PRACTITIONER FRAUD AND ABUSE IN GOVERNMENT MEDICAL BENEFIT PROGRAMS

EXECUTIVE SUMMARY
NATIONAL INSTITUTE OF JUSTICE
U. S. DEPARTMENT OF JUSTICE
GRANT NUMBER (821J-CX-0035)

PRINICPAL INVESTIGATORS
HENRY N. PONTELL
GILBERT GEIS
PAUL D. JESILOW

PROJECT ADMINISTRATOR
MARY JANE O'BRIEN

GRADUATE RESEARCH ASSISTANTS
CONSTANCE KEENAN
STEPHEN ROSOFF

95225

CORRESPONDENCE TO PONTELL OR GEIS, PROGRAM IN SOCIAL ECOLOGY, UNIVERSITY OF CALIFORNIA, IRVINE, CA 92717, (714) 856-5574.

ABSTRACT

This study examined offenses by physicians participating in government-funded medical benefit programs. The research has been guided by theoretical ideas drawn form social science and the law. The project had three major goals. These were: (1) to gain substantive knowledge of abusive and fraudulent practices by physicians participating in Medicare and Medicaid; (2) to interpret this information in terms of social scientific research and theory regarding white-collar crime, deterrence, and medical sociology; and (3) to suggest approaches aimed at the reduction of fraud and abuse against government medical benefit programs.

Data were obtained from more than three dozen interviews with persons responsible for the policing of the Medicare and Medicaid programs at both state and federal levels, medical licensing personnel, officials of the American Medical Association and others. Interviews were also conducted with 42 criminally and administratively sanctioned physicians, almost exclusively from New York and California, the nation's two largest Medicaid systems. Similar interviews were conducted with a control group of 34 non-sanctioned Medi-Cal (Medicaid) providers in southern California. Additionally, we interviewed eight sanctioned psychologists in California, and assembled a demographic portrait of physicians who have been suspended and excluded from Medicare and Medicaid from 1977 through 1982.

The results of our interviews with officials show a need for further improvement in policing the systems in terms of strategies of control and changes in regulations. Many officials expressed frustration and concern over what was seen by them as enormous amounts of dollar losses to the programs through fraud and abuse by all types of providers — not just physicians.

The study found that: (1) billing systems and low reimbursement invite fraud and abuse; (2) some unknown proportion of cheaters go totally undetected; (3) psychiatrists are overrepresented among sanctioned physicians, probably because they bill for time, and are therefore easier to monitor and police; (4) sanctioned physicians generally did not view themselves as cheaters, and were more angry than ashamed about what had transpired; (5) limited resources and access to physician records hamper law enforcement efforts; and (6) there are no major differences between sanctioned and non-sanctioned doctors on a range of attitudes about the programs.

PRACTITIONER FRAUD AND ABUSE IN GOVERNMENT MEDICAL BENEFIT PROGRAMS

Physicians in the United States persistently lead all other professions in the degree of prestige that they are accorded. In a classic study, North and Hatt found that only Supreme Court judges — and there are only nine of these — enjoyed higher standing with the public than doctors.[1] Subsequent public opinion polls have continuously reported the same conclusion.[2]

There are many reasons why doctors are so well regarded. First, of course, they earn exceedingly high incomes. This reason will hardly suffice alone, though, for many business executives earn more than doctors, but as a group they are regarded with jaundiced eyes by the public. Doctors certainly are seen as performing immensely important and valuable social and scientific tasks. They are believed to control a good deal of complicated information and to perform what can be dangerous tasks with skill. The expense and length of its member's training also plays into the public's considerable awe of the medical profession: the fact that only the best students, those with outstanding grades, will be admitted to medical schools.

At the same time that they possess an image as public benefactors and selfless servants dedicated to a noble cause, doctors are also business entrepreneurs, rationally seeking to sell their talents for a good return in a competitive marketplace. In their business pursuits, they enjoy a number of advantages: For one thing, their professional associations adroitly limit entry into

their business, thereby making certain that the supply of services never allows demand to reduce prices. For another, doctors sell a commodity that citizens regard, literally, as vital: good health, prolonged life, and relief from pain.

