION TO THE CONGRESS

We recommend that the Congress consider amending the Social Security Act to require hospitals, as a condition for participating in Medicare, Medicaid, and Maternal and Child Health and Crippled Childrens' Services, to make publicly available information disclosing (1) overlapping financial interests of the board members and key employees, including a statement of the extent of competition involved in acquiring goods and services, and (2) the hospitals' arrangements with hospital-based specialists. Such a provision should also be considered for inclusion in any national health insurance program legislation.

Such an amendment could require hospitals to maintain information showing (1) the extent to which board members and hospital employees hold positions, or have a financial interest, in any concern from which the hospital secures goods or services or which competes with the hospital for the delivery of medical care, or provide consulting or other services to any outside concern which does business with the hospital, (2) the extent of competition involved in acquiring goods and services from firms in which board members or hospital employees hold positions or have a financial interest, and (3) the hospital's arrangements with hospital-based specialists. Disclosure of overlapping financial interest might take the form of an annual listing of board members, their business or profession, and reimbursement received from the hospital during the past year.

AGNECY AND OTHER COMMENTS AND OUR EVALUATION

Comments on our report received from HEW, AMA, AHA, the College of American Pathologists, and the American College of Radiology are briefly discussed below and are shown in full in appendixes I through V. Written or oral comments also were obtained from a consultant for health affairs and from nine of the hospitals discussed in the report and their comments were considered in finalizing the report.

HEW stated that this report provides useful information and concurred with our recommendation to the Congress. In commenting on our report, HEW said:

--The limited number of hospitals reviewed by GAO--a total of 19 in several metropolitan areas--should not be looked upon as a sampling of all hospitals in the country.

--The frequency of "overlapping interests" of hospitals and their board members is not surprising since membership by business and professional leaders on the boards of nonprofit organizations, hospitals among them, is a long-established feature in our society.

Our review of 19 hospitals was not intended to be representative of all hospitals in the country. However, since business and professional leaders typically serve on boards of nonprofit organizations, we believe that review of additional hospitals in other areas would show that the existance of overlapping interest was not unusual.

AHA stated that the issues raised by the report are important, but it believed that the overlapping interest issue could be handled through internal disclosure requirements and other processes already carried out by most health care institutions in meeting their public trust and responsibilities and that existing legislation and regulations or those under development can deal with such issues and a requirement for public disclosure was neither justified nor necessary. AHA also stated that disclosing the types of contractual relationships with hospital-based specialists

would be useful, but it felt that disclosing specific amounts paid to physicians was unnecessary.

The American College of Radiology said it did not object to advising the public of the basis of practice by radiologists, but it objected to publication of contractual relationships and amounts paid those on a contractual basis without explaining their workloads.

The College of American Pathologists stated that contractual relationships between hospital-based specialists and the hospital should not be publicly disclosed. In disagreeing with our recommendation, it stated that disclosing incomes of hospital-based specialists would be discriminatory and would disrupt the goal of quality patient care by forcing hospital-based physicians to reduce their workweek to 40 hours.

We believe that, under our proposal, disclosure of specialists' incomes could be provided in sufficient detail so as to be subject to less misinterpretation than information on specialists' gross income which could often be derived from Medicare cost reports which HEW makes publicly available under the Freedom of Information Act.[1]

AMA did not agree that either overlapping interests of hospital-based specialists or contractual arrangements between hospitals and medical specialists should be disclosed. Its primary arguments against disclosure appear to be that (1) the general public would be confused and misled by the information and (2) the broad publicity and concern for overlapping interest or potential conflicts of interest would discourage highly qualified individuals from serving on hospital boards.

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[1]In April 1974 the Commissioner of Social Security announced that, based on the Freedom of Information Act (5 U.S.C. 552), the agency believed it was required to make Medicare cost report information available upon specific written request to the public and proposed to implement this policy change on May 1, 1974. The instructions implementing the proposal state that the information is to be provided at a standard charge of $.25 a page.

We believe that AMA and AHA comments tend to underestimate the public's sense of fair play and intelligence. We believe the public is capable of reaching logical conclusions when adequately informed. We do not share AMA and AHA concerns that the disclosures we are proposing would be confusing and misleading.

Potential conflicts of interest have received considerable publicity. For example, an article by an AHA trustee on conflict of interest was published in the Journal of the American Hospital Association (July 16, 1974, Vol. 48). The author concluded that hospitals should fully employ the techniques of disclosure and, as a minimum, fully adhere to legal requirements. The author stated that disclosure is very important because it allows the outside interest to be evaluated objectively, thereby protecting the individuals involved from suspicions that might arise if they had concealed their interests or had reported them less formally. Thus, it seems that well-intentioned persons with overlapping interests would prefer public disclosure to show that there are no conflicts of interest or breach of the fiduciary duty as discussed in Stern v. Lucy Webb Hayes National Training School for Deaconesses and Missionaries, supra. (See p. 2.)

AMA also stated that, since our investigation did not disclose any public harm resulting from the lack of public disclosure, no recommendation for such public disclosure is called for. We believe AMA has misinterpreted the purpose of our review. As stated on page 4, our review was not designed to evaluate the propriety or reasonableness of a particular overlapping arrangement but was made to identify and describe the type of information that would be publicly disclosed if such a disclosure requirement--as previously proposed by others--were established.

We believe that disclosures which do not indicate any public harm will enhance the public confidence in the institutions. To accept AMA s position is tantamount to saying that disclosure should be required only in those instances where the public has been harmed and punitive action could be taken against those making the disclosures. We believe that such a position is untenable.

APPENDIX I

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

OFFICE OF THE SECRETARY

Mr. Gregory J. Ahart
Director, Manpower and
Welfare Division
U.S. General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report to the Congress entitled, "Information on Contractual and Financial Arrangements Between Hospitals and Members of Their Governing Boards and Hospitals and Their Medical Specialists." They are enclosed.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

John D. Young
Assistant Secretary, Comptroller

Enclosure

COMMENTS ON GAO'S DRAFT REPORT - "INFORMATION ON CONTRACTUAL AND FINANCIAL ARRANGEMENTS BETWEEN HOSPITALS AND MEMBERS OF THEIR GOVERNING BOARDS AND HOSPITALS AND THEIR MEDICAL SPECIALISTS"

The draft report recommends that the Congress consider amending the Social Security Act to require hospitals, as a condition for participating in Medicare and Medicaid, to publicly disclose (1) overlapping interests with their board members and key employees, including a statement of the extent of competition involved in acquiring goods and services, and (2) the hospitals' arrangements with hospital-based specialists.

