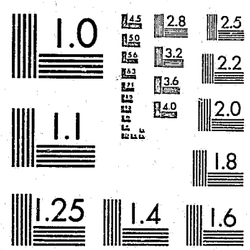


Public Policy Research Organization

University of California, Irvine

The Public Policy Research Organization (PPRO) is an Organized Research Unit of the University of California. The Organization's purpose is to foster empirically grounded research into problems of public policy. This purpose has been translated into three broad organizational goals: (1) to establish major continuing research programs which contribute to substantive knowledge of policy-making and policy effects, (2) to contribute to the evolving methodology of public policy research, and (3) to disseminate research results to those who devise, implement or study public policy.

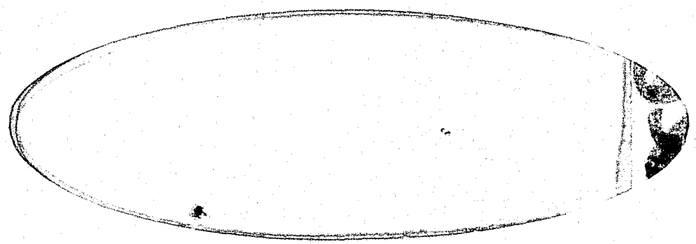
PPRO is not in a policy-making role, but it is in a unique position to assist those who do make policy by providing intellectual support through its research, its advice to government agencies, and its affiliation on specific projects with public and private interest groups.

PPRO's approach to the development of research foci has been to support a core of faculty interested in pursuing a particular public policy issue. This core faculty is encouraged to pursue resources for projects which will create extensive data bases and which will help federal, state or local government overcome impediments to effective management of public programs. Increasingly, projects are being pursued which help business and industry in policy-making and management—both because of the close interconnection of the public and private sectors and because of the importance of the private sector in its own right.

Three primary research foci have emerged. They are: technology and policy, human cost accounting and public and private management. In addition to these primary research foci, PPRO is concerned with the development of research which examines general questions of community development and change in the Orange County context. Examples of recent PPRO projects include:

- A nationwide study of computerized information systems and their impacts on American cities and counties.
- A study of the relationship between economic change and health status in metropolitan areas.
- An annual survey of public opinion and attitudes in Orange County, California.
- A nationwide assessment of the use of deadly force by police officers.
- An assessment of the effect of seat belt restraints on seriousness of injury to children in auto accidents.
- An analysis of primary and secondary employment effects of California's high-technology industries.

As a campus-wide organized research unit, PPRO draws its prinicpal research expertise from the full faculty and student resources of the Irvine campus of the University of California. Of the many faculty and students currently working on research in PPRO, the majority are from the School of Social Sciences, the Department of Information and Computer Science, the Program in Social Ecology, the Graduate School of Management, and the College of Medicine. Among PPRO researchers are experts in law, public administration, economics, public finance, political science, health care, sociology, psychology, planning, and public policy.



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PRACTITIONER FRAUD AND ABUSE IN GOVERNMENT MEDICAL BENEFIT PROGRAMS

Final Report submitted to the
National Institute of Justice
U.S. Department of Justice
Grant Number (82-1J-CX-0035)

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ABSTRACT

This study examined offenses by physicians participating in government-funded medical benefit programs. The research has been guided by theoretical ideas drawn from 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.

Chapter 1

Introduction:
Practitioner Fraud and Abuse in Government Medical Benefit Programs

Fraud perpetrated by practitioners in the health and allied professions takes a heavy toll on the well being and integrity of human life in the United States. Medical care is one of the most expensive aspects of contemporary life. It has been estimated that it cost the U.S. in 1982 $285 billion a year for "curing the ill and diagnosing the diseased"(Time, 1982:54). The toll exacted by fraudulent practices is both fiscal as well as physical. Unnecessary surgery, performed only because a government insurance program will pay the cost, sometimes results in maiming and death, so that medical program violations, besides entailing economic losses, can fall within the realm of crimes against the person and crimes of violence. Note, for example, the case of an opthamologist who performed cataract surgery on persons with healthy eyes only because Medicaid paid $584 per eye for the operation; in the process the doctor "blinded a lot of people" (Personal Interview).

Poor health and inadequate access to medical aid particularly victimize minorities. In this regard, the record of the United States in the world community is not one of which to be proud. On major indices of health, such as infant mortality, the United States ranks behind a dozen western nations (U.S. Bureau of the Census, 1980). Fraudulent practices also undermine attempts to upgrade and equalize access to decent medical treatment. Proposed national insurance schemes are beset with concerns about how to control what is anticipated as enormous fraud (Stotland, 1977).

Joint hearings in 1975-1976 by the U.S. Senate Subcommittee on Long Term Care and Health of the Elderly underlined concern about fraud and abuse in regard to government-funded medical benefit programs. Testimony suggested that as much as ten percent of the money paid to medical practitioners under state benefit programs was obtained in violation of program guidelines. Abuses included charging for services never rendered, ordering superfluous laboratory tests, encouraging unnecessary office visits and surgery, and charging for physician service where nonlicensed personal performed the task (U.S. Senate, 1976). The report included the results of an investigation focused on 'Medicaid Mills" (clinics), primarily in New York City. Physicians working outside of clinics were not examined.

The investigation covered five states which together received more than 50 percent of the nation's Medicaid funds: California, New Jersey, Michigan, Illinois, and New York. In New York, it was found that doctors working in the mills tended to be young foreign medical school graduates whose practice was exclusively Medicaid. "Hawkers" were many times employed by the mills to round up patients for treatments. It was also learned that a small proportion of doctors accounted for a large share of Medicaid payments. In New York, for example, it was ascertained that about 7 percent of doctors participating in Medicaid accounted for 50 percent of total program reimbursements to physicians. The most common abuses in Medicaid Mills included: (1) "ping-ponging," which involves referring patients from one physician to another within the same facility even though such referrals are not medically necessary; (2) "ganging," which refers to the practice of billing for multiple services to the same family and usually occurs when one family member is accompanied by others (usually a mother and her children). The physician "treats" all of them although there are no identifiable health problems or complaints;(3) "upgrading" which involves the practice of billing for a more complex or extensive service than that actually provided;(4) "steering," where the patient is directed to a particular pharmacy for filling drug prescriptions;(5) multiple billings for the same service;(6) false billing for

services actually provided by others or unlicensed personnel; and (7) billing for services never provided in any form whatsoever. Over four months investigators visited about 85 practitioners, usually feigning a headcold as the medical ailment. During this time only one physician told an investigator, "Get out of here, there is nothing wrong with you"(U.S. Senate, 1976:44).

There is little doubt that large dollar amounts are involved in fraud and abuse. A report by the Inspector General's Office in the U.S. Deaprtment of Health and Human Services indicated that up to two billion dollars may be lost to fraud and abuse annually in the Medicare program alone (U.S. House of Representatives, 1980). Realizing the extent of waste of public funds, Congress enacted the Medicare-Medicaid Anti-Fraud and Abuse Amendments to the Social Security Act in October, 1977. The new laws require that practitioners convicted of crimes against the nation's health programs be suspended from further participation. In 1979, the Secretary of the Department of Health, Education and Welfare (HEW) suspended 40 health practitioners. Almost all cases involved billing Medicare or Medicaid for services not rendered. The public announcement by HEW was intended to serve as a general deterrent, a threat to providers who were cheating or contemplating doing so. Through 1982 there have been 147 physician suspensions from Medicare and Medicaid.

It is generally believed that a majority of physicians comply with benefit program regulations, though a very large number of fraud and abuse cases undoubtedly remain unknown. As Lee (1978:30) notes: "It is generally accepted by persons closely associated with the programs that only a small percentage of Medicaid fraud and abuse is detected and/or sanctioned."

Chapter 2

Professional White-Collar Crime

The topic of white-collar crime in the professions has not been an area of major concern to criminologists. A search of the scholarly literature locates very few writings on the subject. Folklore has it that professionals--especially physicians-- are exceedingly honest, which may partly explain the lack of interest in their possible criminal activity. Enforcement efforts and scholarly research have traditionally been aimed at conventional or common "street crimes." Even within the range of white-collar and corporate violations that have been studied, there has been almost no research on crimes by those in the professions, and, more specifically, by physicians, who are generally acknowledged to be members of the most prestigious and powerful profession in society (Hodge, Siegal and Rossi, 1964; Reiss, 1961). As an FBI supervisory agent we interviewed put it: "What other stranger would you go in and take your clothes off in front of? It's that kind of trust" (Personal Interview). Physicians are expected to adhere to lofty standards of conduct and to place patients' welfare above

their own interests (Parsons, 1951). They enjoy exceedingly high socioeconomic status as individuals and exercise considerable power both in their professional role vis a vis patients and as members of a group jousting for economic advantage. That their ethical codes demand high standards of conduct does not mean, of course, that all practitioners meet such standards (Mechanic, 1978). Some physicians may sacrifice for their patients more than others (e.g., make house calls, overlook fees), while some may take unfair or illegal advantage (see e.g., Burgess, 1981).

The social position of physicians, when combined with their law violations, inevitably leads to initial ambiguity on the part of the rule-enforcers and subsequent attempts to reshape their initial image of the professional. A high-ranking state medical officer, for example, noted the following in regard to fraud among doctors:

> I think that percentage-wise the overall amount of fraud is quite low, but when it [fraud] does come out, it's sobering because you don't expect that of this kind of profession. But you know, the more I deal with things, I begin to realize that we're the same kind of population as any other kind of population. As a population, it [medical doctors] is better educated, well-trained, and with valuable resources, but along with that doesn't mean you don't have your bad guys too (Personal Interview).

The redefinition permits actions against identified medical deviants while allowing the prevailing view of the larger group of doctors to remain relatively intact.

2.1 Physicians and Medical Criminality

Physicians have been known to engage in a variety of illegal acts that are linked to their everyday work routines. Sutherland, the progenitor of the term,"white-collar crime," considered the medical profession probably to be more honest than other professional groups, though he was still able to identify a number of illegal behaviors that they engaged in. He states:

> In the medical profession, which is here used as an example because it probably displays less criminality than some other professions, are found illegal sales of alcohol and narcotics, abortion, illegal services, unnecessary treatment, fake specialists, restriction of competition, and fee-splitting (Sutherland, 1940:3-4).

Others have since documented similar abuses of professional trust and crimes by physicians (Lewis and Lewis, 1970; Zimring, 1972). It is clear that in dealing exclusively with fraud and abuse in Medicare and Medicaid, we are not talking about the only kind of physician crime, nor that with, perhaps, the most serious or frequent types of violations. A recent overview of medical law-breaking, for example, points out that 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, under

which referring physicians receive an illegal kickback from the doctor performing the surgery. A 1966 government lawsuit alleged that the 4,500 doctors who own medical laboratories overcharged the public for tests and conspired illegally to keep everyone but themselves out of the medical laboratory business. In 1970, the Internal Revenue Service reported that about half of the 3,000 doctors who received $25,000 or more in Medicare and Medicaid payment failed to report a substantial amount of their income. A 1976 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 believed that at least two million or more were unwarranted. A later survey found that the rate of surgery on the poor and near-poor -- financed by Medicaid -- is twice that for the general population. It was estimated in this survey that the cost of unnecessary surgery in the United States is $3.92 billion (Meier and Geis, 1979:436).

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 (Lanza-Kaduce, 1980). 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 astounding how they could write these 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 in this case, the uneducated, Spanish-speaking people, some of whom will never see a sunrise or sunset again"(Welkos, 1984).

In the month of April 1984 alone, three major stories appeared in the national media which focused on episodes of physician improbity. A New York Times article (Lyons, 1984a) captured its theme in the opening paragraph: "Increasing evidence of widespread cheating and fraud involving the basic examination that doctors must pass before they are allowed to practice medicine is being reported by medical educators, state and federal officials and professional groups." Prices as high

as $50,000 a copy were said to have been paid for examinations before they were to be officially administered. Copies of "Flex" [Federation of State Licensing Examiners] tests had been found on the person of students coming to take the exam in New York City. Later in April, it was reported by a news syndicate, based on a study by the Senate Subcommittee on Governmental Affairs, that "nearly one of every four medical school graduates who accepted millions in federal scholarship money broke their pledge to practice in small towns or inner cities where health care is scarce." ("Doctors, Dentists Not Keeping Word,"1984). And two weeks later, documents indicated that 2,000 fraudulent medical degrees had been granted to North Americans in schools operated in the Dominican Republic. At least "several dozen" of these persons were found to be practicing medicine in the United States (Lyons, 1984b).

We are far from knowing at this time how widespread physician law-breaking actually is because the violations are often extraordinarily difficult to detect, and intent almost impossible to demonstrate to the satisfaction of the law. An estimate by the past president of the Federation of State Medical Boards seems as accurate as any we are apt to get. He believed that:

> ...at least one physician in 20 is a severe disciplinary problem, that between 15,000 and 20,000 private practitioners (as many as one in nine) are repeatedly guilty of practices unworthy of the profession. Most of these physicians commit offenses

> that are unethical rather than prosecutable: substandard care, abandonment, overcharging and the like...If anything, [the figures] are too conservative (Lewis and Lewis, 1970:25).