In the United States, law-breaking by doctors has traditionally been limited to a few kinds of activities associated with their work. Medical access to drugs that could not be sold legally without a prescription made a few doctors susceptible to involvement in illicit narcotics transactions. The outlawing of abortion created a number of doctors who used their training to perform lucrative terminations of pregnancies. Doctors also engaged in fee-splitting, a procedure under which a referring physician receives a kickback from the specialist for having sent the patient to him. This process has been outlawed because it tends to make the availability and size of the remitted money the criteria for referrals, rather than the best medical interests of the patient. American doctors also were known to engage in ghost surgery — whereby, after the anesthesia had taken effect, another doctor performed an operation for the expensive surgeon with whom the patient had contracted for the work. Doctors also most certainly overcharged, collected fees for meaningless procedures, and insisted on unnecessary follow-up appointments in order to enhance their income. But these were never regarded as major problems, particularly during a time where the practice of medicine involved much closer personal contact between doctors and patients, marked especially by the prevalence of house calls, now an anachronism in the United States.

Nonetheless, the strain between the public service and scientific commitment of medical practitioners and their role as economic self-aggrandizers always

possessed potentiality for fraud and abuse. In colonial times in America, for instance, many doctors opposed inoculation for smallpox during the plague of 1721 because, it is believed, "it would have saved the town thousands of pounds that is now in their pockets." The chief opponent of inoculation, Dr. William Douglass, Edinburgh trained and the only physician in Boston with an academic degree, was challenged about his failure to write up his medical observations on the epidemic. He replied that he had found it more important "to begin by reducing my smallpox accounts into bills and notes for the improvement of my purse" rather than to reduce his experiences to notes for the improvement of science.[3]

Part of the explanation for an absence of much public concern with medical wrongdoing, however limited it might have been, clearly lay in the fact that professional associations arrogated to themselves responsibility for virtually all of the policing of their ranks. They tended to be intensely protective of their members, operating on the principle that to air their occasional scandals in public would be to risk tarnishing the image of the entire profession.

This protective shield, however, became permeable in 1967 when the medical profession was incorporated into far-reaching programs of government subsidy of medical care. Two programs were launched in that year: Medicare, which pays 80 percent of the costs of persons past the age of 65, and Medicaid, which covers the medical expenses of poor persons. The programs were carefully structured so that they gave enormous autonomy to the medical practitioner: it was feared that, otherwise, doctors and hospitals would refuse to have anything to do with them. As the profession became more deeply involved in the aid schemes, it became obvious

that they could be milked and bilked for enormous sums. Medicaid and Medicare are based on fee-for-service principles, and routinely pay physicians for whatever it is that they say they have done, no questions asked. The temptation to provide exceptionally thorough medical care was reinforced by this provision particularly in the wake of a proliferation ofmalpractice suits against doctors, and the appearance of a very expensive technology, the price of which had to be amortized by high levels of usage. And some doctors saw the aid programs as a means to increase their incomes by a variety of billing practices that were fraudulent, but unlikely to be discovered; or, if discovered, to eventuate in nothing more than inconvenient consequences. The income of doctors skyrocketed, increasing at a rate very much in excess of inflation figures. Hospital costs in particular drove the budgets for Medicare and Medicaid beyond what the government — itself intent upon funding a vast defense program — found feasible. The inevitable result was that a barrage of structural reforms were proposed, and efforts were inaugurated to concentrate more intensively upon abusive practices so that they might be controlled and their cost to the programs eliminated.

The topics we focused on in this research can be subdivided into five areas. First, we sought to obtain a profile of doctors who had been suspended from participation in the Medicaid and/or Medicare programs because of fraudulent or abusive practices; second, when we determined that psychiatrists constituted a highly disproportionate number of sanctioned practitioners, we looked more closely

at this phenomenon. As a third matter, we surveyed medical students on our University campus to obtain an indication of the dynamics of their views regarding the aid programs, and their attitudes about violations of the laws and rules that governed them. Our fifth probe was into the enforcement processes employed in the state of California and by the federal government. We sought to determine the views of investigators, and to examine the structural aspects of the benefit programs that might contribute to the level of violative behavior. Sixth and finally, we interviewed a panel of doctors who had been sanctioned for practices not in accord with the rules of the aid programs and a comparison group of physicians who had not been sanctioned. We will discuss each of these research inquiries in turn below.

I. Profiling Violators

There is, of course, no reasonable method for determining the precise extent of fraud and abuse in regard to Medicaid and Medicare. Unlike most street crimes, victims — patients and insurance carriers alike — typically remain unaware of violations. Estimates of the extent of fraud usually are in the range of 10 to 20 percent of the $87 billion total of program expenses, but these cannot be taken as more than guesswork.