We are in favor of the recommendation. However, we would suggest that it include Title V, "Maternal and Child Health and Crippled Children's Services" along with Medicare and Medicaid.

While the report provides useful information on a complex subject, the limited number of hospitals reviewed by GAO--a total of 19 in several metropolitan areas--should not be looked upon as a sampling of all hospitals in the country. Furthermore, the frequency of "overlapping interests" of hospitals and their board members, which GAO noted, is not surprising since membership by business and professional leaders on the boards of nonprofit organizations, hospitals among them, is a long-established feature in our society. As the report makes clear, most of the overlapping situations did not seem to constitute conflict of interest or other forms of possible abuse, nor work to the disadvantage of the hospitals or the public.

APPENDIX II

AMERICAN MEDICAL ASSOCIATION

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JAMES H. SAMMONS, M.D.
Executive Vice President Designate
(751 6202)

October 26, 1974

Mr. Gregory J. Ahart, Director
Manpower and Welfare Division
United States General
Accounting Office
Washington, D.C. 20548

RE: General Accounting Office - Draft Report "Information on Contractual and Financial Arrangements Between Hospitals and Members of Their Governing Boards and Hospitals and Their Medical Specialists".

Dear Mr. Ahart:

Recently, a draft of a General Accounting Office report concerning the above subjects was brought to our attention.

We understand this report has been distributed to selected organizations for review and comment, and we wish to offer our comments.

The report, which is intended to be submitted to Congress when finalized, would recommend that Congress consider amending the law to require public disclosure of "overlapping interests" of hospital board members and of the hospital's arrangements with "hospital-based specialists".

In our opinion, the conclusions reached in this report are unsubstantiated and, accordingly, the report should not be submitted to Congress in its present form.

While many questions can be raised concerning the specifics of this report, no attempt is made here to critique it in detail. Generally, the report is based on information from selected institutions without any indication of how or why such selections were made. Furthermore, the study is extremely limited in scope.

The principle of public disclosure of meaningful information as it relates to hospital operations and costs is a salutary one. However, any

specific proposal must be examined with respect to its potential for public benefit or harm.

The report indicates that the goal of public disclosure of financial or other arrangements between a hospital and a hospital trustee or hospital-based medical specialist is greater public accountability, and that such accountability will result in beneficial effects upon the cost and quality of patient care furnished within the hospital. However, the question which needs to be answered, and which this report has not examined, is whether the mere disclosure of certain types of relationships or arrangements provides the kind of meaningful information in and of itself that would enable the public to arrive at an informed opinion regarding the overall beneficial or detrimental effects of such relationships upon hospital costs or upon the quality of medical services provided therein.

Regarding the relationships of hospital trustees to outside organizations, the report recommends that Congress consider amending the Social Security Act to require hospitals, as a condition for participating in Medicare and Medicaid, to publicly disclose "overlapping interests" of their board members and key employees. The phrase "overlapping interests" is used in the report "to mean the holding by a hospital board member or employee of a position or of a financial interest in any concern (1) from which a hospital secures goods or services or (2) which competes with the hospital for the delivery of medical care. A hospital board member or employee who provides consulting or other services to any outside concern which does business with the hospital is also considered to have an overlapping interest." It is clear that the term "overlapping interest" as used in the report is not intended to be synonymous with the term "conflict of interest", which latter term implies self-dealing for one's own interest to the detriment of another's interest.

In identifying and examining certain situations where hospital trustees have been identified as having "overlapping interests", the report makes no finding of improper conduct or resulting harm to the hospital or the public from such relationships. The report's general conclusions are that there is "little evidence" that hospital costs were increased due to an arrangement in which a hospital trustee was connected with an organization providing banking, legal or investment services to the hospital. To the contrary, the report in fact goes on to state that "such arrangements may have been beneficial to the hospitals and their patients from favorable loan arrangements and expert management of hospital assets. Further, in some cases, individuals and/or their companies made donations to the hospital which far exceeded any financial gains that could have been realized from such arrangements." In other words, the report itself does not reach the conclusion that there were any "conflicts of interest" among the "overlapping interests" actually examined, nor any increase in hospital costs because of such overlapping interests, and that they were, in fact, beneficial to the hospital. The logical conclusion based on the report would seem to dictate a recommendation contrary to the one in

the report, namely, that since the investigation did not disclose any public harm resulting from the lack of public disclosure, no recommendation for such public disclosure is called for.

It should be kept in mind that our comments here are aimed only at mandatory publication of such relationships, and are not intended in any way to restrict the disclosure of such information to other hospital board members or to the institution's administration. Disclosures of information to the hospital's governing body or administration concerning an "overlapping interest" are in some cases required by specific statute or in others under general principles of law regarding a corporate director's fiduciary duties.

An institution's board of trustees, or an organization such as GAO, may evaluate such "overlapping interests" in light of each trustee's total relationship to the hospital and the overall beneficial or detrimental effect that any particular "overlapping interest" has for the hospital. However, to say that the board, based upon its knowledge of the hospital's total activities, or that an organization such as GAO, after lengthy and no doubt expensive inquiry, could reach such an informed opinion is not to say that members of the general public could be expected to arrive at a similar informed opinion based merely upon the disclosure of "overlapping" interests. On the contrary, such disclosures may convey to the general public only an inference of conflict of interest or impropriety on the part of a trustee with an overlapping interest, and may place such individual in the position of defending and explaining the hospital's dealings with outside organizations with which he may be connected. Broad publicity and exaggerated concern for overlapping interests or potential conflicts of interest would serve to discourage highly qualified individuals in the community from serving on hospital boards because they would not want to be involved in highly publicized situations in which they were needlessly in effect put on public trial for self-dealing when, in fact, they are motivated by eleemosynary considerations.

We would suggest that mandating public disclosure of "overlapping interests" of hospital trustees has a strong potential for public harm to the extent that such disclosures may unavoidably and unjustly create an appearance of conflict of interest or impropriety in the minds of the public, and place such hospital trustees in a position of having to explain or defend such interests with the attendant likelihood that community leaders and key employees of outside organizations will not be willing to serve as hospital trustees under such circumstances.