Health care has become big business in the United States, with great possibilities for profits as well as prestige. As of 1978, close to 5 million people were employed in health-related occupations (HEW, 1976-1977). A major reason for the expansion of health care personnel is the lure of profit, which has also brought private corporations into major positions of wealth and power (see Waitzkin and Waterman, 1974). Such corporations invest large amounts of money in advertising, public relations and lobbying for legislation which is favorable to their interests. Similarly, medical organizations such as the A.M.A., vigorously engage in lobbying efforts aimed at maintaining professional autonomy, wealth, and power. Any innovation or change that might threaten the status quo is fiercely resisted. As we describe below, this battle over professional autonomy as well as the great wealth at stake in the health care field are important contextual features in crimes by physicians.

2.2 Hiding Medical Mistakes: The Honest and the Crooked

Honest mistakes probably occur quite frequently in medicine, although it is impossible to know the exact degree due to their

lack of visibility to patients, other professionals or to outsiders. Since the expectations for medicine are so great, it could reasonably be argued that it is necessary to protect honest mistakes from excessive scrutiny by outsiders who may not understand or be sympathetic toward the intricacies involved in many areas of medical practice. There is also bound to be great disagreement by doctors themselves regarding proper procedures and diagnoses in many areas of medical practice. This flexibility affords a great deal of protection against the discovery of failures and mishaps (see Friedson, 1970). This same camouflage, however, also serves to cover the wrongdoings of dishonest physicians who take advantage of their autonomous positions to cheat or harm patients, insurance companies and taxpayers.

In order to protect themselves, physicians (as do other professionals) engage in what Mumford (1983) has labeled a "highly developed rhetoric" which is made up of beliefs and myths regarding the profession which serve to sway the public (as well as the profession itself) in a direction favorable for maintaining professional dominance. This rhetoric, however, may be more representative of an ideal state of affairs rather than a true reflection of reality. Besides its usefulness in maintaining autonomy and power for the profession, it can also serve as an effective shield against the accusations of critics; especially those charged with enforcing the law.

Examples of such rhetoric in medicine include the following common statements: "Doctors are selfless beings, whose purpose is to serve patients and cure illness"; "Since doctors deal with life and death issues, only they can really understand medical issues"; "Decisions that are medically informed are necessarily the best decisions"; and "Only a physician can evaluate another physician." Such rhetoric can serve the function of reassuring persons about the practice of medicine, but as Friedson (1970) pointed out, it can also serve to consolidate power, justify increased resources, and maintain absolute authority over the control of medicine within the profession.

2.3 Medical Training and Medical Misfits

The "rhetoric" of the medical profession also extends to the training of physicians. Doctors have long argued that only by limiting access to their profession through strict selection, training and licensing can professional values be upheld and the public protected. While the ideology sounds attractive, the reality is oftentimes quite different. There is no doubt that current selection and training procedures produce many individuals who are not fit for the high ideals contained in formal professional norms. The recent disclosure of widespread

cheating by physicians on licensing and specialty exams is only one small indication of the "ethical standards" of too many medical practitioners (Lyons, 1984a).

Students vying for grades in order to attend medical school (many times for reasons other than to be a "healer" or to "help humanity") may resort to less than acceptable behavior because of the intense standards demanded by admissions committees. Extreme competition before and during medical training oftentimes leads to a feeling of disregard toward others.

Some doctors believe that a growing number of individuals chosen for medical school may not possess altruistic motives for practicing medicine. A director of pediatrics residency at a large hospital presents his position in the following terms:

> Because of my personal backgound and my professional feelings, I still put in sixty or eighty hours a week. But I have a very difficult time finding responsible people who feel the same way I do to help me take care of my patients. By my standards, most practicing physicians and young physicians in training -- regardless of what the new youth are saying -- are primarily interested in ripping off the public and getting power.... In the residency program, it's exhilarating to see the brilliance, concern and conscientious output of the same percent of residents now as there were when I started twenty years ago. On the other hand, twenty years ago, I would have one, two, at the most three people whom I would consider avariciously motivated monsters. My experience is that this group is now five to ten times larger than it used to be -- comprising 25 to 30 percent of the trainees. These people are taking advantage of the system, of their colleagues, of the nurses that work with them, and of their patients. Some of them are just peculiar nuts who want to go to medical school and get some kind of

> graduate degree because they want to prove they can do it. The system has created a challenge for these people -- they go into medicine as "the highest profession" (Rabinowitz, 1981:60).

Moreover, there is evidence that suggests that medical exams (MCAT's) are not good predictors of clinical aptitude following graduation from medical school (Richards et al.,1962,1974; Korman and Stubblefield, 1971), that the needs of society regarding health care may not be met by the "best student" definitions employed by medical school admission committees (Light, 1982), and that a self-selection process is involved whereby students who are "survivors" form the pool of persons selected for medicine because of the intense demands of formal training. Whether or not these persons necessarily possess those traits most desirable for doctors is a matter open to question.

The "fate of idealism" in medical school has been studied by Becker and Geer (1958) who found that while early in training students showed enthusiastic conviction about what an "ideal physician" should be, this feeling dissipated for many in the later years of training and was replaced by cynicism. Becoming a doctor also involves nurturing a great degree of self-confidence, which can manifest itself as a feeling of invulnerability. Given the tremendous amounts of money available and the relative ease in obtaining it, simple greed undoubtedly influences law- and rule-breaking.

To obtain some current information on issues such as these -- as they related to our study subject -- we surveyed medical students enrolled at the University of California, Irvine. We particularly sought their views about four major issues: (1) the quality of government benefit programs; (2) the seriousness and prevalence of physician fraud and abuse; (3) the recommended punishment of violators; and (4) the causes and prevention of fraud and abuse in government medical benefit programs.

We found that fourth year students were much more critical of the aid programs than those in earlier classes, and more tolerant of physical exploitation of the programs. They set forth lesser punishments for hypothetical violations we asked them about than did their comperes in the earlier years of medical school, and they more often "blamed" the structure of the programs for physician violations, things such as lax enforcement policies, low reimbursement rates, and other "temptations."

It is apparent that the medical profession has undergone extraordinary logistic changes in the past two decades. It fought with considerable ferocity (and extraordinary resources) the involvement of the government in mandated aid programs. Doctors lost that battle in many regards, but they won the war. That is, the government did intercede across a broad

spectrum of medical services, most notably with the Medicare program for the aged. But in doing so, the government was forced to concede a great number of points to the medical profession. The result was that control of the programs was lax, reimbursement rates very high. Physicians and other health care professionals, as a result, are now earning salaries much higher than they had earlier, with the increase being well beyond the rate of inflation. Some citizens regard many physician salaries as virtually extortionate, and the profession seems to have undergone a decline in prestige, partly because medical incomes have risen in phenomenal fashion.

Simultaneously, medical costs have soared -- in part triggered by new technology as well as by physician income -- and this has placed a cost conscious government in the position of having to begin to exercise control that always was implicit in its assumption of some of the expenses of medical treatment. Physicians, therefore, have come under much more intense scrutiny than ever before in the profession's history in the United States. It is elements of that scrutiny, as it regards violations of Medicaid and Medicare laws and rules, that will specifically be addressed in the following segments of this report.

Chapter 3

Medicare and Medicaid Fraud and Abuse

Medicare is the federally funded program designed primarily for the elderly, while Medicaid is predominantly state funded and administered largely for the benefit of the needy. The inauguration of the programs created new medical malefactors. There would be no point, for instance, in performing extensive diagnostic tests upon a poor person unable to meet their cost: but if an insurer will pay the charges there is a great deal to be gained by doing such work, needed or not, and doing it as cheaply as possible. Bills have been submitted for payment by doctors which proved on investigation to be for x-rays done without film, blood and urine tests never analyzed, and treatments much different -- and more expensive -- than those that were actually carried out.

Psychiatrists, who constitute 18.4 percent of the Medicare and Medicaid violators, the most disproportionate number for any medical specialty, have been caught charging for individual therapy for patients seen as a group, for analytical treatment which proved to be sexual dalliance between patient and doctor,

for "therapy" when what was done was only the writing of drug prescriptions. The high rate of apprehended psychiatrists seems to stem from the fact that they bill for time rather than services, and therefore are easier to catch when they inflate charges. Indeed, several psychiatrists have been caught because they billed the government for therapy sessions for hours far in excess of those in a day (Geis, et al.,1984).

The fee-for-service structure of the benefit programs, built upon typical medical payment procedures, makes it easy to overcharge, double-bill for services, to ping-pong, to family gang, to prolong treatments, and to carry out additional fraudulent schemes. Fee-for-service can contribute to the disintegration of ideals and altruism among physicians, as Keisling (1983) has noted:

> ...fee-for-service medicine subtly corrupts its own practitioners. Motives for entering medicine are many and complex but the strongest is the desire to be a healer....Unfortunately, the feelings of dominance that inevitably accompany the healer's role frequently overpower whatever native idealism a doctor might have brought to his profession. The grueling 100-hour weeks spent as a resident encourage him to feel unappreciated for his important work. As he gets older, he also begins believing that the same power and respect he commands in the office or operating room should extend into the community, where the badges of success and status, instead of centering on the value of one's work, center on material possessions and social standing. And as the fee-for-service system combines with the doctor's revered status to make these things so accessible, what increasingly becomes important are not the satisfactions of medicine itself but the benefits that result from practicing it. For these doctors, stories of million-dollar incomes do not provoke

outrage, but envy (p.30).

Besides the conflict created by the physician's role as both "healer" and "entrepreneur" under the fee-for-service system, there is also a conflict between the dictates of government regulation and the desire of the profession to remain autonomous. In addition, government programs are apt to have relatively low reimbursement rates, payment delays, and what are considered to be excessive red tape and paperwork requirements. Officials insist what they do is necessary for proper accountability; doctors prefer private health care where the marketplace and their own interests operate more freely (Waitzkin, 1983). The inability of the aged to bear unaided the costs either of adequate private insurance or, assuredly, of uninsured medical expenses was largely responsible for inauguration of programs such as Medicare. These programs, at the same time, have put physicians "on welfare," and have allowed the government to bring its enforcement arm to bear on unearthing medical violators. The extent of fraud associated with government benefit programs is believed to be extremely high. A recent case involved overpayment of more than half a million dollars to three California physicians (Los Angeles Times, October 20, 1983). Officials believe that between 10 and 40 percent of program monies are lost to fraud and abuse -- a sum that would be in the range of 10 to 40 billion dollars annually.

It must also be noted that doctors are only one group that can bill for services under these programs. Hospitals, medical supply businesses, pharmacies, nursing homes, medical laboratories, ambulance companies, and other vendors can also bill for services provided to program beneficiaries. There is no reason to believe that doctors are more dishonest than others who utilize the system. They do not comprise the largest billing category of providers; hospital bills account for the greatest share. However, hospital billings are in no small way generated by physician behaviors, including the decision to hospitalize, diagnosis, treatment, surgery, and the like.

Though they certainly are not responsible for most of the monies lost in the aid programs, physicians nonetheless represent a group worthy of closer study. First, there has been no large-scale systematic scholarly research on physicians and white-collar crime. Government investigations can be seen as self-serving in many respects, and are not likely to be regarded as "scientific" by the medical profession (Geis, et al.,1984). Similarly, media stories, while exposing the details of different kinds of physician wrongdoings cannot be considered to constitute systematic research. A study of physician wrongdoing can lead to more accurate information which can help inform policy as well as theory. A particular advantage of a focus on fraud perpetrated by medical

practitioners is that it allows more concentrated analysis of a highly educated group of persons whose violations cannot in any reasonable way be laid to the malaise created by poverty, inadequate socialization (though medical school training might be found to be deficient in the inculcation of adequate ethical standards) or similar "explanations" of more traditional kinds of criminality.

3.1 Backgound of Government Health Programs and Early Enforcement Efforts

Practitioner fraud and abuse in Medicaid and Medicare were not regarded as a serious problem until the mid-1970's, when program costs had increased drastically, prompting the government to look more closely at both providers and beneficiaries participating in the programs. In a very real sense, the laws and regulations regarding the programs had "created" a new class of criminal in the medical profession. Not much attention had been paid to the possibility that some providers would take advantage of the programs because it appeared that physicians could be trusted not to abuse the system, though it literally afforded them an almost unlimited opportunity to enrich themselves. Additionally, the specter of fraud and abuse by society's highest profession would not have

given the programs a good start, and would have aroused further suspicion, disagreement, and concern by policy makers and the public regarding these novel programs, which were controversial enough to begin with (Stevens and Stevens, 1974). Thus, the potential for fraud, abuse, and waste were pushed to the background in an effort to gain support and momentum for the newly-created programs.

The Medicare and Medicaid programs were signed into law by Lyndon Johnson in 1965. Medicare aimed at filling the health care needs of a growing elderly population. Funds for the program came from federal revenues, and the administration was housed in the U.S. Department of Health, Education and Welfare (HEW). To enlist the support of the medical profession, the Medicare law avoided prescribing a fee schedule for physicians, but mandated instead that doctors of Medicare patients be paid their usual and customary fee, provided that the fee was "reasonable" (Marmor, 1970).

Medicaid provides access to medical care for the poor. The administration of the program is the responsibility of the states, but HEW (now Health and Human Services) monitors the state programs, since they are partially financed with federal dollars. Not all states have Medicaid; Alaska, for example, has been unwilling to pass legislation since projected costs of the program are said to be too great for the state to bear,

given the high indigency level among the Eskimo population.