The names of 358 health care practitioners have appeared on lists issued since November 1977 by the federal Health Care Financing Administration of persons excluded from participation, usually for five years or less, in the benefit programs. Of the 358 providers, 147 were identified by us as physicians.

Except for 1981, the number of suspensions and expulsions has been rising each year, with the 49 cases for 1982 — the last period for which figures were available — higher than for any other 12-month time. The increase is believed to be related to stepped-up enforcement efforts rather than to any change in physician behavior.

To obtain background information on the sanctioned physicians, we first sought data from the American Medical Directory. For physicians not listed in the Directory, and to validate information from that source, we wrote to the state licensing boards.

Of 138 doctors for whom we found information, 50 (36%) were foreign medical school graduates. The largest number from a single traning center were three doctors from the University of Havana. Among the domestically-trained doctors, Meharry Medical College had the largest number of violators, a total of six. It is a school for black students located in Tennessee. California accounted for 41 sanctioned doctors (28% of the total), followed by New York with 25 (27%). These states are also the largest participants in the programs. Family or general practitioners made up the largest percent of violators (27%), followed by psychiatrists (18%), general surgeons (11%), internists (8%), and obstetricians and gynecologists (8%).

Like most statistics portraying law-breaking, the results undoubtedly tell us as much or more about enforcement priorities as they do about the malefactors. Enforcement stress tends to be placed on cases in which the dollar amounts involved are high, the aberrancies, identified most usually by computer checks on billing practices as measured against established norms, are striking, intent to commit fraud is reasonably clear, and the case seems relatively easy to prosecute -- - all matters that recommend action to a prosecutor who has a great deal of discretion about what cases will be accepted. Cases which involve "overutilization" of medical regimens do not get as high a priority as those which involve bills submitted for services never rendered. The former often involve very complicated "paper chases" and arguable medical judgments.

The concentration of foreign-trained and black doctors among the violators seems to be related to their location in inner-city practices, where large "Medicaid mills" flourish. These mills handle cases of poor people and routinely charge for a vast array of unnecessary treatments, often involving an entire family, if its members accompany the patient. Investigators for the U. S. Senate, visiting some of these mills as undercover agents with feigned ailments found themselves subjected by 85 different doctors they saw to 18 electrocardiograms, 8 tuberculosis tests, 4 allergy tests, hearing and glaucoma tests and three electroencephalagrams. They had told the doctors they saw that they were suffering from a common cold.

II. Psychiatrists

There are some 378,000 physicians in the United States. Psychiatrists represent 8 percent of this total, yet constituted 18.4 percent of the violators against the benefit programs, by far the most overrepresented speciality. The disproportionality is particularly highlighted when it is understood that psychiatrists rarely participated in aid programs because the rules tend to limit mental health treatments that will permit government reimbursement.

The high percentage of sanctioned psychiatrists, our research disclosed, was very likely a function not of their excessive cheating but rather of the manner in which enforcement proceeded. Almost all doctors bill for specified treatments rendered — for examinations, injections, surgeries, and similar office and hospital procedures. The question of fraud centers primarily on whether these practices actually were carried out. Fraud can be blatant, as when bills are submitted for patients who were never seen, or, more subtle, as when things such as x-rays are taken with a machine empty of film. In psychiatry, however, compensation is not measured primarily by services delivered, but rather for how long the service has been accorded.

Under such conditions, the temptation to inflate the time spent with a patient proves irresistible to a number of psychiatrists; and the ready ability to catch them doing this is what induces investigators to focus particularly heavily on psychiatrists' fraud against the benefit programs. The investigators employ a variety of tactics: they can themselves secure spurious Medicaid cards and pose as patients. they then can compare how long they are seen by the doctor with how

much time he billed for. Equally readily, investigators can photograph traffic to and from a psychiatrist's office, with a telltale clock as part of the background. It is also possible to check with the patients themselves to learn how much time they recall seeing a psychiatrist compared to his billing time. A surprising number of convicted psychiatrists also have been caught because they submitted bills for work for more hours than exist in a day.