One additional factor which should be remembered is that there already exists a variety of legal, fiduciary, and moral responsibilities working in the public interest to compel an avoidance of actual conflicts of interests of hospital trustees and outside organizations with which they may be connected.

In our opinion, the potential for public harm in requring public disclosures of information which may result in an unwarranted appearance of a conflict of interest merely by virtue of such disclosure, combined with the report's own findings of lack of harm resulting from any omission of such public disclosure in the situations of "overlapping interests" actually examined, would indicate that a recommendation for legislation to mandate such disclosures should not be made.

Our concern with the report's second recommendation, that is, public disclosure of a hospital's arrangements with hospital-based medical specialists, is similar to that expressed above regarding the relationships of trustees with outside organizations. This concern centers on the fact that mandatory public disclosure through legislation of a hospital's financial and other arrangements with hospital-based specialists as called for in this report may unavoidably carry an inference of wrongdoing or conflicts of interests on the part of such specialists where none exist. Again, the issues which this report have not answered are first, whether the findings support the recommendation, and second, whether such disclosures would not be misleading to the public.

The report's recommendation for public disclosure of the contractual arrangements between hospitals and medical specialists is based on certain statements in the report that such arrangements might either reduce the quality of services provided or inflate the cost for such services. Such statements, however, are not supported by the report's own findings. The report merely states the arrangements existing in the few hospitals reviewed. The report appears careful to avoid any assertion of any impropriety with respect to any particular hospital arrangement for compensating specialists, and makes no actual finding or assertion that any particular arrangement in fact lowered the quality of services provided or increased the costs of such services. On this basis alone the recommendation has not been justified.

The question must also be asked as to whether the mere disclosure of a compensation method would be meaningful and beneficial information for the public. For example, does the fact that one specialist may be earning significantly more money than another specialist in a different hospital indicate that the costs per procedure were higher in the first hospital than in the second? Does the mere disclosure of salaries or of the type of financial arrangement convey meaningful information concerning the relative size or class of the hospital or the amount of work performed therein? Disparities in income of hospital-based specialists may be based on a variety of factors pertinent to the individual setting--factors which the patient would not be in a position to evaluate. These may include higher work loads, more efficiency, greater skill and competency, and other valid reasons. Certainly, there is no objective data in this report that would indicate that the cited differences were not based on valid reasons. The mere public disclosure of salary figures, gross compensation, or payment mechanism, would not convey relevant factors

APPENDIX II

to the public, and, therefore, would be without meaning and could even be misleading.

Also, disclosures called for in this report would not reflect the portion of the hospital's charges for a salaried specialist's services which are above and beyond the amount necessary to meet the salary of such specialist and the costs of the particular department, nor would such disclosure reflect the hospital's charges for specialty services in situations where the specialist is on other than a salary basis, such as a percentage basis.

An additional factor which should be considered is that hospitals, consistent with their obligations to provide quality care at reasonable costs, are unlikely to negotiate contracts with medical specialists which would impair fulfilling such obligations. To presume that any specific contractual arrangement would result in deterioration of care or increased costs is to impute ill motive not only to the specialist but also to the hospital administration. We cannot concur in either. Certainly, at the end of any given contract period, if a hospital determined that specialist services either were being inadequately provided or were too costly, such hospital would be free and under obligation to contract for such services with other specialists. Similarly, we believe that the medical staff would not permit such services to be continued if they were not being provided according to proper medical standards. The types of disclosures recommended by this report regarding hospital-based specialists would in no way convey information to the public relative to the value or quality of such services, and would, in many instances, be most likely to be misleading concerning such factors.

The report does not disclose evidence that the contractual relationships reviewed between hospitals and hospital-based specialists actually resulted in either a diminution of quality of services or in increased cost of such services. Until such evidence is ascertained, disclosure, with its attendant risks for misleading the public, should not be recommended. The report merely sets out a random recitation of circumstances existing in a few hospitals, without citing any resulting public harm attributable to a particular instance or to a particular manner of specialist compensation. This is grossly insufficient information on which to base even inferences justifying the recommendation in the report.

We are of the opinion that the publication of this report has not been shown to be in the public interest. The recommendations are not substantiated by the findings. We recommend that the report in its present form should not be submitted to Congress.

Sincerely,

James H. Sammons, M. D.

APPENDIX III

AMERICAN HOSPITAL ASSOCIATION
840 NORTH LAKE SHORE DRIVE CHICAGO ILLINOIS 60611 TELEPHONE 312 645-9400
TO CALL WRITER, PHONE 312 645- 9551

September 27, 1974

Mr. Gregory J. Ahart
Director
Manpower and Welfare Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart

On behalf of the American Hospital Association, I am responding to your letter requesting our comments and reactions to the GAO draft report on "Information on Contractual and Financial Arrangements Between Hospitals and Members of Their Governing Boards and Hospitals and Their Medical Specialists." We appreciate the opportunity to review this document.

I would like to commend the GAO for its objectivity. This area is one that has had a substantial number of subjective judgments and statements made over the past several years, and we greatly appreciate your efforts to place these issues in some proper perspectives. We were especially impressed with your recognition of the fact that duality of interest is not in and of itself detrimental to the institution and, in fact, can be quite beneficial as long as such duality does not become a true conflict of interest. In addition, we were gratified to see the references you have made to AHA's recently developed Guidelines for Resolution of Conflicts of Interest in Health Care Institutions.

After a careful review of the draft submitted to us for comments, we make the following suggestions:

1. While the issue you are attempting to get at in the proposed recommendation to Congress found in Chapter 4 is an important one, we believe that legislation and regulations already in place or under development can effectively deal with the GAO concerns. It is our view that further special amendments to the Social Security Act are not necessary in this regard. For example, the existing authority includes provisions for assuring that reimbursable costs are "reasonable"; that there be exclusions from reimbursable costs of any part of incurred costs found to be "unnecessary in the efficient delivery of needed health services"; and that participating institutions act

CABLE ADDRESS AMHOSP

APPENDIX III

"prudently" in the purchase of goods and services for the institution. In addition, the Joint Commission on Accreditation of Hospitals is now in the process of evaluating changes in the current standards and procedures for accreditation, particularly with respect to the issues of potential conflicts of interest. As you know, JCAH accreditation serves as the basis for participation in the Medicare program.