The Medicaid population includes about 30 million persons. Program expenditures are heavily weighted toward institutional services, especially long-term care. Individual physicians (not including those who billed through hospitals) receive about 10 percent of medical expenditures.

Fraudulent and abusive practices by health care providers were not articulated concerns of administrators or policymakers during the early years of the medical programs. Participation by physicians in the programs was a primary consideration. Enhanced medical care for the elderly and indigent would have been impossible without the support of the medical profession.

Besides the aid of organized medicine, public confidence in the programs was another necessary element for their success. Officials felt that to highlight questions of fraud and abuse early on might undermine that confidence. An official in the Health Care Financing Administration of the Department of Health and Human Services (HHS), which sets regulatory policy for Medicare and Medicaid, related the situation in these terms: "The more we came up with fraud and abuse, the worse it was. So what they did was try and stop this fraud and abuse work" (Personal Interview). A high-ranking enforcement official noted further:

> It seems as though when all this was originated

> they said, let there be a program. They felt they were dealing with a community group that was full of integrity and would not violate the precepts of the program. From 1965...until about 1968 there was no such thing as fraud and abuse (Personal Interview).

This benign notion altered as the cost of the programs rapidly escalated. The 1965 price tag of $1.9 billion had grown to $37 billion dollars by 1977 (Brown, 1979:203). Both governmental and private interests now saw a need for cost containment; the heady rhetoric extolling a new era of medical treatment was abandoned in the face of fiscal concerns.

The characterization of fraud and abuse as a "non-problem" by early Medicare and Medicaid policymakers had affected the manner in which initial control efforts were organized. Early enforcement efforts were thwarted by the absence of satisfactory legal tools and adequate program regulations with which to control the abuses beginning to be uncovered. An official noted:

> You could identify it [fraud and abuse] but there weren't laws and regulations to support it...The controls weren't built in and I find that to be the largest problem of anything, whether it's General Motors or IBM or whatever. You build this magnificent edifice but you don't build in any security precautions at all (Personal Interview).

Moreover, there was no integrated system specifically designed to uncover, investigate, prosecute and sanction errant providers. Gardiner and Lyman (1981:4) argue that even today no "coherent 'policies' or 'systems' regarding fraud control

exist" because of the lack of planning. Rather, the "system" grew "topsy-turvy".

3.2 Enabling Structural Features for Benefit Program Fraud and Abuse

The nature of laws and regulations for administering Medicare and Medicaid are held by some persons we interviewed to "cause" the problem of abuse and fraud by health providers. Regulations are said to be too loose to provide an adequate basis for criminal or administrative investigations, and to be too restrictive of medical practice, leaving doctors little choice but to violate program rules. The reimbursement mechanism in Medicaid which provides doctors with about one-half of what they usually would charge is a major structural feature of the program which is said to encourage fraud and abuse. In addition, the fee-for-service mechanism offers great temptation through the seemingly unlimited ability of the system to pay the billed costs of health care delivery. Physicians are "encouraged" to overbill and overtreat patients by fee-for-service reimbursement.

A recent survey of California doctors has shown that they many considered inadequate levels of reimbursement, bureaucratic interference, and denial of reimbursement for

services already provided as "critical" problems in the state's Medicaid (Medi-Cal) program (Jones and Hamburger, 1976). Another report notes that reduced levels of reimbursement to health providers actually increases overall health care costs. Some physicians drop out of the program, leaving patients to seek care at more expensive facilities (e.g., hospital emergency departments) (Leighton, 1980). The structure of government benefit programs has no rewards for economy. But it is not clear that changing regulations will eliminate abuse and fraud. Some officials believe that there would merely be different types of frauds. As one experienced investigator noted:

> For the next ten years you fellows could think of schemes and these devils will think of how to beat it in 15 minutes (Personal Interview).

But a veteran federal official noted that "cleaning up" regulatory policies would at least leave a clearcut group of criminals to contend with rather than the persons who get caught up in regulations and those who are "marginal conformists":

> If government cleaned up its act...you would be left with a group of providers that really would be thieves no matter what walk of life they got into (Personal Interview).

The same official noted that under the current structure he "wouldn't be surprised if 85 to 90 percent of all practitioners...nickel and dime from time to time." Another

administrator noted in the same vein:

> Overutilization [abuse] is destroying the Medicare and Medicaid programs. There are no two ways about it. If you could get all the frauds tomorrow... and put them on a ship someplace the program would still go broke because the people who are killing us are the overutilizers (Personal Interview).

The medical benefit system whose rules and regulations allow fraud and abuse to flourish is fundamentally a construct of the medical profession itself. Both the American Medical Association and state medical organizations exerted a major influence on the laws and regulatory policies concerning control mechanisms in government benefit programs. The medical groups fiercely resist any attempts to reduce autonomy in the practice of medicine. The use of undercover agents to "shop" providers under investigation for fraud is extremely limited in some states, for example, due to the efforts of medical groups to block such tactics. Program officials also are aware that "too much" of a crackdown might result in a lowered rate of physician participation, denying services to those the system is expected to service. At the moment, about one-quarter of all primary care physicians refuse to accept Medicaid patients, allegedly because of low reimbursement rates (Buchberger, 1981). The drop in the number of physicians who accept Medicaid patients is said to be "alarmingly high" (Levin, 1980:22). Another important area involves access to physician records, for which no federal legislation exists, making investigations

more costly and cumbersome if the physician refuses to allow auditors to examine patient records. Such structural features of the programs handicap effective policing, which, according to most officials, results in additional program violations due to the extremely low likelihood of detection and sanctioning.

Doctors, the record of medical program fraud indicate, may be more sensitive than most of us to economic and material considerations. One investigator noted her re-evaluation of the medical profession after beginning her duties.

> When I first became an investigator with the Department of Health, I felt a little bit intimidated about going to a hospital and dealing with doctors. The first time I walked into a hospital I remember looking at the parking lot and seeing the doctors' cars; Porsches, Mercedes, a Ferrari. I thought they're not quite what I think they are. It showed me a playboy image that I wasn't thinking of before. I had been thinking of doctors as very conservative. They have more of a flashier, money image (Personal Interview).

It must be appreciated that the practice of medicine tends to be a solitary enterprise with the physician accorded enormous respect and the fiscal income that can solidify a self-image of a person of great importance. It is but a short step from such a position to one of arrogance and invulnerability and it is that step that doctors appear often to have taken when they cheat Medicare and Medicaid.

3.3 Motivations and Mechanisms for Engaging in Fraud and Abuse

Overcharging for services and overordering tests is a way for some physicians to "make back" what they feel they would and should be earning if it were not for government reimbursement schemes. Such practices appear to be particularly widespread among doctors whose clientele is largely indigent. These doctors may engage in fraud as the only means they see to maintain adequate health care for the poor among their patients and earn what they regard as a "reasonable" income. Some examples of this phenomenon from the accounts of sanctioned physicians include the following:

> I would go completely broke if I didn't give some consideration to the financial aspect....
>
> By cutting down on the quality of medical care [the program] allows the patient to become more seriously ill....
>
> Most doctors feel like we're being cheated...I think you're always going to have some fraud when we do not feel adequately compensated....
>
> They believe the patient is an animal. This is the American way to treat the patient. It's terrible...like an animal, like a physiological unit....
>
> I still see Medicaid patients, but I don't bill Medicaid. I charge them or I don't charge them, depending on what they can afford. I'm not Robin Hood, but it's a nice thing to do....
>
> There weren't too many doctors at that time taking Medicaid patients. The Medicaid patients are by no means the best kind of patients. They're filthy. They don't keep appointments. They keep the place in turmoil. They're the toughest to treat, and I think

> I did a damned good job. I resent ending up having to defend myself. I was carrying out what I thought was a wonderful service for these people....(Personal Interviews).

Other physicians may see their participation in the government program as a game to be played and won. In these instances, it does not matter how fair the guidelines are; the doctors would look for loopholes by which to gain an upper hand. A pair of cases illustrates this idea of game playing, which may entail participation of other professionals. In the first instance, two individuals agreed to bill Medicaid fraudulently for x-ray services. One of the conspirators did the x-rays without meeting government performance requirements. A physician in another city would then bill Medicaid for the work and falsely describe it as having been performed by himself. In a similar case, a physician signed and submitted false claims stating that pap smear evaluations were performed in his office, when, in fact, they were done in a pathology laboratory located in another city. In both instances, the physicians had established a mechanism to bill Medicaid for services other than their own. Statements from doctors about this idea of "game playing" include the following:

> An older doctor told me, "You simply don't know how to play the game. If you know how to play the game, you can stay out of trouble and you can milk the program"...My case could have been prevented if I really was a crook and I knew how to play the game....

> If everyone thought they were going to get caught, no one would do anything. You always think you're smarter and you can get away with it...and you can play it just a little cooler than anyone else....
>
> I always looked upon Medicaid as a game. In order to make a profit off Medicaid you have to cheat...Colleagues who use the program play it; they know which buttons to push to get the most out of it...Thousands abuse the system routinely....(Personal Interviews).

The odiousness of government regulations to physicians who enjoy "professional dominance" (Friedson, 1970) supports informal professional norms which encourage some doctors to exploit benefit programs. The behavior which enables a doctor to engage in fraud probably is at least partially usually learned from others in the profession; professional values may effectively neutralize the doctor's conflicts of conscience. Doctors take satisfaction in what they see as the sympathy of their colleagues if they themselves encounter difficulties. A criminally convicted physician noted:

> My colleagues are very unhappy. They feel they have to fill out a thousand forms and answer a thousand questions for a lousy seven dollars. Then they have to wait six months to get paid. I know for a fact that after what happened to me, many discontinued seeing Medicaid patients. They dropped out of the program (Personal Interview).

Physicians decisions to commit fraud are also partly due to how they view themselves in terms of being professional persons versus business people. Many individuals undoubtedly become doctors because of anticipated high fiscal rewards. Quinney (1963), for example, found that pharmacists with a "business

view" were more likely to be prescription violators than colleagues who had a "professional view." We find a similar conflict of roles with physicians. The following comments attest to the dual roles of physicians, and the conflict such roles generate in the everyday practice of medicine.

> I don't think anyone could make an honest living practicing on Medicaid...I think at this point everyone considers Medicaid a laughable program in this area because we're all rich and we all service upper class people....
>
> Private industry and private work and the profit system is our way of life, and yet we're not able to charge fees that are commensurate with our costs. If we were to depend strictly on Medicaid fees and practice good medicine, which is also honest medicine, we would go broke....
>
> There is no way to treat patients equally when you get $25 for one and $10 for another...You just can't do it....
>
> Medicine is a business. You've got the media convincing doctors that it's a business...My feeling is, if you go to medical school to make money, you're crazy....
>
> Medicine does not really have the kind of thing that I fell in love with at first. I get the feeling that it has become more business than medicine....(Personal Interviews).

Doctors who engage in fraud and abuse can also rationalize that sanctioning is impossible because of their social position and the inadequacies of program policing. A supervising investigator notes that doctors may be unaware of the government's capabilities and activities in policing the program, and that even when such knowledge exists, they may

still feel that they are beyond reproach due to their high social status.

> A lot of doctors don't believe that we have computer records that will show one whole year's history right in front of us. I don't think they believe we have that or they wouldn't cheat the way they do. The bottom line is that they have egos, and they think that welfare recipients are stupid. That's their biggest mistake because there are a lot of bright people on public assistance and we go out and interview these people...They feel that those people pitted against them in court are never going to be believed. But they are believed. That's the part they don't understand. These recipients will go into the courtroom...tell their simple little story, and the doctor's going to fall. They just don't believe that (Personal Interview).

It is arguable whether or not this attitude on the part of some doctors is due to arrogance or naivete or some combination of the two. Arrogance may have a lot to do with committing fraud, an arrogance that high-handedly dismisses the violation of program rules as insignificant behavior on the part of a doctor. Most doctors were bitterly resentful of enforcement authorities and the way they said they were treated and sanctioned. Very few displayed remorse for their wrongdoings, but preferred instead to attack the programs and officials as the "causes" of their violations. This is not very different from what Sykes and Matza (1957) described as a form of deviance neutralization that is typically employed by delinquents and involves the process of shifting blame to the accusers. It is not merely a rationalization after the fact (although sometimes it might be), but rather a strong feeling

that others are wrong, that allows rule-breaking behavior to occur in the first place while leaving a positive self-identity intact. This process is undoubtedly effected through a feeling on the part of the deviant that his/her moral and/or behavioral codes are superior to those of the law. Professional norms may support such arrogance in the face of government regulations regarding medical benefit programs. One case, involving a psychiatrist, illustrates this point. The doctor was convicted of stealing about $5,000 from the Medicaid program. He had served time in jail when a license revocation hearing was held. The following transpired at the hearing, according to the state investigator who handled the case:

> I was called to testify and he brought defense witnesses who testified for him. He was on the Board of Directors of the major local hospital here. The deputy attorney general would ask these people from the hospital, "You mean you have reelected him to the Board of Directors of the hospital even though he's pled guilty to a felony?" And they said, "Sure." And [the deputy attorney general] said, "Don't you realize that he plead guilty to Medicaid fraud?" And this physician on the board said, "Yeah, but you know Medicaid doesn't pay very much anyway." And that was the response that was actually right at the hearing. They didn't revoke the license (Personal Interview).