Thus, it must remain uncertain whether psychiatrists are less honest than other medical specialists or whether their large representation among those sanctioned is because of their unique billing mechanisms. Arguments for tying the violations to the practice note that psychiatry has a low position among medical branches in the United States, in part because it is not regarded as "real" medicine, and in part because the earnings of psychiatrists tend to be less than those from most other specialties. On the other hand, persuasive ideas can be found to support the view that psychiatrists are apt to be more honest than their colleagues in other fields. For one thing, they presumably took up psychiatry with a certain disregard for high earnings. In addition, psychiatry appears to be a field with a notably strong commitment to people in contrast to material things. At any rate, the satisfactory resolution of this issue must remain for future research.

III. Medical Education and Fraud

We also undertook a survey of medical students at the University of California, Irvine, to determine their views about government medical benefit programs and their attitudes toward the problem of fraud and abuse in such

programs. Medical school is regarded as the most intensive phase of professional socialization and as a major influence on the ideas that physicians hold throughout their careers.

We distributed questionnaires to 350 students and received 144 responses, a rate of about 36 percent. The returns were considerably higher for first- and second-year students who were still in residence at the medical school: the students in upper classes had to be contacted by mail in a variety of extramural hospital settings.

Fifty-eight percent of the respondents were male, 37 percent female. Students were asked to rate features of the benefit programs on a 5 point scale, with 1 being "poor" and "5" being "excellent." The best average score, 2.95, was recorded by "quality of care delivered" and the poorest, 1.73, for "program efficiency." In-between were (1) ability to reach all those in need of services; (2) cost effectiveness; and (3) reimbursement rates. Obviously, the students thought that the medical profession's performance was the best part of the aid programs.

Most students estimated that less than 20 percent of the physicians involved in the programs commit fraud or abuse. The students also were confronted with three hypothetical cases and asked to select the most appropriate penalties. Illustrative is a case of overutilization of program services, in which a physician had billed for extra laboratory tests and x-rays worth $21,000 over a three-year period. Each student was asked to indicate three preferred penalties for the case. Seven believed that incarceration was appropriate, while nine indicated that no penalty was in order. The remainder of the responses fell into the following

pattern: Monetary penalty - 114; suspension from the program - 95; community service - 53; warning - 51; criminal probation - 34; lose medical license - 20. Fourth-year students were more lenient in their responses than those in earlier classes. As the possible threat becomes more real, self-interest may exert more influence.

Structural features of the programs were most often blamed for physician violations. These included low reimbursement rates, inefficiency and red tape, lack of adequate monitoring procedures, and too restrictive program rules. Only a little more than a quarter of the students mentioned physicians' motivations, attitudes, and deficiencies as causal factors in fraud and abuse. "Greed" was the most frequently cited factor, followed by "lack of ethics and responsibility," and "feeling justified in cheating because the program abuses physicians."

Interestingly, only one of the 144 respondents cited education as a means for preventing fraud and abuse. That student advocated courses in medical ethics in the training program. Perhaps students already so identify with the physician role that to imply the need for courses on ethics would be taken to signify a certain existing deficiency that they do not care to acknowledge. The findings clearly indicate that students form attitudes toward medical benefit programs while they are still in training.

IV. The Enforcement Apparatus

Interviews with enforcement officials at the state and federal level provided information about a number of aspects of the process by which doctors are

monitored and punished for their violations. A number of the officials (like the medical students) believe that the "cause" of fraud and abuse lies in the nature of the laws and regulations for administering the programs. The fee-for-service mechanism came in for the greatest criticism. Under it, doctors will be paid for costs that they say they incur, with little control over excessive procedures or amounts. In contrast, a health maintenance approach in which practitioners would be given a certain sum for each patient would contain expenses, it was stressed by the officials, though it might lead to undertreatment by doctors in order to retain as much of the prepayment sum as possible.

A high-ranking official explained how fraud was accomplished under a prepaid benefit system:

> The scam worked like this: the entrepreneur would send two recruiters to the neighborhood. The first would go through the poor neighborhood where there was going to be a high proportion of Medicaid patients. First, they would go to the door and say, "We're doing a survey on the health of your family — how many people, how healthy are they, have you had any diseases," all those questions. then, if it turned out that this was a person or family that statistically was not likely to produce medical problems, the second person who came through would sell them on joining the prepaid program — sign them up for it. So they got a higher proportion of well people than the payments contemplated and their profit margin

> was increased. Then by eliminating the high-cost operations like emergency rooms, weekend service, and by sending people to other hospitals, they increased their profit even more. When it began to look as if they were going to be caught, they declared bankruptcy and walked away . . . . (Personal Interview).