2. In the draft supplied to us for comment, several direct quotations seem to be taken from an AHA document entitled Relationships: Hospitals and Hospital-Based Specialists. This document is currently under revision by the Association, and some of the quotations utilized in the draft may well be changed in the new publication that will result from our current efforts here. I am in the process of obtaining a copy of the latest revision that is now under consideration and will contact you directly if there are potential changes.

3. We think that it should not be necessary for you to publish specific amounts paid to physicians in the institutions that the GAO studied. This kind of information is often considered to be privileged. It also should be noted that recent Social Security Administration policy established on disclosure of information in the Medicare program is most pertinent here. We do believe that the information you have compiled on the types of contractual arrangements and controls for fee structures is useful public information, however.

The American Hospital Association is most interested in the issues studied by the GAO and raised by your draft report. We have some specific suggestions to make regarding Item 1 above and I will be following up this letter with a telephone call to you so that we can discuss this further.

Sincerely

Paul W. Earle

Paul W. Earle
Director, Management Services

eap
cc: Robert Iffert

APPENDIX IV

AMERICAN HOSPITAL ASSOCIATION
ONE FARRAGUT SQUARE SOUTH WASHINGTON, D.C. 20006 TELEPHONE 202 [illegible]

November 20, 1974

Mr. Gregory J. Ahart
Director
Manpower and Welfare Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

I am following up my letter of September 27 in regard to the GAO draft report on "Information on Contractual and Financial Arrangements Between Hospitals and Members of Their Governing Boards and Hospitals and Their Medical Specialists". Two problems we have with the draft report will be covered in this letter.

First, we do not believe that the basic recommendation to Congress in the draft report is an appropriate one. In fact, we don't see how the findings of the GAO study of 19 hospitals really support the conclusion that there should be mandatory public disclosure of "overlapping interests" on the part of hospital board members and employees, and mandatory public disclosure of hospital arrangements with hospital-based medical specialists. The study clearly demonstrates that there were no findings of wrong doing or inappropriate behavior within hospitals; in fact, the report states that "overlapping" interests are beneficial to the institution in many instances. Moreover, as pointed out in my earlier letter, there are already adequate federal legislation and regulations in place to effectively deal with any problems that might arise.

Second, the report includes a number of quotations from the AHA document Relationships: Hospital and Hospital-Based

Specialists that is now under revision by the Association. Unfortunately, the fully revised document, to be entitled Contractual Relationships Between Hospitals and Physicians, will not be available in time for your use in the report. Consequently, I hope that any quotes that you wish to use will include the notation that the document is in the process of revision.

Some additional comments on these quotations are in order, since several were not in the proper context and are therefore subject to misinterpretation.

1. At the top of page 6, there is a paraphrase of AHA's viewpoint on the general subject of contractual arrangements with physicians. This paraphrase is somewhat out of context in that a portion of the statement comes from a specific section in the document on leasing arrangements. A more accurate reflection of our general views here would be to state that the AHA believes that the interests of the community must be given full consideration through the hospital's accountability to the public and, in keeping with this concern, has adopted certain principles for contractual relationships between hospitals and physician specialists.

2. On page 31, middle paragraph, a more up to date statement on AHA's policy here would reflect a more positive position, for example, that the AHA approves any arrangement between a hospital and physician that is (1) fair to the parties involved, (2) conducive to high quality medical care, and (3) supportive of the interests of the patients and the community served by the hospital.

3. The last paragraph on page 31 repeats the paraphrase noted in 1. above, and our same recommendations would apply here.

4. On page 33, item (5) in the middle paragraph is not really a specific arrangement or method of compensation for hospital-based specialists, and should be dropped from the list. Moreover, item (6) would be more accurate if it read "cost per unit of service", rather than "fee schedules".

Ahart/3 11/20/74

5. In regard to the quotations from the other AHA document referenced in the report, the Guidelines for Resolution of Conflicts of Interest in Health Care Institutions, the paraphrase on page 2 is not fully accurate in that it leaves out the clarifying phrase "with administrative responsibilities". This phrase should be added to the end of the second to last sentence in the first paragraph.

To restate our basic concern with the report, we think that the proposed recommendation to Congress for various mandatory public disclosures is not justified by the findings of the study and is not necessary in light of existing legislation and regulations. We also believe this recommendation has the potential for serving against the public interest to the extent that a simple public disclosure of "overlapping interests" could well undermine public confidence when in reality the dual interest benefits the institution and the public, and also to the extent that such simplistic and universally applied disclosure requirements could discourage qualified community leaders from serving on hospital boards. We believe that the duality or "overlapping interest" issue is far better handled through the kinds of internal disclosure requirements and other processes already carried out by most health care institutions in meeting their public trust and responsibilities.

Sincerely yours,

Paul W. Earle
Director, Management Services

cc: Robert Iffert

vlb

GAO note: Page numbers referred to may not correspond to those of the final report.

APPENDIX V

COLLEGE OF AMERICAN PATHOLOGISTS / WASHINGTON OFFICE
ALFRED [illegible] PARK DRIVE
[illegible] STREET, N.W.
WASHINGTON, D.C. [illegible]
PHONE [illegible] 466

October 21, 1974

Gregory J. Ahart, Director
Manpower and Welfare Division
United States General Accounting Office
Washington, D.C. 20548

RE: DRAFT REPORT "INFORMATION ON CONTRACTUAL AND FINANCIAL ARRANGEMENTS BETWEEN HOSPITALS AND MEMBERS OF THEIR GOVERNING BOARDS AND HOSPITALS AND THEIR MEDICAL SPECIALISTS".
GPO: 1970-406-317.

Dear Mr. Ahart:

The College of American Pathologists is a non-profit organization, headquartered in Chicago, Illinois, and represents over 6,000 physician-members, who practice in the speciality of Pathology. Our members are affiliated with the various medical schools in the U.S.; they serve as hospital-based physicians; they operate independent medical laboratories; and they serve in various capacities in the military forces and branches of the Federal government. The College appreciates the opportunity to comment on this draft report.