Chapter 4

Patterns of Control and Enforcement

4.1 Medicare

Current policing efforts in Medicare are in no small part shaped by prosecutors. Reiss notes that "by legal theory and by practice, prosecutors have the greatest discretion in the formally organized criminal justice network (1974:690)." Prosecutors' definitions of what constitutes "fraud" help to shape the actions of federal investigators who must work up cases. The necessity of proving criminal intent is paramount in control agents' working definitions of fraud and abuse. A universal view exists among agents that fraud cases must involve "something willful." As one puts it:

> There is some intent to defraud or cheat the government and there is no question but that it's willful...Abuse, on the other hand, is just basically giving people more than they need in terms of medical service -- excessive treatment, treatment that is not necessary, billing for more services than are needed -- anything that is above and beyond what the diagnosis calls for but doesn't involve a willful intent. The difference between fraud and abuse, as far as I'm concerned, is in the case of fraud, services aren't rendered. In abuse cases the

> services are rendered but there is more given than is necessary based on the diagnosis (Personal Interview).

Official attempts to define "overutilization" as fraud are frustrated by prosecutors' needs for proving intent. One high-ranking official complained:

> An internist in the city of Pittsburgh will see a patient with a certain condition six times, and I'll identify a guy who sees a patient with that condition 20 times. And now I think that somebody should tell us that this guy has seen him 14 times too often and we should get our money back. When we put this before a medical review group they'll say, "Oh well, you know, it's malpractice time and I can understand why he might have ordered unnecessary tests" (Personal Interview).

It is part of medical practice folklore that physicians are unwilling to label the actions of other physicians as wrong. Also, lacking total agreement among physicians regarding diagnosis and treatment, as well as specific regulations in benefit programs that clearly define treatment categories, criminal prosecution of overutilization would be futile, since it would not be possible to show "willful intent" beyond a reasonable doubt.

The Office of Inspector General (OIG) of the U. S. Department of Health and Human Services (HHS), the agency that investigates fraud by Medicare providers (as well as all crimes involving HHS programs), will normally take on only those cases that prosecutors agree to. As one agent noted:

> Very early on in the investigation, before we expend a lot of investigative resources, we'll go directly to the prosecutor [and make a] presentation...We'll set forth the allegations and facts as developed preliminarily and then ask the prosecutor, "If we substantiate these allegations, given the dollar amounts, the proofs, and so forth, will you prosecute this case?" So we are right up front in our system of priorities whether or not to make a commitment of our resources or end it right there (Personal Interview).

In many respects an agent has to sell a case to the prosecutor. Medicare provider fraud must compete with other federal offenses which account for most of the time of the U.S. attorney. An invesigator commenting on prosecutors in one federal district noted:

> Their priorities are bank robberies, drugs, immigration, and terrorists. The workload of the assistants is huge. Somebody goes and blows up nine airplanes and then you come in the next day with a doctor who is [stealing] from Medicare and Medicaid. Where are their priorities? They will be more concerned with violent crimes (Personal Interview).

Because of such priorities, prosecutors usually consider the absolute dollar amounts involved and the amount of resources necessary to prove a case in assessing whether or not it is worth pursuing. An investigator explained:

> The first thing they always look at is money. You can get a guy whose [fraudulent] Medicare bills are $3,000 or $4,000 a year. No matter how good the complaint is, it's probably not going to warrant federal prosecution. Then you get into other questions. How much work are we going to have to do on this case? Are you talking about a guy adding an injection where he's getting an extra $2 per claim so that you're going to have to interview 1,000 or 2,000 people? If that were the case, he may feel that it's better [to pursue] civil action. The fact is that there is going to be a lot of work. Just because

there's going to be a lot of work shouldn't be a criteria, and it usually isn't. But there are times where you have somebody bucking for one or two dollars per claim. The amount of evidence you need to prove it beyond a reasonable doubt...just becomes burdensome (Personal Interview).

The same respondent went on to point out that the U.S. attorney will also consider the weight of the evidence:

> If it's an open and shut case where this guy is obviously committing a fraud and the intent is there, and the evidence is there...it may not be a lot of money, but the evidence is going to outweigh it and so they may prosecute it. Usually if you get patient abuse, that may not overwhelm the assistant, but a lot of times that may be the one extra thing. Say the guy's taking x-rays with no film, or he's allowing his secretary to prescribe drugs, then sometimes that will outweigh some of the other factors. It's kind of a scale. The amount of dollars is taken into effect, the amount of work, or what you're going to have to prove. On the other side is what is the evidence going to show? Is it going to be overwhelming; is he really fooling around with patients' welfare? (Personal Interview).

U.S. attorneys' decisions not to prosecute certain cases where there is ample evidence of wrongdoing means that cases originally identified as possible fraud are either dropped entirely, or are relegated to the less serious category of abuse and referred for administrative action.

One important cost not mentioned by most agents, although undoubtedly important in legal and social respects, is the harm done to patients. It was interesting to us that most of the interviews with control personnel centered on costs in financial, rather than in human terms. This, we believe, has

little to do with insensitivity on the part of officials. Rather, it is a product of the organization of control which focuses on recoupment of payments and sanctioning violators.

4.2 Medicaid

Medicaid fraud cases are usually investigated by state Medicaid Fraud Control Units (MFCU). There are currently about 30 states with such units which became operational in 1978 as a result of federal legislation. Their total number changes as some states start up units, while other states end participation. New units receive 90 percent of their funding from federal revenues and are certified by HHS. The state's share of the cost is increased to 25 percent after three years. New York's unit is the largest with well over 100 positions, including investigators, auditors and prosecutors. California has the second largest in the country, with over 60 people at the time of this writing. Units usually are housed in the state's Attorney General's Office, making prosecution less burdensome than in federal cases. An attorney's opinion is immediately available, and in-house prosecutors handle only Medicaid cases. Smaller state units rely on prosecutors located in the criminal justice system. The chief investigator in a smaller MFCU commented:

> We will have two attorneys. They're not going to be prosecutors, primarily. They're going to be "prosecutive consultants"--a name I like to give them. We're going to rely on the county prosecutors and we're going to have these guys available to advise and recommend and everything else. And if a county does neglect a case or refuse a case for frivolous reasons, we have authority under the Welfare Act to prosecute it ourselves...and every one of these cases is a federal case also and we've got good liaison with the U.S. Attorney's Office, so there's nothing stopping us from going in there (Personal Interview).

In addition, MFCU attorneys have been given courtesy appointments as U.S. Attorneys, which allows them to prosecute medical benefit fraud cases in U.S. courts.

A major force affecting sanctions against errant providers in medical benefit program cases are the financial resources of the investigative units. The capacity of the system to enforce laws and mete out punishment is in no small measure related to the "production" of fraud and abuse by authorities. It has been observed that:

> Environmental demands on organizational resources and the distribution of those resources in the criminal justice system may be largely responsible for what the system actually "produces" in terms of reported crime rates, arrests, convictions, and sentences (Pontell, 1982:131).

Similar constraints on health care enforcement agents affect whether a provider's behavior will be treated as an abuse or a fraud. The first level of the control process is housed in the carrier -- an insurance company under contract with a state or the federal government to administer payments to providers.

The carrier is required to perform basic program integrity functions involving both pre- and post-payment reviews. Physician billing patterns that are highly aberrant are "flagged" by computer for further investigation to determine if the program is being abused or defrauded.

> The carrier will then start to screen invoices and usually what that involves is that they will pick 10 to 15 claims of an individual provider and contact the patients by mail or by phone and say, "Did you get or did you not get the service?" If enough of those people did not get the service or in some way don't verify what this provider has billed for, that package is then referred for possible fraud investigation (Personal Interview).

The ability of carriers to conduct these preliminary investigations ("work-ups") is limited by budget constraints. Recent cuts in Medicare and Medicaid programs have reduced the number of investigations that carriers can conduct. This has greatly handicapped the ability of the system to detect and sanction fraudulent health care providers. One administrator gave the following characterization of the situation:

> Take the universe of 15,000 doctors such as in New York. They can still identify 450 aberrant doctors every year. It hasn't decreased. However, they can only work each year on less and less as the budget calls for less and less. But because they're working on 50 cases this year, while last year they were working on 100, doesn't mean there are 50 less aberrant doctors out there (Personal Interview).

Cases that are not "worked" are treated as abuses and are handled within the carrier, or may be referred to the state health department for administrative sanctioning. In such

cases, "Sometimes they decide they're just going to get an overpayment back and send an educational letter to the doctor. Usually they meet with the doctor and try to give him an opportunity to explain," an agent notes. State health department units responsible for program integrity, for example, may do any of the following: (1) warn the physician about any incorrect billing; (2) demand reimbursement for overpayments; (3) establish a special claim procedure under which full documentation of services rendered must accompany all future bills; (4) demand that the physician seek prior authorization before accepting non-emergency patients; (5) suspend the physician from the program, which is the most difficult sanction to achieve; (6) refer the case to state licensing agencies for possible disciplinary action (Pontell, et al., 1982).

One thing is clear from our observations of control efforts at both state and federal levels. Both the structure of the programs and the minimal budgets for control agencies make the likelihood of detection and sanctioning of errant providers rather low. There is no question that there enormous sums of money that are lost to fraud and abuse along with human life and health. Only careful research and government agency coordination and cooperation can truly answer the question of "how much?" There seems to be little doubt among control experts that many providers "slip through the cracks." The

capacity of governmental control organizations to detect, investigate, and successfully prosecute fraud cases appears to far exceed the typical problems involved with punishing common crime (Pepinsky, 1982; Pontell, 1982,1984).

4.3 Deterrence and Prevention of Fraud and Abuse

A major set of propositions regarding prevention of fraud and abuse can be found in the criminological literature on deterrence. The basis of the deterrence doctrine is that crime rates are negatively related to properties of punishment; particularly the perceived certainty of legal punishment. The literature suggests that white-collar criminals such as physicians acting illegally may be more sensitive to deterrence efforts. "[I]t seems likely," Zimring and Hawkins (1973:127) write, "that those who attain high status will possess many of the characteristics that may be associated with maximum threat influence, such as a sense of the significance of the future and a strong loyalty to a social system that has been responsible for much of their success." Similarly, Geerken and Gove hypothesize that "the effectiveness of [a] deterrence system will increase as the individual's investment in and rewards from the social system increase (1975:91)." Of course, these propositions refer only to those attributes which may

positively effect deterrence. As we mentioned earlier, sometimes legal threats are thwarted by structural and organizational arrangements, and an arrogance on the part of some doctors that they are "above the law." Under such circumstances deterrence may be minimal for those the system would perhaps most like to deter. The reality of deterrence is oftentimes quite different than what "should happen" according to theory because of how limited the criminal justice system is in a free society. In regard to deterrence theory, however, the high occupational status of physicians would suggest that they are among the most "rational" element in society. Physicians should likely learn the lesson intended by punishment.

Some qualitative and quantitative evidence regarding deterrence and physicians does exist. Lindesmith (1965) argues that the government was able to deter physicians from dispensing heroin to addicts. Prior to 1919, physicians often would prescribe narcotics for those addicted. In their medical opinion, addiction was a disease and the addict was a patient to whom they could prescribe drugs to alleviate the distress of withdrawl. The Treasury Department, however, interpreted the existing law regarding the dispensing of opiates to prohibit a doctor's prescription for an addict. In addition, law enforcement efforts drove narcotic usage into slum areas (Ball and Cottrell, 1965: 475). Doctors soon found narcotic addicts

to be unrewarding patients, with a high degree of intransigency and a low rate of payment (Geis, 1979:111). Most doctors simply stopped having anything to do with addicts and the few who did not do this found themselves threatened by prosecution (Lindesmith, 1965:7). The flow of narcotics from doctor to patient addict abruptly ceased.

Similarly, Andenaes suggests that physicians were easily deterred in regard to illegal abortions. He argues that the reason for this was that "the medical profession on the whole is quite susceptible to the threat of law and the censure of society" (1971:545).

A survey of 388 obstetricians undertaken prior to the amendment of many state laws on abortion, however, found 10 percent admitting that they referred patients to abortionists. They also believed that 14 percent of their colleagues did so. For the majority of those making such referrals, there were four or five cases each year, though a few said that they referred from 30 to 40 cases annually (Lader, 1965:46,59). Zimring (1972:715), in a study of the change in abortion practices after Hawaii liberalized its abortion law, reached a similar conclusion. "Physicians were intimately involved in prechange abortion practice at least in a referral capacity." It is not easy to interpret these figures. Perhaps it can be said that for at least a minority of physicians there proved to

be a willingness to violate the law if: (1) a patient's welfare was involved; and (2) the physician did not have to take direct and brazen illegal action.

In a more recent test of the effects of deterrence in regard to medical practitioners, an official carrier reviewed claims data of pharmacies of Lake County, Indiana, before and after the criminal conviction of one of their number. He found "a sizeable decrease after all the publicity (Personal Interview). A more sophisticated technique was used by a high ranking enforcement agent in HCFA. He examined the claims data of the 20 largest providers (in dollars amounts) in one medical specialty in the New York City area. Again, billings were compared for a time period before and after a "highly publicized" conviction of members of the specialty in the City's area. The official reviewed HCFA's records of the providers to eliminate any who might have had a structural change in their business (for example, relocation), as well as those who had been included in the prosecution. The agent reported a 52 percent drop in billing charges following the conviction (Bailey, 1982). Similarly, a regional enforcement office noted that "doctors' earnings go down when they realize they're being investigated" (Howard, 1982). In short, if such results can be generalized, efforts to deter physicians from abusing and defrauding medical benefit programs might reasonably be regarded as likely to be successful.