Program officials also expressed concern that "too much" enforcement would alienate the support of the medical profession, which is crucial to the operation of the programs, given the absence of a comprehensive state-supported medical plan in the United States. At the moment, the decline in the number of doctors participating in the programs has been said to be "alarmingly high."

Analysis of structural issues suggest that only a thorough overhaul of the programs is apt to allow monitoring that will reduce fraud to more reasonable levels. Heavy publicity for cases involving program suspension has been suggested and, more importantly, wider use of criminal sanctions. These processes might serve as a mechanism which would educate physicians regarding enforcement activities. And publicity, while perhaps of little or no consequence to outright thieves, could influence marginal conformists and those who skim small amounts of money from the aid programs. It might also make the general populace more aware of criminal and abusive practices in medical programs and generate new cases. Also, there appears in particular to be a need to allow investigators greater access to medical records. Physicians often hide behind the doctor-patient privilege to prevent adequate investigation of cases. Patients' confidentiality assuredly needs

to be protected, but there are ways to accomplish this that also allow the cumulation of satisfactory evidence of doctor wrongdoing.

V. Interviews with Malefactors

A major portion of our work focused on interviews with doctors who had been sanctioned by federal or state governments for violations of benefit program rules or laws. Our interviews were largely carried out in California and New York, the states with the two largest programs.

It had been argued that the physicians who had been punished would not be agreeable to talking with us. We found otherwise; a large majority of the persons we sought to talk with freely offered information. We stressed that we were university-based researchers and that we were concerned with getting their side of the story.

We began with the names of 125 prospective persons to interveiw in the two states. We first approached them with a letter explaining our task, and stressing our desire for their help with our work. Many of the addresses we had been given turned out to be incorrect, and we ultimately resorted to telephone calls to try to contact members of our sample. In the end, we located all but 19 of the 125 doctors. Forty-two (almost 40 percent) agreed to be interviewed, 17 refused; 43 did not respond to letters or calls, and 4 fell into an "other" category (one, for instance, had died). We then matched these doctors with a comparison group of non-sanctioned physicians. We conducted about two-thirds of the interviews in person, the remainder by telephone. Surprisingly, our response rate from nonsanctioned

physicians (16%) was strikingly lower than the 40 percent for those sanctioned, indicating perhaps the greater desire of those punished to discuss the programs and their experience with them, or, perhaps, the larger amount of time they now had on their hands.

Members of the sanctioned group of doctors were significantly older than those in the nonsanctioned cohort, a somewhat surprising result. We had anticipated that it would be the younger doctors, needing money and forced to practice high-speed cafeteria-style medicine, who would cheat the most. Older doctors apparently become disenchanted, perhaps lazy, and perhaps their age begins to cut into their earnings. The average age of members of the sanctioned group was 57.2 compared with 48.2 for the nonsanctioned doctors.

There were no significant differences between the two groups in regard to how they saw the aid programs or about reimbursement rates. Indeed, the nonsanctioned physicians were more often vehement in their denunciation of low fees. Members of both groups overwhelmingly criticized the management of the benefit programs, with observations such as "Medicaid is run by incompetent politicians."

A particularly notable difference appeared when the doctors were asked about the likelihood of sanctions for wrongdoing. Not surprisingly, given their experience, almost two-thirds of the sanctioned doctors thought that punishment was likely for some providers, compared to only 9 percent of the nonsanctioned physicians. Sanctioned physicians were much more likely than the others to view enforcement efforts as inconsistent, a view later supported, we found, by their belief that they

had been singled out for punishment while a host of other perpetrators went unnoticed. The sanctioned doctors were also violently condemnatory of the manner in which they had been apprehended; hardly any blamed himself for wrongdoing or expressed remorse. Common expressions on this point included:

> These various agencies sent people to my office under the subterfuge that they were drunks. I am by nature a very trusting person. I don't look at people as if they are fiends. I'm a physician . . .

> It was like a t.v. scene. Outside, the house was circled. They had walkie-talkies. I don't know what they thought, that I'd start a shoot-out or run out the back door? (personal interviews).

An interesting sidelight on the self-justifications appeared in a follow-up question. Only 33 percent of the violating physicians felt that fraud and abuse were contrary to ethics of professional trust. Ninety percent of the nonsanctioned physicians thought so. Unsurprisingly, many more sanctioned doctors thought there was "a lot" of fraud and abuse in the programs compared to the nonsanctioned doctors.