In the draft report, the Government Accounting Office suggests that the public should be informed of the methods used to comepnsate hospital-based physicians because certain reimbursement methods may deter the specialist from incurring expenses needed to improve patient care. In addition, American Hospital Association spokesmen were quoted as being concerned that such specialists might be unduly influenced because of their percentage contracts and fail to recommend hospital expenditures that would improve patient care. They further suggest, for similar reasons, that a pathologist might not wish to accept a reduction in his personal income to compensate an additional colleagues.

APPENDIX V

Pathologists are physicians and as such must take medical and legal responsibility for medical services provided by them or under their direction. Pathologists have reflected great leadership in the advancement of the use of the laboratory in modern medicine and have been responsible for the introduction of many new procedures. In addition, peer review of the laboratory by other physicians in the area, especially where other laboratories and/or other hospitals exist, will cause a constant comparison of services available by the referring physicians. The hospital's medical staff will demand a constant up-grading of procedures and add new services. These improvements will, of necessity, increase the quality and volume of work, and therefore indirectly could only lead to an increase rather than a decrease in the laboratory's income. Such statements as attributed to the American Hospital Association fail to recognize the demonstrated contributions of pathologists to the medical education of their community, and their development and participation in the initial and continuing education of paramedical laboratory personnel and physicians throughout the United States.

These statements by spokesmen for the American Hospital Association, in our opinion, are expressions of sentiment and cannot be supported by any significant evidence.

The American Hospital Association spokesmen are quoted as having stated that a lease arrangement involved a possible loss of effective administrative control over services for which the hospital governing authority is responsible.

The hospital and its lay board of trustees cannot be medically responsible for medical services provided within the hospital. Only the physicians, in this case, the pathologists, can assume this responsibility. The degree of administrative responsibility required by the hospital can be spelled out in the lease arrangement.

It is true that the patient does not have the immediate choice of his or her pathologist when admitted to a hospital. The patient's personal physician is delegated that responsibility by the patient, just as the attending physician is usually delegated the responsibility of choosing other consultants, such as a surgeon, internist, etc. The hospital-based physicians have to apply for medical staff privileges and these privileges are reviewed and granted by the members of the active medical staff which would include the patient's own personal physician.

APPENDIX V

The Government Accounting Office recommends that hospitals should publicly disclose their contractual arrangements with hospital-based specialists regarding the furnishing of facilities and personnel to support specialists, the establishing of patient charges for x-ray and laboratory services, the method of compensation and the amounts paid, the limitations on the specialist's medical practice outside the hospitals, and other financial dealings between the hospitals and specialists or firms for which the specialists have financial interests.

This recommendation assumes that the hospital represents a public utility and as such has been mandated to total public disclosure. This is not the case. At the present time, there is no mandate that a person's personal income shall be made general public information. As a matter of fact, the Internal Revenue Service works diligently to protect the right of privacy of the individual taxpayer. Mandated disclosure of personal incomes of hospital-based specialists would be prejudicial and discriminatory. Wide application of the principle that all persons serving the public should have public disclosure of their income would mandate that all physicians, bankers, paramedical personnel, lawyers and government employees so disclose.

Public disclosure of incomes could have a very adverse affect on medical practice throughout the United States. The inference appears to have been made by the Government Accounting Office and others that there is something wrong with large incomes. Hospital-based physicians have difficulty controlling their income because they must provide the services ordered by all hospital staff physicians for their patients. Hospital-based pathologists, generally acting as consultants to other physicians, have to respond to the needs of these physicians and their patients. If he is not incorporated and in private practice, he has no built-in pension or other fringe benefits, such as those provided by industry and government to their employees. Therefore, these have to be provided for by income retained after taxes. If public pressure to reduce the income of pathologists results from public disclosure, the only practical response available to the pathologists is to reduce the amount of work he performs per week to the number of hours acceptable in the nonmedical area. that is 40 per week. For years, salary limitations placed on pathologists closed the door of this vital specialty to many qualified physicians, reducing the number entering the field and causing, in part, the great shortage which has existed until recent years. We would hope that such a discriminatory policy as public disclosure of income would not be used by the government because it would have an almost immedicate and obvious adverse effect.

APPENDIX V

In addition, public disclosure of income could have a very disruptive effect, both within the medical community and outside. The functions, responsibilities, duties, and capabilities of pathologists vary widely between individual physicians. Unqualified comparison of income would introduce many petty comparisons and jealousies both within and without the medical specialty, and would disrupt the goal of quality patient care. Pathologists incur massive direct supervisory responsibility with the assumption of medical responsibility for large groups of paramedical personnel performing services at their direction, responsibilities of a magnitude seldom required of other practicing physicians.

Publication of incomes will not be recorded on an equal basis. Variations in accounting procedure, deferred income, fringe benefits, expenses accrued in continuing medical education, etc., could cause great confusion if the public compared income on a gross dollar basis alone. Such publication of incomes would have a tendency to promote mediocrity by representing an average level of income as the median and with the categorical and possibly derogatory inferences about physicians at the extremes.

As the volume of the laboratory increases, the responsibilities, duties and obligations for time increase for the pathologist, and conceivably his income could increase. We cannot see how this public disclosure would serve in any way to improve the quality of health care available to a community and its citizens. We would urge that public disclosure of contractual relations between hospital-based medical specialists and the hospital they serve not be recommended to the Congress.

We would be happy to discuss any of these points with you in the future, if you so desire.

Yours truly,

Robert C. Horn, Jr., M.D.
President

RCH/sm

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October 29, 1974

Gregory J. Ahart
Director
Manpower and Welfare Division
United States General Accounting Office
Washington, D.C.

Dear Mr. Ahart:

Reference is made to the draft GAO report on the relationships of hospitals to trustees and to "hospital-based" physicians. The American College of Radiology regrets the delay in this response. However, as noted verbally, copies of the draft report were not received for nearly two months after your August letter. Just the same, on behalf of the 9600 members of the College, we are happy to comment.

It should be noted, in general, that radiologists do not favor reference to themselves as "hospital-based" physicians for a variety of reasons. This phrase was coined by the insurance industry, adopted by federal agencies and is used, as in your report, to assert a difference between the practice of radiologists and the practice of other physicians in the same institutions. However, the usage is widespread and, having objected, we will pursue the substance of our concerns with your draft report.