Chapter 5

Methodology for Physician Interviews

We are not aware of any earlier research studies in which deviant and criminal physicians have been interviewed. An early reservation regarding our research design was based on the assumption that no, or very few doctors would grant us interviews. This assumption turned out to be incorrect; a sizeable number of physicians agreed to be interviewed. Moreover, the vast majority of our respondents offered information freely, and were very cooperative in answering all questions put to them. We attribute this to the fact that we are university-based persons, and to a carefully worded and non-threatening interview schedule. We were also in a position to be "good listeners" and were able, as outsiders, to empathize with respondents. Many of the physicians we interviewed had what they felt to be justified dissatisfaction with Medicare and/or Medicaid. For these doctors, we served as a sounding board, allowing them to tell us their side of the story. Frustrated with official channels and attorneys, some expressed relief and gratitude that someone was engaged in a

study of the situation. Whatever the reasons for our success, perhaps our most important achievement was to prove the feasibility of a research approach that was doubted by academic and official experts. We hope that this study will help support similar research endeavors concerned with securing information about professional white-collar criminals from such offenders themselves.

5.1 Interviews With Sanctioned Physicians

Physicians in our study were those who had been administratively sanctioned for abusive practices which violated government health program guidelines or who had been convicted of fraudulent activities concerning these programs. Our search for case file data on sanctioned physicians was limited to closed cases in government agencies. All of our cases involved Medicaid violations of some sort, though in a number of instances case histories and interviews revealed punishments that were brought on by issues involving quality of care matters not directly related to program fraud or abuse. As a result of such deviant practice patterns, physicians might be sanctioned by the Medicaid program for not performing up to minimal standards of medical practice as outlined in program regulations. Such a case might involve, for instance, a

psychiatrist reported to the authorities for a sexual alliance with a patient. That behavior itself could be a ground for disciplinary action, but such action perhaps was taken after basis of the fact -- discovered subsequently -- that he was billing Medicaid for his sexual dalliances. In the majority of cases, however, physicians were sanctioned for direct abuses and frauds against the Medicaid program.

We obtained case file information for 64 physicians: 30 from California, and 34 from New York, as well as the names of 61 additional providers sanctioned for Medicaid ("Medi-Cal") abuse in California. In New York, we obtained 1 or 2 page summaries for 14 fraud cases involving physicians which were given to us by the state Medicaid Fraud Control Unit in New York City. Most of these cases involved practitioners from New York City, with some from upstate rural and suburban areas, Westchester, and Long Island. Case details were also obtained from the New York State Department of Social Services, the agency administering the Medicaid program in New York. The materials largely dealt with administrative violations by physicians.

We were able to obtain the most complete and numerous data regarding deviant and criminal physicians from California agencies, who displayed great cooperation with our efforts. This occurred despite resource constraints and political volativity (there was, for example, a major change in

government administration with a new governor elected in California during our study) at least as severe as in other state and federal settings. We collected 28 comprehensive histories on closed fraud cases involving physicians from the Medicaid Fraud Control Unit of the Attorney General's Office in Sacramento. In addition, the Department of Health Services, which administers the Medi-Cal (Medicaid) program in California, supplied us with 2 case histories and 61 names of physicians who were administratively sanctioned for program violations. Some of these physicians were also found guilty of criminal charges, which was ascertained at the time of the interview. All told, we were able to collect names of 125 prospective interviewees who were administratively and/or criminally sanctioned for fraud and abuse in California and New York -- states with by far the largest Medicaid systems in the country, together accounting for about 40 percent of the program expenditures in the nation.

5.2 Obtaining Case Files

A note on our experience in obtaining names and files of sanctioned physicians might be beneficial to further research efforts in this area. While all agencies we contacted were interested in our research, generally supported the study, and

appeared genuinely interested in the potential results, obtaining file information from them was not an easy task, and took many telephone calls, assurances and reassurances and delicate negotiations. Particularly frustrating and discouraging was the official attitude of the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services. After initial indications that there would be "no problems" as long as their legal counsel approved (which she did), support was withdrawn. This surprised us since the Inspector General had approved of our talking with his staff, and had assigned a Deputy Assistant Inspector General to serve as the central contact for any information we needed. Many officials in the office with whom we spoke were very supportive of our efforts, and saw the research as beneficial to their understanding and detection of fraud and abuse. Our initial working relationship was so good, in fact, that we were able to have students from Indiana University work as summer interns for the OIG. They were there essentially to help with the administrative tasks involved in putting together case file materials, as we were told that extra manpower would be needed to satisfy our request for information. In anticipation of their cooperation, the principal investigator hand delivered an approved copy of all grant materials to the OIG legal counsel as soon as the grant was officially sanctioned by the Department of Justice. We received legal counsel approval, but

subsequently were denied access. Later, we received a letter from an Assistant Inspector General which reiterated the denial of access to case files on the ground that "after careful consideration" it had been concluded that the research was not important enough for them to be bothered with administratively. We later learned that the OIG does not have an adequate filing or data recovery system regarding their ongoing or closed cases, a situation that may partly explain their reluctance to be cooperative.

The OIG's backsliding left it the only agency we worked with which did not supply case file information or the names of sanctioned physicians. Politically, such data may be sensitive since they involve detailed accounts of wrongdoing by rather well-off professionals, who, both individually and as a group, can command great power in affecting law and government policies. Closed cases are technically public information, but other information in the files such as witness and patient names are not. It is purely a mechanical operation to remove such material, which is usually concentrated on a few pages. Agencies such as the OIG or state Medicaid Fraud Control Units are highly politicized organizations which can come under intensive scrutiny by government leaders and legislatures. Thus, they are perhaps justifiably guarded when there is any intrusion into their affairs from outsiders -- whether they be from academics or others. A 1982 report issued by Congress

which was highly critical of state efforts at controlling fraud and abuse in Medicare and Medicaid (U.S. House of Representatives, 1982) is just one example of the possible vulnerability of such agencies.

The second major problem is more of an organizational nature per se. We were not in any position as outsiders to "force" or "require" that an organization cooperate with us, nor did we feel that it would help our research to go to higher levels of authority (Congresspersons, Presidential Aides, Department Secretaries) in order to coerce "cooperation." This would have strained our working relationships with officials and diverted time and resources from the project's main tasks. After our experience, we would recommend that agencies be required to cooperate with reasonable requests of government funded research projects to avoid the waste of resources and produce more sensible collaborative efforts. It seems counterproductive to have an office of the Department of Health and Human Services deny access to legitimate research efforts funded by the Department of Justice which involves products beneficial to the mission of both agencies.

We raise these issues to make a basic point. There is no benefit in urging further research if necessary information is withheld by government agencies, or they do not bother to keep careful filing systems. Perhaps agencies are so politically

charged and vulnerable that outside requests are likely to be seen as potential political liabilities, regardless of the importance and potential benefit of the outcome of the effort for the agency itself.

The foregoing discussion points to a final consideration which bears on our process of collecting data for this study. Despite our successes in New York and California in obtaining case files and information on sanctioned physicians, we had very little control over the selection of cases, and trust that we were given all of them by officials. The cases we assembled should represent closed physician fraud and abuse cases from California and New York involving Medicaid violations through the year 1982.

In conclusion, we see a need for more serious government coordination, inter-agency cooperation, and data gathering in order to provide the best possible database to aid in planning and research. Nonetheless, as we will show, we were able to amass a considerable amount of new and useful information on fraud and abuse despite the paucity of official data.

5.3 Contacting Physicians for Interviews

5.3.1 Sanctioned Physicians

Given the potential sensitiviy of the subject matter and the elite status of our research subjects, we thought that the best way to approach each prospective interviewee was with a letter on university stationery signed by the principal investigators which explained our research and asked for their cooperation. The tone of the letter was guided by the following considerations: (1) asking for their help in an academic research endeavor; (2) stressing government regulation as a source of violations in the health care field; (3) emphasizing that they could have input into completing the picture concerning violations, since virtually all other information derives from official sources; (4) telling of our willingness to listen to their point of view regarding problems in government medical programs and what might be done about them; (5)underlining the confidentiality of the interview and arranging it at their convenience; (6) acknowledging their limited time and expressing gratitude for their consideration of our request; (7) providing a return postcard; and (8) alerting them that we would try reaching them by telephone in about one week.

Many of the addresses given to us by authorities with the names and files of physicians turned out not to be current, and almost one third of the letters were returned. For these doctors, we first tried checking with telephone information to acquire a new number. If there was a working telephone number,

we called the doctor's office to obtain a current address. Where we could not find a telephone number, we checked with the American Medical Association Directory, state medical directories, licensing boards, and alumni associations of medical schools for addresses. In one case, an alumni association called us back to see if we had been able to locate a physician who had been convicted of Medicaid fraud. It had been trying for some time to mail him an award.

We followed up our first letter with a telephone call, or a second letter when we could not speak with the doctor directly. All told, we were not able to locate or contact at all approximately 15 percent, or 19 out of 125 potential respondents.

5.3.2 Non-Sanctioned Physicians

Our original intention was to employ what could be termed a "quasi-matched control group design," which would enable us to compare responses of physicians who were violators with a group of physicians with similar characteristics who were not sanctioned for Medicaid fraud or abuse. We could not exactly stratify this sample according to characteristics of the sanctioned group because of time and resource limitations, but were still able to produce a control group that did not seem to vary along major dimensions from the characteristics of the

sanctioned interviewees. A major reason for why we could not pre-stratify the control group was because official agencies could not produce Medicaid provider listings categorized by any fundamental traits (age, type of provider, specialty, location, etc.). We were thus left to our own resources to try and produce a group that could be considered "quasi-matched" with the sanctioned interviewees.

The most important and obvious consideration was to interview physicians who had a sizeable Medicaid clientele. Since most of our interviews with sanctioned physicians were done in California (79%), we felt that selecting prospective non-sanctioned interviewees from California was justified, and because the majority of our sanctioned sample was from southern California, we chose our non-sanctioned population using telephone directories for the Los Angeles area. The "Physician" listing in classified telephone directories were used for the following areas: Orange County, Long Beach, and Los Angeles (South District). Physicians listed under the sub-heading "General Practice," were called and their receptionists (or, in a few instances, the doctors themselves) were asked if they accepted Medi-Cal patients. If they responded "Yes," they were sent a cover letter and reply postcard asking them if they would be interviewed. Those telephone directory listings that specifically mentioned acceptance of Medi-Cal were automatically sent a letter with no

telephone contact, as were any specialists (non-general practitioners) who listed themselves as Medi-Cal providers. In Los Angeles, we avoided calling physicians in areas such as Beverly Hills that were obviously too affluent to have many Medi-Cal providers. The Los Angeles sample came primarily from communities such as Inglewood, Hawthorne, San Pedro, Torrance, Redondo Beach, East Los Angeles, Hollywood, and Culver City.

Finally, to insure that we interviewed a sizeable number of psychiatrists (almost one-third of the sanctioned group was psychiatrists), we obtained from the Los Angeles County Medical Association names of psychiatrists who accepted Medi-Cal. This list by no means included all such providers. Our list was randomly selected by the receptionist of the Los Angeles County Medical Association in accordance with their policy that only 3 names per given community can be given in answer to a telephone inquiry. After repeated telephone calls (and cheery greetings from the bemused receptionist), we selected psychiatrists who were practicing in poorer communities that were likely to have relatively large Medi-Cal beneficiary populations. Each psychiatrist was mailed a cover letter and reply postcard. These procedures for selecting our non-sanctioned sample provided a remarkably well matched group of physicians according to all the dimensions we could measure; that is, there were practically no statistically significant differences between the distributions of the two groups for major

characteristics examined.

5.4 Response Rates

5.4.1 Sanctioned Physicians

We obtained a total of 125 names of sanctioned providers from authorities in New York and California. Of these, using the techniques previously discussed, we could not locate 19. This fallout represents about 15 percent of the sanctioned physician population in New York and California for closed cases available to us through 1982. With these removed from our sampling base, we were left with 106 persons who we had the opportunity to speak with. This is the figure upon which we base our response rates.

As shown in Table 1, we were able to interview almost 40 percent of the doctors for whom we had addresses and telephone numbers. This represents 42 physicians. We completed 33 of these interviews in California between June and September of 1983. About one-third of the interviews were conducted by telephone either because of convenience for the subject or our resource constraints for single cases in rural areas. An additional 9 interviews were conducted in October and November with physicians sanctioned in New York. Most of these were done

by telephone. Almost all of our interviews were tape recorded with the permission of the doctor for coding purposes.

Only 16 percent of the doctors refused outright to grant us an interview. This represented 17 of the physicians we were able to locate. An additional 41 percent (43) did not respond to our letter, nor were we able to speak with them directly about participating in the project. It seems likely that most of these physicians would have turned us down if we had spoken with them. Some may have forgotten about our letters or were not motivated enough to respond either way. In any case adding those who did not answer to those who refused represents a little more than half of our potential respondents (57%). Finally, the "other" category includes 3 physicians who had ongoing cases of one sort or another involving Medicaid who were willing to talk with us, but whose lawyers felt otherwise. In one case the physician was deceased.