Finally, we had asked the physicians about changes in the size of their practices within the last five years. There was a statistically significant difference between the two groups. Almost 70 percent of the sanctioned doctors reported declining practices compared to 41 percent of those in the nonsanctioned group.

Seven percent of those sanctioned reported growing practices, against 35 percent of the nonsanctioned. The explanatory material with this response is revealing:

> Things are not going very well because of the case . . . Tremendous strain, tremendous strain . . . My wife chose to take the children and leave the country . . . The children were coming home from school in tears, being told by playmates that your dad is a crook and should be in prison. . . .

> It's the end of the world for a doctor who's been knocked down by the government. It's the end of the world. He might as well die . . .

> We had to move from an area we all loved to an area where economically it's great, but how would you like to live here? I have very little in common with the people here . . . The ones that were hurt the most were my children. One in particular would have turned out much better had we stayed. All his old friends are achieving something and he's not . . .

> One way [to possibly deter others] would be when a new physician enrolls in the program, to send some case vignettes — ways in which transgressions have occurred, and the penalties that resulted — so that one could read it as a case study to find out the possible consequences . . . . (Personal Interviews).

Conclusions

In his original statement on white-collar crime, Edwin H. Sutherland employed medical practice for illustrative purposes, noting:

> In the medical profession, which is here used as an example because it probably displays less criminality than some other professions, are found illegal sale of alcohol and narcotics, abortion, illegal services, unnecessary treatment, fake specialists, restriction of competition, and fee-splitting.[4]

It is arguable today (and perhaps it was then) that the medical profession displays less violation of the law than other professions. Probably doctors are more honest than lawyers as a group because they are not thrown into demanding situations as often for which the "best" solution involves breaking the law. That is, it takes a bit more initiative for doctors to commit professional crimes than lawyers, and one of the standard inhibitors of violation is lethargy, the unwillingness to take the trouble and assume the anxiety of transgression.

It is likely that doctors cheat on their income taxes as much or more than members of other professional groups, in part because it is relatively easy for them to do so, particularly if they are paid their fees in cash. One survey of a small sample of New York physicians who had received more than $30,000 from Medicaid found that half of the group had failed to report as much as half of the amount on their tax returns.

Focus on fraud perpetrated by medical practitioners highlights a well-educated group of elite persons whose violations cannot be laid to the malaise created by poverty, inadequate socialization (though medical school training might be deficient in the inculcation of adequate ethical standards), or similar "explanations" of more traditional kinds of crime.

Recent studies of white-collar crime have been absorbed with attempts to disentangle the symbiosis between organizations and their executive employees. Essentially, they assume that the imperatives of the organizational processes account for the wrongdoing and that the individuals who carry out the illegal acts are more or less automatons responding to the given situation. If Individual A were not to commit the offense, another person much like him or her would be recruited to do it. The task is not to focus on the person but to determine what aspects of the organization provoked the law-breaking. Obviously there is fundamental reasonableness in the organizational approach. Indeed, it probably could be transferred to analysis of street crimes as well. Why, we would ask, do certain countries or certain groups within particular geographical areas manifest such different crime patterns than others? The individuals who commit the crimes obviously are products of those cultures and, for analytical purposes, their traits are relatively unimportant. The problem here is that individuals do vary, and there remain in all societies persons who have been so socialized that under no conditions would they agree to some forms of lawbreaking. Why this is true can be as interesting and as important a question for study as the determination of the organizational dynamics that relate to criminal activities. Doctors, as individual

entrepreneurs, allow for an easier comprehension than do business executives of the importance of the person in the commission of white-collar crime. It is always analytically helpful when only some members of the group being studied violate; this allows comparisons to be drawn between those who offend and those who do not, with the expectation that differences in traits and circumstances can be informative. In the case of fraud by doctors, particularly under the newly-inaugurated benefit programs, it also becomes possible to ascertain how changes in structural arrangements "create" a new cohort of lawbreakers. After all, there was no point in overtreating a poor patient if that patient had to — but could not — bear the expense of the treatment. Only when insurance companies pay the bills can overtreating such patients become a vehicle of self-aggrandizement. Obviously, though, neither personality nor world view nor opportunity will entirely explain medical wrongdoing. As with all crime, some roots lie buried within the general values of the culture in which the practices occur. In the United States, the patent emphasis on unlimited wealth and conspicuous consumption must act as a spur to doctors who by most standards would appear to be exceedingly well off. In addition, clues to violation have to be sought in the nature of the practice of medicine itself as facets of the work bear upon different kinds of persons entering it.