Essentially, our concern is with just this basic notion that the practice of radiologists in hospitals is different from the practice of other physicians in the same institutions and should be managed under different terms. Specifically, we have supported the right of radiologists to practice in hospitals on the same terms as do other members of the medical staff and where other members of the staff bill patients for professional services, for the radiologists to do likewise, subject to the same responsibilities and controls.

This was stated by the American Medical Association House of Delegates on October 1, 1965 and substantiated on other occasions:

> Hospital-based medical specialists are engaged in the practice of medicine. The fees for the services of such specialists should not be merged with hospital charges. The charges for the services of such specialists should be established, billed and collected in the same manner as are the fees of other physicians.

Also in October 1965, the ACR Board of Chancellors adopted a statement that:

> It is the policy of the American College of Radiology that members of the College shall separate their professional fees from hospital charges and present their own bills to patients.

APPENDIX VI

Since that time, a steady shift away from contract practice by radiologists has resulted in a current situation in which a majority of radiologists practicing in voluntary hospitals do so on the same basis as other staff members. The most recent survey of its members by the ACR at the end of 1970 indicated that 55.3 percent were then practicing independently of any financial relationship with their hospitals. A current survey is now underway by the College. College committees active in that area have predicted that the response will indicate about 65 percent independence.

It should be noted that there have appeared to be inconsistent responses between the ACR surveys and periodic efforts by others to assess the same situation. The ACR survey is based upon the numbers of radiologists, not the numbers of hospitals, and the data base is limited to responses from radiologists practicing in voluntary hospitals where any physicians bill patients for professional service. Thus, federal facilities are excluded, as are prepayment plans.

In terms of the final recommendation that hospitals be required to make public their contractual relationships with physicians, it is the ACR's policy that radiologists have no contractual basis for practice in hospitals. However, where these persist, often despite the radiologist's preference for change, publication of them would be clearly discriminatory and often misleading.

Much is made of the argument that the "monopoly" of radiology in hospitals justifies a distinctive set of controls on delivery of professional service, scales of charges and levels of professional compensation plus limitations on professional freedom. Essentially, the College rejects these arguments as they apply to a great majority of American hospitals.

Historically, radiologists and most other specialists have had monopolies on their services in most hospitals by virtue of their scarcity. Only in the last few years have the numbers of radiologists begun to reach anything like the perceived national needs. But the same is true of many categories of physicians, neurosurgeons, gastroenterologists, oncologists, cardiologists and pathologists, among others. Even where there is competition among internists or surgeons, such competition is still limited by staff rules, the bed and other capacity of the hospital and appropriate governing and review mechanisms of the hospital's board and staff. The College in 1965 also supported the principle of open staff in radiology to the extent desired by a hospital and its staff.

A second argument for uniqueness is the provision of support for radiology within a hospital. However, it is difficult for most radiologists to perceive any significant difference in principle between a hospital's employment of x-ray technologists and its employment of nurses to staff the wards and operating suites. It is difficult to perceive a difference between a hospital providing x-ray equipment in the radiology department and providing the detailed monitoring equipment in an intensive care unit or the sterile facilities of the surgery. There are sometimes differences if the hospital provides full clerical assistance to a full-time radiologist but not to other chiefs of service. As more radiologists become financially independent of hospitals, they employ their own personnel for practice management, utilizing hospital employees in a manner parallel to relationships with other medical staff members.

A point is raised about the common practice of hospitals in seeking to restrict the professional activities of radiologists on their staffs. While such questions are often couched in terms of assuring adequate coverage, they may equally often be found to relate to the desire of a hospital administration to prevent the radiologist from opening his own office. Where this is so, there is an arbitrary constriction of ambulatory patients into a hospital x-ray department, frequently leading to its expansion of that department. This could well be one of the elements obliquely cited as tending to cause a specialist to deliver less than his best possible care.

One further point is the claim that hospitals should set the fees of their "hospital-based" specialists. Where the radiologist practices under a contract, the participation of the hospital in setting such fees is implicit, as is the hospital's collecting of the total charge for the technical and professional components of the services rendered. However, until hospitals are obligated by Medicare requirements and other federal review systems to end their historic practice of using radiology as a profit center, it cannot be argued that such a practice is supportive of savings to patients.

It has been the observation of ACR committees that where radiologists bill independently, the tendency is for their fees to rise more slowly than hospital charges. For all practical purposes, the allowable fees of radiologists, like those for any other physician, are monitored and restricted by third parties. When Medicare, by law, will pay no fee above the 75th percentile of community charges, that quickly represents a ceiling.

For the radiologist practicing independently, his income is a straightforward multiple of the number of procedures he performs minus his cost of doing business. Most of the time, the element of independence has had a deeper intrinsic value to radiologists than merely the opportunity to set fees and the admitted bother of collecting them.

Thus, in turning to specific references in the body of your draft report, may we urge at pages 6 and 7 that additional material reflecting our viewpoint of desirable relations between radiologists and hospitals be offered as a counterpoint to the existing quotations from the American Hospital Association. Certainly in reference to current court rulings, as in the Darling case frequently cited by AHA, there would be a greater onus on the hospital if it is established that a radiologist is an employee than if it is established that he is a member of the medical staff with full professional independence.

At page eight, it might be noted that the possession of a lease on a hospital department by a radiologist imposes upon him a total responsibility to administer the department, attend to its logistics and personnel, satisfy the medical staff and achieve all of this within the general policies of the hospital. Thus, the responsibilities of the lessor are greater than those of the appointed chief of a department. And the hospital has the final authority to alter or cancel the lease. The ACR recognizes a lease as an acceptable basis for practice in a hospital but stipulates that the possession of a lease by a radiologist should not infringe upon the rights of the medical staff to request other radiologists to practice in the department.

At page nine, we would note that the hospitals in which a salaried radiologist makes $33,000 yearly are not likely to be attractive practice opportunities if the situation is a full-time responsibility.

We have discussed above the issues raised in your first paragraph on page 10 concerning the natural monopoly characteristic and the forms of support provided to radiologists. We would suggest that if these paragraphs remain, that the ACR viewpoint also be stated concerning the issues raised.

Moving to your page 31, we have cited the policy positions of the AMA and the ACR, which we would suggest adding to your present discussion of AHA viewpoints.