A particularly significant finding regarding the response rates for sanctioned physicians is the fact that we were able to complete interviews with 40 percent of them. Our original expectation had been about one-third or possibly less. The design shows that satisfactory response rates can be obtained in research of this sort, a result which should encourage further research using different violator populations and perhaps larger numbers of violators.

5.4.2 Non-Sanctioned Physicians

The response rate for non-sanctioned physicians using the methods previously described was only 16 percent (34 interviews from 212 physicians we contacted). This was considerably lower than the response rate for sanctioned physicians (40%), a totally unexpected result. If anything, most persons would think that deviant and criminal physicians would be less likely to grant interviews than those in good standing. The unanticipated result may be explained by two possible factors. First, non-sanctioned physicians may have been busier than sanctioned ones, many of whom had reported experiencing a considerable or total decline in their professional practice. Thus they may have simply been less available for research probes such as ours. Second, the non-sanctioned doctors perhaps were less interested in this particular study, as they may have had less emotional stake in speaking to us; that is they may not have had any axe to grind on the subject of our concern. That far fewer of the non-sanctioned physicians as compared to those sanctioned agreed to be interviewed, though we employed an identical approach, is a counterintuitive finding of some interest.

5.5 Test for Sampling Bias In Sanctioned Physician Interviews

Since our respondents were a self-selected group who voluntarily agreed to be interviewed for the purposes of the study, it was necessary to ascertain whether or not they were significantly different on a range of possibly important dimensions from those who were not interviewed. Such information is important for grounding our findings as well as for generalizing from our results. There proved to be but few significant differences in characteristics among those who were interviewed and those who were not.

To test for significant differences we first divided the sanctioned physicians into two groups; those who were interviewed and those who were not. Our interviewed sample numbered 42, and we had case file information for 46 additional physicians who were not interviewed. This produces 88 physicians for whom data were available out of a total of 125 sanctioned physicians in New York and California. Those for whom data were missing represented administratively sanctioned physicians in California. Thus, if anything, our non-interviewed group might be slightly skewed toward more serious cases. For the majority of physicians not interviewed (46 out of 83) we were able to obtain enough information to make meaningful comparisons with the interviewed group. Table 2 displays descriptive statistics for those interviewed and those not interviewed for whom case data were available, as

well as for both groups combined (the universe of sanctioned physicians for whom data were available).

No significant differences were found between interviewees and those not interviewed for the following dimensions: (1) pleas (not guilty, guilty or nolo contendere); (2) sanction status (about two-thirds of each group were criminally sanctioned, whereas about one-third were only administratively sanctioned); (3) sex (both groups were overwhelmingly male); (4) specialty (both groups were predominantly comprised of general practitioners followed by psychiatrists); and (5) sanctions (mean length of probation, incarceration, restitution, fines), with the exception of community service. The interviewed sample averaged 683 hours of community service, while the non-interviewed group averaged 213 hours. This difference was significant at the .05 level (Fisher Test).

We found significant differences (.05 level or better) for the following two dimensions: community service sanctioning (33% of interviewees were sanctioned with community service as compared to only 11% of those not interviewed); and theft/larceny charges (31% of those interviewed were originally charged with theft or larceny, whereas 54% of the non-interviewed group were charged with these crimes). The most frequent category of original charges was filing false claims, followed by theft/larceny in both groups. The

significant difference in the proportion of theft/larceny charges in the two groups could indicate that the interviewed sample was comprised of less egregious violators. There is not much other support for this possibility, however, since charging practices could vary widely by case and agency; also no significant differences were found for practically all other dimensions measured. Moreover, as mentioned earlier, there is a good possibility that our non-interviewed group would be slightly skewed toward more serious cases, since all of the missing casefile information was for administratively sanctioned physicians. Overall, then, we found no significant differences on a range of major characteristics between those sanctioned physicians who were interviewed and those who were not.

Chapter 6

Analysis and Results

Our analysis entails a comparison of responses between sanctioned and non-sanctioned physicians on a range of variables related to fraud and abuse in government medical benefit programs. The analysis is necessarily exploratory given the small number of respondents, but nevertheless, some significant differences arose between the groups. Perhaps most importantly, many of the original hypotheses we had about differences between the groups did not turn out, and some were actually opposite of what the literature might have predicted would be the case.

6.1 Background and Demographic Characteristics

Physicians who were interviewed were predominantly from California rather than New York (33 and 9 respectively). This was the case because most of the closed cases we received were from California, and also because our response rate was higher

in California (36% versus 26%). The physicians interviewed were almost exclusively male (95%). We found no significant differences between the sanctioned and non-sanctioned groups as far as where they were trained. About seventy percent of each group was educated in U.S. medical schools or schools of osteopathy (see Table 3). There was also little difference between the groups in the proportion attending the same undergraduate schools as their medical schools. Thirty-six percent of the sanctioned group and 29% of the non-sanctioned group had attended the same school for their medical training as for their undergraduate education.

Table 4 shows some differences by specialty between the two groups which are statistically significant ($p<.05$). Both groups are most heavily represented by general practitioners followed by psychiatrists and other specialties. The sanctioned group is made up of 38 percent general practitioners and 31 percent psychiatrists, while the non-sanctioned group is overwhelmingly composed of general practitioners (71%) followed by psychiatrists (18%). These differences, however, are more a function of the fact that we could not completely stratify the non-sanctioned group. It is nonetheless interesting, however, to note the disproportionate number of psychiatrists in the sanctioned group. We have taken up this issue in a separate report which deals specifically with psychiatrist fraud and abuse in Medicare and Medicaid (see Appendix A).

We found no significant differences between the groups as far as marital status or ethnicity as well. The sanctioned group was slightly more represented by hispanic physicians, but this difference was not statistically significant (see Table 5).

There also were no significant differences found for type of main practice between the two groups. Seventy-six percent of the sanctioned group were solo practitioners as compared to 65 percent of the non-sanctioned group at the time of the interviews (see Table 6). Both groups were similar in terms of their accountability to others in their practices. This is a structural variable measuring organizational accountability, which we believed might affect the occurrence of fraud and abuse. There were also no significant differences in types of other business interests. Between two-thirds and three-quarters had no other business interests besides their medical practice. Both groups also reported having similar types of friendship networks. Most physicians in both groups said they had a variety of friends rather than just business or professional ones.

The sanctioned group was significantly older ($p < .05$) than the non-sanctioned interviewees. The average age of those sanctioned was 57.2 years versus 48.2 years for the non-sanctioned group. This also correlated with date of medical degree. The mean for the sanctioned group was 1953

while for the non-sanctioned interviewees it was 1963 ($p < .05$). The sanctioned group also reported practicing in more locations, which could again be correlated with the older age of this group or the fact that its members were sanctioned and needed to move in order to revive their practices. The average number of practice locations was 2.6 for the sanctioned group versus 1.9 for those not sanctioned ($P < .05$).

6.2 Attitudes Toward Programs, Sanctions, and Fraud and Abuse

We had hypothesized that sanctioned physicians would view program reimbursement in less favorable terms than non-sanctioned doctors. We presumed that such views would have originally given rise to violative behaviors. But we found no significant differences between the groups as far as their feelings about low reimbursement rates in the programs. In fact, the non-sanctioned group reported more frequently that reimbursement was too low (see Table 7); slightly more than half (57%) of the sanctioned physicians reported that reimbursement was too low in the program, while 73 percent of the non-sanctioned physicians felt this way. One non-sanctioned physician spoke for many doctors when he claimed during our interview: "The reimbursement system is completely unfair." Similarly, as Table 8 shows, there is a significant

difference ($p < .01$) between the two groups in their complaints about unnecessary regulations. This contradicts the hypothesis that sanctioned physicians would find more regulations unnecessary. Almost two-thirds of the sanctioned physicians (62%) as compared to only 23 percent of the non-sanctioned physicians reported no complaints about unnecessary regulations concerning the aid programs.

When asked about the legitimacy of government medical programs, there were no significant differences in response between the two groups (see Table 9). Over half of each group reported that the programs were not in fact legitimate in the eyes of the medical profession, while only about 10 percent of each group stated that the programs were legitimate. Although there were no significant differences, the answers indicate widespread dissatisfaction with the programs amongst those in the medical profession. Rules and laws can more easily be broken when they are not seen as legitimate, and the conflict between government regulation and professional autonomy is evident in the response patterns. Comments about legitimacy from both sanctioned and non-sanctioned doctors includes the following remarks:

> Medicaid is run by incompetent politicians....
>
> The problem is the people who are managing the programs....
>
> One of the most corrupt, immoral forces in this world is the U.S. government....

Another question asked related to the fairness of Medicaid shows a similar pattern. While no significant differences were found between the two groups, both overwhelmingly responded that the program is not fair, with non-sanctioned physicians answering more negatively. (see Table 10). As one non-sanctioned physician told us, "It's like tying someone's hands and telling them to lift a big rock with their hands tied." Very few physicians said that the Medicaid program was fair.

If awareness of regulations is a factor in the frequency of fraud and abuse, it is not evident from our data. There were no significant differences between the two groups of physicians in their awareness of regulations. In fact, the sanctioned group reported a slightly higher degree of knowledge concerning program guidelines. This was not, however, statistically significant (see Table 11). Of those responding to this question, 61 percent of the sanctioned physicians reported that they were fully aware of the regulations at the time of their violations, while only 46 percent of the non-sanctioned group reported similar familiarity at the time of the interview.

In addition, regarding awareness of sanctions for wrongdoing and the process by which they are applied, there were no significant differences between the two groups of physicians (see Table 12). About two-thirds of the sanctioned group

reported that they were not familiar with sanctions before their cases, while a little over half (53%) of non-sanctioned physicians reported the same. It seems clear from this response pattern that doctors are not aware, by and large, of the possible consequences for violating program regulations.

There was a significant difference ($p < .05$) between the groups when asked what they thought the likelihood of sanctions was for wrongdoing (see Table 13). Very few respondents in either group felt that they were very likely, but almost two-thirds of the sanctioned group as compared to only 9 percent of the non-sanctioned physicians felt that punishment was likely for some providers. Almost 90 percent of the non-sanctioned physicians did not venture to guess the likelihood of sanctions as compared to only 26 percent of the sanctioned group. That the sanctioned doctors reported a much higher likelihood of sanctioning makes intuitive sense, since they had undergone punishment. Overall, however, the data show that physicians in general have little idea as to the certainty of punishment for violating program rules.

There was also a significant difference ($p < .05$) in responses to what physicians felt about the consistency of enforcement efforts (see Table 14). Sanctioned physicians saw enforcement as inconsistent (74%), while non-sanctioned doctors were almost evenly split among three possible responses: consistent (30%),

inconsistent (38%), and don't know (32%). The most frequent types of inconsistencies noted were very similar for both groups. These included: (1) bias against certain specialties (33%);(2) bias against big vendors (28%);and (3) bias against minorities (23%). Other inconsistencies in enforcement included bias against city doctors, taking the easiest cases, politics, and bias against solo practitioners. These together accounted for an additional 18 percent of the responses. Some physicians voiced their disapproval of enforcement efforts in the following terms:

> 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....
>
> They used Gestapo tactics....
>
> My investigation centered around an effort to dispose of older doctors....
>
> I knew at the time they tried to get me that they were out to get psychiatrists. They didn't like them in the program at all. They wanted to make an example out of me....
>
> It was like a scene from T.V. 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?....
>
> It was a kangaroo court....
>
> For $1,800, the government spent half a million on my case. Who in all sanity would jeopardize a $300,000 a year practice for $1,800?....
>
> Their main concern is looking for some vendor who is cheating them. That's their job, and that in itself is very disconcerting. Their attitude is to start off by not trusting anybody. They should be thankful. I think a little more trust would be in order and I think that once they investigate and find that a man has been working for x number of years and doing a good job, they should be less stringent on those rules that are impractical. I would like a more personal relationship between the welfare department and the practitioner....
>
> Doctors are presumed to be crooks....(Personal Interviews).

Another item asked whether or not the doctors felt that fraud and abuse involved a violation of professional trust. Of those responding, there was a significant difference ($p < .05$). Only 33 percent of sanctioned physicians answered "yes" (we did not ask it of those who told us they were not aware that they were violating any rules), while 90 percent of those non-sanctioned felt that it was an abuse of professional trust (see Table 15).

There was also a significant difference ($p < .05$) between the groups in their attitudes toward the overall prevalence of fraud and abuse in Medicaid and Medicare (see Table 16). There is a bi-modal distribution for those sanctioned. That is, relatively high proportions of them feel that there is both a little and a lot of fraud and abuse in the programs. About one-third did not have any idea about the prevalence as compared to almost one-half of the non-sanctioned group. About one-third of the sanctioned group felt that there was very little fraud and abuse as compared to only 12 percent for the non-sanctioned physicians. Twenty-nine percent of the non-sanctioned group felt that there was "little" fraud and

abuse as compared to only 5 percent of the sanctioned physicians. Twenty-two percent of the sanctioned doctors responded that there was "a lot" as compared with none from the non-sanctioned group. These results show that only between a third and a half of the doctors had no idea about the prevalence of fraud and abuse, which seems at odds with official statements from medical organizations which claim that the rate of occurrence of such practices is extremely low. The bi-modal distribution for sanctioned physicians could be related to two distinct views toward fraud and abuse. First, a physician might rationalize violative behavior by claiming that "everyone is doing it, so what's the big deal?" Another view would be that it is a small problem that is usually dredged up by authorities who don't understand medical practice and have nothing better to do. Both of these viewpoints were in fact dominant in our interviews with sanctioned doctors. Comments from doctors on this point included the following:

> I think everyone who takes Medicaid is cheating....
>
> I think the violation is more on the government end....
>
> The Justice Department seems like they're really out to get us...I imagine they're very jealous....
>
> Most doctors are dishonest as hell....
>
> I think we're a pretty honest group, and I think we do a lot of things for free that the public's not aware of....
>
> Thousands abuse the system routinely....