Sir William Osler, generally acknowledged in the Anglo-Saxon world as the preeminent medical practitioner of the past century, located one of the primary sources of medical crime in the isolation and arrogance that often attends medical practice:

> No class of men needs friction as much as physicians; no class gets less. The daily round of a busy practitioner tends to develop an egoism of a most intense kind, to which there is no antidote. the few setbacks are forgotten, the mistakes are often buried, and ten years of successful work tend to make a man touchy, dogmatic, intolerant of correction, and abominably self-centered.[5]

An overview of medical lawbreaking helps to round out our inventory of fraud and abuse in the profession. The American College of Surgeons has charged that about half of the operations done in American hospitals are performed by unqualified doctors, largely because of fee-splitting. A government lawsuit alleged that the 4,500 doctors who own medical laboratories overcharge the public for tests and conspire illegally to keep everyone but themselves out of the medical laboratory business. A study by Cornell University investigators maintained that from 11 to 13 percent of all surgery in the United States is unnecessary, a function of diagnostic incompetence or of greed, stemming from the lure of high fees for surgery. There are about 20 million operations performed in the United States annually: the Cornell researchers believe that at least two million or more are unwarranted. A later survey found that the rate of surgery on the poor and near-poor — financed by Medicaid — was twice that for the general population. It is estimated in this survey that the cost of unnecessary surgery is $3.92 billion.[6]

Unnecessary surgery, of course, can be regarded as equivalent to assault, so that medical crimes can be seen to not only involve theft of money but also

maiming and death. In a 1984 case, described as "shocking" by the judge, a California opthamologist was convicted of performing unneeded cataract surgery on poor patients in order to collect Medicaid fees. In one instance, he totally blinded a 57-year-old woman when he operated needlessly on her one sighted eye. Oddly, if the patients had private insurance or were well off, the surgery was done skillfully and successfully; Benefit program patients simply were treated in a more slipshod fashion. The judge, in sentencing the doctor to four years in prison and substantial fines, was particularly critical of other physicians who had supported the defendant, urging leniency for him: "It's astonishing how they can write those letters," he said. "They seem to think the whole trial was a contrivance by the attorney general's office." Then the judge emphasized what had particularly upset him: "In not any of the letters has there been one word of sympathy for the true victims of this case, the uneducated . . . people, some of whom will never see a sunrise or sunset again."[7]

Deviance among professionals — their white-collar crimes — has not been a major area of research in criminology. Lanza-Kaduce has recently defined professional deviance in terms of violating "public service norms."[8] In this sense, physician abuse of government benefit programs constitutes a preeminent example of professional deviance. We have studied this behavior in terms of factors which may contribute to deterrence, particularly in regard to the laws governing the structure and control of the activities. Medical fraud is notably important as an issue of law and public policy because it involves, most fundamentally, matters of life and death. "We have proved conclusively," an official we interviewed as part of

our study noted, "that the one who is defrauding the program was also defrauding the patient, because he does not provide the services that are needed or does so only perfunctorily at best."

Footnotes

1. National Opinion Research Center, "Jobs and Occupations: A Popular Evaluation." Opinion News, 9 (1947), pp. 3-13.

2. Alex Inkeles and Peter H. Rossi, "National Comparisons of Occupational Prestige." American Journal of Sociology, 61 (1956), pp. 329-339.

Robert W. Hodge, Paul M. Siegal and Peter H. Rossi, "Occupational Prestige in the United States, 1925-1963." American Journal of Sociology, 70 (1964), pp. 286-302.

3. Kenneth Silverman. The Life and Times of Cotton Mather (New York: Harper & Row, 1984), p. 345.

4. Edwin H. Sutherland, White Collar Crime. (New York: Dryden, 1949), p. 12.

5. Harvey Cushing, The Life of Sir William Osler. (London: Oxford University Press, 1940), p. 447.

6. Robert F. Meier and Gilbert Geis, "The White-Collar Offender." pp. 428-445 in Hans Toch (ed.), The Psychology of Crime and Criminal Justice. (New York: Holt, Rinehart and Winston, 1979).

7. Robert Welkos, in Los Angeles Times, April 27, 1984.

8. Lonn Lanza-Kaduce, "Deviance Among Professionals: The Case of Unnecessary Surgery." Deviant Behavior, 1 (1980), pp. 333-359.

END