At page 34, it is worth pointing out in terms of the presumption that hospitals now identify the elements of their charges to patients for x-ray and other services that this is not necessarily so. Despite current assaults from federal and insurance plans, the practice of global budgeting remains basic to many hospitals. We see nothing wrong with asking hospitals to document and publicize the basis for all of their charges to patients, particularly since the Medicare regulations have required this now since 1971. We have no objection to advising the public of the basis of practice by radiologists, though we think publication of a physician's income without explaining his work load is grossly unfair. Similarly, we think it appropriate to require a hospital to assert that it seeks to impose a restrictive covenant upon its radiologists where that is the case. And if a radiologist is the provider of anything besides professional services to the patients of a hospital, that should be public knowledge to the same extent that the hospital's relationships with other providers is public knowledge.

The points on your page 42 have been discussed above, as have the same ones repeated in the summary on pages 46 and 47.

On behalf of the College and its members, we appreciate the opportunity to comment on this report. Given a balance in viewpoints which our comments can provide, it could make a contribution to the knowledge of federal agencies about its subject. If we can provide any additional information, please request it of us.

Sincerely,

Robert E. Wise

Robert E. Wise, M.D.
Chairman, Board of Chancellors

cc: Executive Committee

GAO note: Page numbers referred to may not correspond to those of the final report.

APPENDIX VII

SUMMARY: INSTANCES OF OVERLAPPING INTERESTS OF BOARD MEMBERS OF HOSPITALS IN THE WASHINGTON, D.C., METROPOLITAN AREA AND IN MISSOURI

Firms with which hospital board members are associated	Hospitals: Washington, D.C., metropolitan area A	B	C	D	E	F	Missouri G	H	I	J	K	L	M	N	O	P	Q	R	S	Total
1. Banks	9	2	1	4		2	3			2				4	1		5		7	40
2. Legal	3						1		1				1	2	1			1		10
3. Investment	2	1		1																4
4. Insurance									3					2					4	9
5. Newspaper/Printing										1	1			2			2			6
6. Utilities								1									2		5	8
7. Industrial/Supplies							1	1					1	8	1	1		3	6	22
8. Data processing																	1			1
9. Pharmaceutical							1							1						2
10. Other	3	1					1							3			2	1		11
Other relationships of hospital board members																				
1. Stockholder or board member of parent corporation/subsidiary						22														22
2. Partner of supplier of major hospital medical service	1					7														8
3. Member of partnership dealing with the corporation						9														9
4. Associated with competitive hospital						1														1
Total	18	4	1	5	0	41	7	2	4	3	1	0	2	22	3	1	12	5	22	153

Note: Appendix VIII shows information on hospitals with more than five board members having overlapping interests and appendix IX shows information on hospitals with zero to five board members having overlapping interests.

APPENDIX VIII

INFORMATION ON HOSPITALS WITH MORE THAN FIVE BOARD MEMBERS HAVING OVERLAPPING INTERESTS

Hospital A

Governing body	Functions	Total members	Members with overlapping interests: Number	Members with overlapping interests: Percentage
Board of trustees	Governing	[b]45	[a]15	33

Board member relationships:

Firm	Board of trustees: Officer 1	2	3	4	5	6	Member 7	8	9	10	11	12	13	14	15
1. Bank	X		X		X	X		X			X	X	X	X	
2. Legal firm		X										X	X		
3. Investment broker							X	X							
4. Auto dealer										X					
5. Food vendor				X					X						
6. Medical specialist															X

[a]For details of these relationships, see pp. 7 to 9.

[b]Includes emeritus and honrary trustees.

Hospital F

Governing Body	Function	Total members	Members with overlapping interests: Number	Members with overlapping interests: Percentage
Board of directors	Governing	27	[a]22	82

Board member relationships:

Firm and relationship	Board of directors: Officers 1	2	3	4	5	6	Directors 7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
Firm																						
1. Bank						X												X				
Corporate relationship																						
2. Stockholder of parent corporation	X	X	X	X	X	X	X	X	X	X		X	X	X	X					X		X
3. Board member of parent corporation or subsidiary		X		X	X	X					X						X					
Other relationship																						
4. Partner of supplier of major hospital service	X	X	X		X		X	X	X													
5. Member of partnership dealing with the corporation	X	X	X	X				X						X	X					X		X
6. Member of competitive hospital																					X	

[a]For details of these relationships, see pp. 9 and 10.

APPENDIX VIII

Hospital G

Governing body	Function	Total membership	Members with overlapping interests	
			Number	Percentage
Board of trustees	Governing	20	3	15
Advisory trustee board	Advisory	10	4	40
Corporate board of directors (religious order)	(a)	10	-	0
Total		40	7	18

Board member relationships:

Firm	Board members						
	Board of trustees			Advisory trustee board			
	1	2	3	4	5	6	7
1. Bank		X				x	x
2. Legal					X		
3. Construction				X			
4. Pharmacy	X						
5. Supplies			X				

[a]This board has delegated authority for management of the hospital to the board of trustees.

APPENDIX VIII

Hospital N

Governing body	Function	Total membership	Members with overlapping interests: Number	Members with overlapping interests: Percentage
Board of directors	Governing	36	[a]14	39

Board member relationships:

Firm	Board of directors 1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Bank						X	X			X	X			
2. Legal firm			X									X		
3. Insurance													X	X
4. Pharmaceuticals									X					
5. Newspaper													X	
6. Printing	X													
7. Tractor & implement	X	X												
8. Airline	X		X											
9. Motor & supply	X	X												
10. Electrical & plumbing				X										
11. Variety					X									
12. Machinery								X						
13. Bottling												X		
14. Paper													X	

[a]For details of these relationships, see pp. 11 and 12.