Finally, we asked physicians about the size of their practices within the last five years and found a significant difference in the responses of the two groups ($p < .05$). Almost 70 percent of sanctioned doctors reported that their practices had declined as compared to only 41 percent of non-sanctioned physicians. Only 7 percent of those sanctioned reported that their practices were growing as compared to 35 percent of those non-sanctioned. About a quarter of each group reported no change (see Table 17). This significant difference between the two groups may point to a consequence of sanctioning which goes beyond the mere aspects of legal penalties. The fact that sanctioned physicians reported declines in their practices may in fact be the greatest penalty involved in sanctioning from the physician's point of view, and an important finding given that authorities generally feel that a "pocketbook approach" to sanctioning works best with physician violators who may be overly concerned with monetary consequences. Many physicians we spoke with were quite willing to talk at length about the suffering they believed they endured as a result of their sanctions.

> There's one thing about the whole legal system I found -- there is no justice...You get an attorney, they make deals....
>
> God has strange ways. He knows, He knows what kind of crook I am. He's the only one, He's the only one....
>
> 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....

I have had my eyes opened up to the way of the world. When the government acts, it doesn't let the Constitution stand in its way. A man can be plucked out of nowhere and shipped to Siberia. That's how it was with me....

If this is happening to me -- the unfairness of it all -- I now feel for those other doctors who may be punished in a manner that I think is unfair....

Sanctions should be a corrective thing, not a punitive thing....

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 feel like I'm in exile. 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 consequence....(Personal Interviews).

Chapter 7

Conclusion

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 (1949:12).

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 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 the amount on their tax returns.

Focus on fraud perpetrated by medical practitioners highlights a well-educated group of elite persons whose violations cannot in any reasonable way be laid 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 employess. 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 recently 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, and in many cases epitomize such cultural values. 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 it 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 (Cushing, 1940:447).

A number of officials (as well as medical students and

physicians) believe that the "cause" of fraud and abuse lies in the nature of the laws and regulations for administering the Medicare and Medicaid 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 organization (HMO) 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.

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 and civil money penalties. These processes might serve as mechanisms which

would educate physicians about enforcement activities, although no scientific study can attest to their effectiveness in this regard. 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.

An overview of medical lawbreaking helps to round out our inventory of fraud and abuse in the medical 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 researchers 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 investigators 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 (Meier and Geis, 1979).

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"(Lanza-Kaduce, 1980). 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."

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APPENDIX A.

TABLES

TABLE 1

RESPONSE RATES FOR SANCTIONED PHYSICIANS

Outcome	Percent	Number
Interviewed	39.6	42
Refused Interview	16.0	17
No Response	40.6	43
Other	3.8	4
Total	100.0	106

TABLE 2

FREQUENCY DISTRIBUTIONS FOR SANCTIONED PHYSICIANS

Characteristic	Interviewed Group %	(N)	Non-Interviewed Group %	(N)	Total %	(N)
Sanction Status						
Criminal	67	(28)	61	(28)	64	(56)
Administrative	33	(14)	39	(18)	36	(32)
Sex						
Male	95	(40)	95	(44)	95	(81)
Female	5	(2)	5	(2)	5	(7)
Specialty						
G.P.	38	(16)	35	(16)	36	(32)
Psychiatrist	31	(13)	24	(11)	27	(24)
Other	31	(13)	24	(11)	27	(24)
Missing	0	(0)	17	(8)	9	(8)
Charges [1]						
False Claims	57	(24)	67	(31)	62	(55)
Theft/Larceny *	31	(13)	54	(25)	43	(38)
Drug Related	14	(6)	13	(6)	14	(12)
Sex Related	7	(3)	4	(2)	6	(5)
Other/Missing	0	(0)	2	(1)	1	(1)

TABLE 2

FREQUENCY DISTRIBUTIONS FOR SANCTIONED PHYSICIANS

(CONTINUED)

Characteristic	Interviewed Group %	(N)	Non-Interviewed Group %	(N)	Total %	(N)
Plea						
Guilty	38	(16)	46	(21)	42	(37)
Not Guilty	21	(9)	17	(8)	19	(17)
Missing	40	(17)	37	(17)	39	(34)
Sanctions [2]						
Probation	57	(24)	37	(17)	47	(41)
Restitution	36	(15)	52	(24)	44	(39)
Fine	33	(14)	37	(17)	35	(31)
Incarceration *	26	(11)	26	(12)	26	(23)
Community Service *	33	(14)	11	(5)	22	(19)

(1) Percentages are based upon total number of charges found for cases.
(2) Percentages are based upon total number of sanctions found for cases.
(*) Difference between groups is significant at .05 level or better.

TABLE 3

TYPE OF MEDICAL SCHOOL BY SANCTION STATUS

INTERVIEWED PHYSICIANS

	Sanctioned		Non-Sanctioned	
Medical School	%	(N)	%	(N)
Foreign	31	(13)	29	(10)
United States	52	(22)	42	(14)
U.S. Osteopathy	17	(7)	29	(10)
Total	100%	(42)	100%	(34)

TABLE 4

MEDICAL SPECIALTY BY SANCTION STATUS

INTERVIEWED PHYSICIANS

	Sanctioned		Non-Sanctioned	
Specialty	%	(N)	%	(N)
General Practice	38	(16)	71	(24)
Psychiatry	31	(13)	18	(6)
Obstetrics/Gynecology	7	(3)	0	(0)
Internal Medicine	5	(2)	0	(0)
Other	19	(8)	11	(4)
Total	100	(42)	100	(34)

TABLE 5

RACE/ETHNICITY BY SANCTION STATUS

INTERVIEWED PHYSICIANS

	Sanctioned		Non-Sanctioned	
Race/Ethnicity	%	(N)	%	(N)
Caucasian	69	(29)	76	(26)
Hispanic	14	(6)	6	(2)
Black	10	(4)	9	(3)
Asian	7	(3)	6	(2)
Total	100	(42)	100	(34)

TABLE 6

TYPE OF MAIN PRACTICE BY SANCTION STATUS

INTERVIEWED PHYSICIANS

	Sanctioned		Non-Sanctioned	
Practice	%	(N)	%	(N)
Solo	76	(32)	65	(22)
Small Group (1-3)	19	(8)	20	(7)
Large Group (4+)	5	(2)	15	(5)
Total	100	(42)	100	(34)

TABLE 7

RESPONDENTS STATING THAT PROGRAM REIMBURSEMENT

WAS TOO LOW BY SANCTION STATUS

INTERVIEWED PHYSICIANS

Reimbursement too Low	Sanctioned %	(N)	Non-Sanctioned %	(N)
Yes	57	(24)	73	(25)
No	43	(18)	27	(9)
Total	100	(42)	100	(34)

TABLE 8

NUMBER OF COMPLAINTS ABOUT PROGRAM BY SANCTION STATUS

INTERVIEWED PHYSICIANS

Number of Complaints	Sanctioned %	(N)	Non-Sanctioned %	(N)
None	62	(26)	23	(8)
One	36	(15)	68	(23)
More Than One	2	(1)	9	(3)
Total	100	(42)	100	(34)

Chi-square is significant at .01 level.

TABLE 9

PERCEPTION OF PROGRAM LEGITIMACY BY SANCTION STATUS

INTERVIEWED PHYSICIANS

	Sanctioned		Non-Sanctioned	
Perception	%	(N)	%	(N)
Not Legitimate	52	(22)	59	(20)
Legitimate	12	(5)	12	(4)
Don't Know/No Answer	36	(15)	29	(10)
Total	100	(42)	100	(34)

TABLE 10

PERCEIVED FAIRNESS OF THE PROGRAM

INTERVIEWED PHYSICIANS

	Sanctioned		Non_Sanctioned	
Perception	%	(N)	%	(N)
Fair	17	(7)	15	(5)
Unfair	78	(33)	85	(29)
Don't Know/No Answer	5	(2)	0	(0)
Total	100	(42)	100	(34)

TABLE 11

AWARENESS OF PROGRAM REGULATIONS*

BY SANCTION STATUS

INTERVIEWED PHYSICIANS

Fully Aware of Regulations	Sanctioned %	Sanctioned (N)	Non-Sanctioned %	Non-Sanctioned (N)
Yes	60	(25)	47	(16)
Somewhat	5	(2)	18	(6)
No	36	(15)	35	(12)
Total	100	(42)	100	(34)

* Awareness at time of, or directly before case for sanctioned physicians.

TABLE 12

AWARENESS OF SANCTIONS AND SANCTIONING PROCESS*

BY SANCTION STATUS

INTERVIEWED PHYSICIANS

Aware of Sanctions	Sanctioned %	Sanctioned (N)	Non-Sanctioned %	Non-Sanctioned (N)
Yes	5	(2)	12	(4)
Somewhat	21	(9)	32	(11)
No	67	(28)	53	(18)
No Answer	7	(3)	3	(1)
Total	100	(42)	100	(34)

* Awareness at time of, or directly before case for sanctioned physicians.

TABLE 13

PERCEIVED LIKELIHOOD OF SANCTIONS

BY SANCTION STATUS

INTERVIEWED PHYSICIANS

Likelihood of Sanctions	Sanctioned %	Sanctioned (N)	Non-Sanctioned %	Non-Sanctioned (N)
Very Likely	7	(3)	3	(1)
Likely for Some	65	(27)	9	(3)
Not Very Likely	2	(1)	0	(0)
Don't Know/No Answer	26	(11)	88	(30)
Total	100	(42)	100	(34)

Chi-square is significant at .01 level.

TABLE 14

ATTITUDE TOWARDS THE CONSISTENCY OF ENFORCEMENT PRACTICES

BY SANCTION STATUS

INTERVIEWED PHYSICIANS

Response	Sanctioned %	Sanctioned (N)	Non-Sanctioned %	Non-Sanctioned (N)
Consistent	7	(3)	30	(10)
Inconsistent	74	(31)	38	(13)
Don't Know/No Answer	19	(8)	32	(11)
Total	100	(42)	100	(34)

Chi-square is significant at .05 level.

TABLE 15

RESPONSE TO THE QUESTION OF WHETHER FRAUD AND ABUSE BY PHYSICIANS

ENTAILS AN ABUSE OF PROFESSIONAL TRUST

BY SANCTION STATUS

INTERVIEWED PHYSICIANS

	Sanctioned		Non-Sanctioned	
Response	%	(N)	%	(N)
Yes	33	(5)	90	(26)
No	67	(10)	7	(2)
Sometimes	0	(0)	3	(1)
Total*	100	(15)	100	(29)

Chi-square is significant at .01 level.

* Question not asked, or data missing for 27 sanctioned, and 5 non-sanctioned physicians.

TABLE 16

PERCEIVED PREVALENCE OF PHYSICIAN FRAUD AND ABUSE

BY SANCTION STATUS

INTERVIEWED PHYSICIANS

	Sanctioned		Non-Sanctioned	
Prevalence	%	(N)	%	(N)
Very Little	32	(13)	12	(4)
Little	5	(2)	29	(10)
Moderate	5	(2)	3	(1)
Moderate to a Lot	5	(2)	9	(3)
A Lot	22	(9)	0	(0)
Don't Know/No Answer	32	(14)	47	(16)
Total	100	(42)	100	(34)

Chi-square is significant at .05 level.

TABLE 17

REPORTED CHANGE IN PRACTICE SIZE IN LAST FIVE YEARS

BY SANCTION STATUS

INTERVIEWED PHYSICIANS

	Sanctioned		Non-Sanctioned	
Reported Change	%	(N)	%	(N)
Growing	7	(3)	35	(12)
Declining	69	(29)	41	(14)
Same	24	(10)	24	(8)
Total	100	(42)	100	(34)

Chi-square is significant at .01 level.

APPENDIX B.

INSTRUMENTS

INTERVIEW SCHEDULE

Sanctioned Physicians

Introduce Self and Study — exchange business cards

Study: 1. at UCI

2. Professors Geis and Pontell, sociologists

3. Working on grant from the U. S. Department of Justice on government regulation of medial practitioners in government benefit programs.

As part of this project we feel that it is important to hear about the situation from the physician's side—what you see as important in this issue. Thus, we're interested in your perceptions, opinions and attitudes toward the enforcement process and your own experiences in dealing with it. All your responses are strictly confidential.

(Ask and answer any questions or comments and wait until respondent is at ease before beginning interview.)

I'd like to start with a few basic demographic questions.

1. Date of birth

2. Medical school and date of degree

3. Undergraduate school

4. States in which licensed to practice

5. Specialties and certifications

6. Main practice (type-solo, group, etc.) and proportion of entire practice. How long?

7. Other practices (types) and hospital affiliations (and types)

8. Was this same as at time of your case?

9. Married?_____ Divorced?_____ Children?_____

No._____ No._____ No._____

10. Practiced in other geographic areas? (types, dates, locations)

(After these demos, ask physician to describe the case. Ask....)