APPENDIX VIII

Hospital Q

Governing body	Function	Total membership	Members with overlapping interests: Number	Percentage
Board of trustees	Governing	21	4	19
Hospital association	Advisory	24	3	13
Advisory committee	Advisory	30	3	10
Total		75	10	13

Board member relationships:

Firm	Board members: Board of trustees				Hospital association			Advisory committee		
	1	2	3	4	5	6	7	8	9	10
1. Bank	XXX				X			X		
2. Financial services						X				
3. Data processing					X					
4. Newspaper		X								
5. Printing & design									X	
6. Auto dealer										X
7. Power company			X							
8. Telephone company				X						

APPENDIX VIII

Hospital S

Governing body	Function	Total membership	Members with overlapping interests: Number	Percentage
Board of trustees	Governing	15	[a]10	67

Board member relationships:

Firm	Board members 1	2	3	4	5	6	7	8	9	10
1. Bank	X	X		X	X	X	X			X
2. Insurance	X	X	X		X					
3. Conglomerate								X		
4. Industrial			X							
5. Manufacturing							X			
6. Brewery			X			X			X	
7. Telephone company	X									
8. Gas company				X						
9. Power company			X		X		X			

[a]For details of these relationships, see pp. 13 and 14.

INFORMATION ON HOSPITALS WITH ZERO TO FIVE BOARD MEMBERS WITH OVERLAPPING INTERESTS

Hospital B (university operated)

Governing body	Functions	Total members	Members with overlapping interests: Number	Members with overlapping interests: Percentage
Board of directors (university)	Governing	20	-	-
Board of regents (university)	Advisory	50	4	8
Total		70	4	6

Board member relationships (advisory):

1. The president of the bank which handles the university's payroll account.

2. The chairman of the board of a second bank which maintains both checking and savings accounts for the university.

3. A member of the principal investment broker used by the university.

4. An executive vice president of a major oil company. The university owned bonds in the amount of $250,000 and 17,000 shares of stock in this oil company.

Hospital C

Governing body	Functions	Total members	Members with overlapping interests: Number	Members with overlapping interests: Percentage
Board of trustees	Governing	22	1	5

Hospital C (cont'd)

Board member relationships:

1. Executive vice president of the bank which maintains the hospital's operating, workman's compensation, and investment accounts. Daily balances of the operating account averaged $313,211 during a recent annual period.

Hospital D

Governing body	Functions	Total members	Members with overlapping interests	
			Number	Percentage
Board of trustees	Governing	30	5	17

Board member relationships:

1. The secretary of the board is president and managing officer of a savings and loan association which maintains a $23,000 certificate of deposit for the hospital.

2. A second member is president and director of the bank which maintains operating and endowment fund checking and three savings accounts for the hospital. The operating fund daily balance has recently averaged $168,020; balances maintained in the savings accounts recently totaled about $6,700.

3. Two members are the president and vice president of the bank which maintains building fund checking accounts and several savings accounts for the hospital. Savings accounts totaled about $37,440 at this bank.

4. A fifth trustee is a member of the investment brokerage firm which handles the hospital's stock transactions. The hospital pays no compensation for these services.

Hospital E

Governing body	Function	Total members	Members with overlapping interests Number	Percentage
Board of trustees	Governing	14	-	-

Board member relationships:

None

Hospital H

Governing body	Function	Total members	Members with overlapping interests Number	Percentage
Board of trustees	Governing	29	2	7

Board member relationships:

1. A vice president of the local gas company, the only natural gas supplier in the area, is president of the hospital board.

2. The co-owner of a bedding company which rebuilds mattresses for the hospital. During a recent annual period the hospital paid $3,021 to the company for this service.

Hospital I

Governing body	Function	Total membership	Members with overlapping interests Number	Percentage
Board of trustees	Governing	13	[a]4	31

[a]For details of these relationships, see pp. 10 and 11.

Hospital I (cont'd)

Board member relationships:

1. The president and two other associates of an insurance agency providing insurance coverage for the hospital.

2. An associate of a legal firm providing services to the hospital.

Hospital J

Governing body	Function	Total membership	Members with overlapping interests Number	Percentage
Board of trustees	Governing	5	-	-
Community staff	Advisory	17	3	18
Total		22	3	14

Board member relationships (advisory):

1. The vice president of a bank which maintains a hospital checking account. The bank recently contributed about $5,000 to the hospital.

2. The vice president of a second bank which maintains a hospital pension fund of $20,000. The bank made an annual charge of about $326 for this service.

3. The owner of a newspaper in which the hospital advertises for employees. During a recent annual period the hospital paid $2,196 for this service.

Hospital K

Governing body	Function	Total membership	Members with overlapping interests Number	Percentage
Board of trustees	Governing	5	1	20

Board member relationships:

1. An associate of a newspaper in which the hospital advertised for employees. Recent annual payments to the newspaper were about $100.

Hospital L

Governing body	Function	Total membership	Members with overlapping interests Number	Percentage
Board of directors	Governing	35	-	-

Board member relationships:

None

Hospital M

Governing body	Function	Total membership	Members with overlapping interests Number	Percentage
Board of directors	Governing	15	2	13

Board member relationships:

1. An attorney who provides legal services to the hospital. Fees amounted to $2,325 for a 3-year period.

2. An owner of a department store which sold merchandise to the hospital amounting to $934.

Hospital O

Governing body	Function	Total membership	Members with overlapping interests Number	Percentage
Governing board (religious order)	Governing	7	-	-
Advisory board	Advisory	21	3	14
Total		28	3	11

Board member relationships:

1. Chairman of the board of a bank which maintains a checking account for the hospital. The account's balance was about $15,952.

2. An attorney associated with a legal firm serving the hospital. During a recent annual period the hospital paid $8,100 for retainer fees and services.

3. The vice president of an electrical and plumbing supply firm which provided about $1,000 of supplies during a recent annual period.

Hospital P

Governing body	Function	Total membership	Members with overlapping interests Number	Percentage
Advisory board (four city hospitals)	Advisory	12	1	8

Hospital P (cont'd)

Board member relationships:

1. The president of a uniform company which sells supplies to the hospital. During a recent 8-month period the company sold merchandise totaling $11,441 to this and three other city hospitals.

Hospital R

Governing body	Function	Total membership	Members with overlapping interests	
			Number	Percentage
Board of directors (religious order)	Governing	5	-	-
Advisory board	Advisory	15	[a]5	33
Total		20	5	25

Board member relationships:

1. A partner in a legal firm serving the hospital.

2. Two vice presidents and the vice chairman of a national brewery which supplies the hospital.

3. The vice president of a national aircraft corporation, a subsidiary of which supplies financial services to the hospital.

[a]For details of these relationships, see p. 12 and 13.

APPENDIX X

PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE RESPONSIBLE FOR ADMINISTERING ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Caspar W. Weinberger	Feb. 1973	Present
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969

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