11. Now I'd like to turn to some questions about your experiences with government benefit programs.

Could you describe your situation to me?

(Keep it short—10 min.—probe for specifics, chronological sequence of events, etc.)

12. One of our concerns that we would like to know your opinion of is the fairness of the system. Do you feel that the reimbursement system is fair? (If not, ask what would be fair? **Why?** Probe for specifics and illustrations.)

13. Did you have copies of regulations and guidelines for Medicare or Medicaid? (If yes: Where did you keep them? Did you receive updates? Did you keep them together? Did you have them before the case? Did you keep them in the same place at that time?)

14. Were you fully aware of the regulations and guidelines? (Before? And after the case?)

15. Which regulations do you find most unreasonable? How would you change them? Why do you think this would be an improvement?

16. Do you believe that your colleagues would feel pretty much the same way? (Probe- Why do you think this is so?—evidence used to make this judgment, etc.)

17. About what percentage of your total practice income was from (Medicaid-Medicare) at the time of your case? (What percentage 2 years before, during the investigation?

18. About what percentage of your work time is spent directly on:

Type of Work	Percentage (now)	Percentage (before case)
(1) Medical Practice		
(2) Other business interests		
(a) medically related (specify which ones)		
(b) non-medical (specify)		

Has this changed as a result of your case? If yes, how much? Why?

19. Were there any notable changes and/or problems directly prior to your case, relating to: (For each, probe if possible, approximate time before, specifics, etc.)

(a) Your practice

(b) Business, investments

(c) Personal lives, family matters

(d) Professional—hospitals, medical associations, etc.

20. What about problems and/or changes during or after your case? (Repeat question list for subsequent to or during case—approximate times.)

21. Overall, how would you say the state of your practice has changed in the last 5-10 years? Grown? Declined? Approximately how much?

22. Were there any changes in your satisfaction with (1) career, (2) income, (3) practice, after the case? (Probe—times, types of changes, what they were due to)

Now I have a few questions about the sanctioning process.

23. What specific sanctions were applied in your case? (list specific ones)

24. **Prior to your** investigation were you familiar with the sanctioning process or government control mechanisms? (Probe—what types of sanctions, what types of control practices?)

[If they are familiar, ask, How did you know such things? (probe for specifics)]

25. Did these views change subsequent to your case? How? (Probe—perceive as greater or lesser: (1) certainty of sanctions, (2) severity of sanctions, (3) which sanctions?)

26. Do you believe that the sanctions were fair? (Probe—explain)

I have a few more questions regarding the "fairness" of the sanctioning process and the system in general.

27. Were the persons involved fair to you? (How? Which ones?)

28. Was the hearing and/or court process fair? (How? Which ones?)

29. What about the program rules? Do you feel that the government medical program rules are legitimate in the eyes of the medical profession? In your eyes? (Probe—Which rules? Why do they think this way?)

30. Do you believe that such rules are consistently applied? (On what do they base their opinion—examples, illustrations?)

31. What do you think caused you to get into trouble with the system? Do you blame yourself, the system, others? (How much due to each—explain)

32. What might have best prevented this in your case? (explain—What would it have taken to deter you? What about others, how could they best be deterred?)

33. Were you aware that you were violating the rules while you were doing it? (If yes, answer question 37.)

34. At the time, did you feel that your actions entailed an abuse of professional trust?

35. Do you feel the same way now?

[If answered yes to 034, ask 037-041.]

36. What was going through your mind at the time of the violations? What were you thinking about generally?

37. Did you think it was serious?

38. Did you think you'd get caught?

39. What was the worst think that you thought would happen if you were caught? (lose license? suspension from the program, conviction, jail, slap on the wrist, reimbursement of money, fine?)

40. How do you view the violations and possible sanctions now?

[Do you perceive it (violation) as serious?—more, less, same as before? How do you view the chances of getting caught now?—more, less, same as before? What do you now think the worst possible consequences of such actions could be?—more severe, less severe, same as before?]

Just a few more general questions.

41. Do you feel that the medical profession has the ability to police itself? (Probe—Is there any role for others in the policing process? Why?—specific areas for outside policing?)

42. Very briefly, how would you best describe your general attitude(s) toward Medicaid and Medicare? (How do you feel about the general idea of National Health Insurance?)

43. Do you have any guess as far as the prevelance of fraud and abuse in government medical programs by physicians? (percent, types of doctors, dollars—**ALSO,** Would you say that there is much more, some, or little that remains uncovered?—Probe, is this view based on anything specific?)

I'd like to ask just a couple more questions about yourself.

44. What is(are) your attitude(s) toward patients generally? (Do you make distinctions between patients? On what basis?)

45. What are your professional and personal goals? Have these changed? (Why? Due to what?)

46. How would you describe the general orientation of the close friends and acquaintances that you spend your leisure time with? Are they professionals? (MD's?) Businesslike? Other?

47. Any other things you would like to add?

Thank respondent for their time and thoughts.
Ask if/where any letters should be sent.

INTERVIEW GUIDE
Sanctioned Physicains

I. Demographics

_____ A. Date of Birth
_____ B. Medical School and date of degree
_____ C. Undergraduate School
_____ D. States where licensed
_____ E. Specialties and Certifications
_____ F. Main Practice Type; percent of total; locations; how long
_____ G. Other practices and hospital affiliations
_____ H. Marriages; divorces; children

II. Case and Career Data

_____ A. Describe Case
_____ B. Fairness of system; reimbursement
_____ C. Regulations: copies; where; before; after
_____ D. Aware of Regulations: before; after
_____ E. Which most unreasonable; improvements
_____ F. Colleagues' views—same
_____ G. Percent of income from Medicare/Medicaid before; after
_____ H. Work schedule breakdown (before, after)—practice; business interests
_____ I. Changes: problems before: practice, business, personal, professional, other
problems after: practice, business, personal, professional, other
_____ J. Satisfaction with career; income; practice

III. Sanctions

_____ A. Which sanctions applied
_____ B. Familiarity before—how did they know
_____ C. Views change after
_____ D. Fairness: (1) sanctions
(2) people involved
(3) court process
_____ E. Rules <u>legitimate</u> in their eyes; other doctors
_____ F. Rules consistently applied?

IV. Prevention and Deterrence

_____ A. What caused their trouble
_____ B. What could have prevented them; others

V. Feelings toward violations, possible consequences

_____ A. Aware violating regulations
_____ B. Acts constitute abuse of professional trust—feelings then, now
_____ C. What thoughts at time of violations
_____ D. Think it was serious
_____ E. Worst imagined consequences
_____ F. Current views towards violations, consequences/changed

VI. General

_____ A. Can medical profession police itself
_____ B. General attitude toward Medicare/Medicaid
_____ C. Prevalence of fraud and abuse—covered; uncovered; types; specialties
_____ D. Attitudes toward patients
_____ E. Professional and personal goals—changes since case
_____ F. Orientation of close friends? (leisure time)
_____ G. Any last words?
_____ H. Letter?

INTERVIEW SCHEDULE

Non-Sanctioned Physicians

Introduce Self and Study — exchange business cards

Study:
1. at UCI
2. Professors Geis and Pontell, sociologists
3. Working on grant from the U. S. Department of Justice on government regulation of medical practitioners in government benefit programs.

As part of this project we feel that it is important to hear about the situation from the physician's side—what you see as important in this issue. Thus, we're interested in your perceptions, opinions and attitudes toward the enforcement process and your own experiences in dealing with it. All your responses are strictly confidential.

(Ask and answer any questions or comments and wait until respondent is at ease before beginning interview.)

I'd like to start with a few basic demographic questions.

1. Date of birth

2. Medical school and date of degree

3. Undergraduate school

4. States in which licensed to practice

5. Specialties and certifications

6. Main practice (type-solo, group, etc.) and proportion of entire practice. How long?

7. Other practices (types) and hospital affiliations (and types)

8. Married?_____ Divorced?_____ Children?_____

No._____ No._____ No._____

9. Practiced in other geographic areas? (types, dates, locations)

10. Have you ever had any conflicts with Medi-Cal or Medicare regarding allowable treatments or claims filing procedures?

(If yes, could describe them briefly? What happened?)

11. One of our concerns that we would like to know your opinion of is the fairness of the system. Do you feel that the reimbursement system is fair? (If not, ask what would be fair? **Why?** Probe for specifics and illustrations.)

12. Do you have copies of regulations and guidelines for Medicare or Medi-Cal? (If yes: Where do you keep them? Do you receive updates? Do you keep them together?)

13. Do you feel you are fully aware of the regulations and guidelines?

14. Which program regulations do you find most unreasonable? How would you change them? Why do you think this would be an improvement?

15. Do you believe that your colleagues would feel pretty much the same way? (Probe-Why do you think this is so?—evidence used to make this judgment, etc.)

16. About what percentage of your total practice income is from Medicaid-Medicare now, and five years ago?

17. About what percentage of your work time is spent directly on:

Type of Work	Percentage (now)	Percentage (5 years ago)
(1) Medical Practice		
(2) Other business interests		
(a) medically related (specify which ones)		
(b) non-medical (specify)		

Has this changed much in the past five years? If so, why?

18. Overall, how would you say the state of your practice has changed in the last 5-10 years? Grown? Declined? Approximately how much?

19. Are you familiar with government control mechanisms or the sanctioning process in Medicare or Medicaid? (Probe—what types of sanctions, what types of control practices?)

(If yes, how do you know such things? Have these views changes in the past 5 years?)

20. Do you believe the sanctioning process is fair? (Probe—why or why not?)

21. What about the program rules? Do you feel that the government medical program rules are legitimate in the eyes of the medical profession? In your eyes? (Probe—Which rules? Why do they think this way?)

22. Do you believe that such rules are consistently applied? (On what do they base their opinion—examples, specifics?)

23. What are your feelings toward physicians who are convicted of violating medical program regulations? (Probe—In your opinion, what causes some doctors to get into trouble with the system? Are the doctors themselves completely to blame? the system? others?)

24. What do you think it would take to deter Medi-Cal providers from violating program rules and regulations?

25. Do you feel that violations of Medi-Cal rules entail an abuse of professional trust? (Probe—why or why not?)

26. Do you feel that the medical profession has the ability to police itself? (Probe—Is there any role for others in the policing process? Why?—specific areas for outside policing?)

27. Very briefly, how would you best describe your general attitude(s) toward Medicaid and Medicare? (How do you feel about the general idea of National Health Insurance?)

28. Do you have any guess as far as the prevelance of fraud and abuse in government medical programs by physicians? (percent, types of doctors, dollars—ALSO, Would you say that there is much more, some, or little that remains uncoverer?—Probe, is this view based on anything specific?)

I'd like to ask just a couple more questions about yourself.

29. What is(are) your attitude(s) toward patients generally? (Do you make distinctions between patients? On what basis?)

30. What are your professional and personal goals? Have these changed? (Why? Due to what?)

31. How would you describe the general orientation of the close friends and acquaintances that you spend your leisure time with? Are they professionals? (MD's?) Businesslike? Other?

32. Any other things you would like to add?

Thank respondent for their time and thoughts.
Ask if/where any letters should be sent.

CA. - Letter 1
Sanctioned

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PROGRAM IN SOCIAL ECOLOGY

IRVINE, CALIFORNIA 92717

Dear Dr.

We are writing to you in the hope that you can assist us in an ongoing research project being conducted at the University of California, Irvine. The study concerns government regulation of professionals, with a central focus on health programs and practitioners. We believe that both official and newspaper accounts of violations by health care professionals offer only a limited perspective about such occurrences. A more complete and balanced picture can be gained by listening to those professionals who have been negatively sanctioned by the government.

Your name came to our attention from lists published by the government of those persons who have been suspended from government benefit programs. We are interested in your perceptions regarding your particular circumstances leading to the suspension, your attitudes regarding problems in the programs, and your suggestions about how the programs might be improved. Given the dissatisfaction expressed by the majority of the medical profession, we want to get the views of those of you who have had problems with these regulations.

We would like to arrange a personal interview with you at a time and place of your convenience. We expect that the interview will take less than one hour. All of your responses will be kept strictly confidential. This research has been approved by the Human Subjects Committee at the University as complying with all aspects of confidentiality requirements.

We understand that your schedule is extremely limited and would greatly appreciate your talking with us for a short time. For your convenience we have enclosed a self-addressed stamped postcard for arranging the best time and place for a brief meeting. If you have any questions about the study or interview, please contact us at the above address, or call (714) 833-5574 or 833-6153. We will try to reach you by telephone in about one week.

Thank you in advance for your assistance and cooperation. We look forward to meeting with you and discussing important issues which concern the medical profession and society as a whole.

Sincerely,

Henry N. Pontell
Assistant Professor

Gilbert Geis
Professor

CA - Letter 2
Sanc.

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PROGRAM IN SOCIAL ECOLOGY

IRVINE, CALIFORNIA 92717

NO ITEM TO INSERT

Dear
NO ITEM TO INSERT
:

As you may recall we wrote to you two weeks ago describing an ongoing research project we are conducting at the University of California, Irvine. The study examines physicians' attitudes toward government health benefit programs, and we are particularly interested in interviewing physicians who have had difficulties with these programs. The interviews are non-adversarial and would require only about one hour of your time. Our main objective is to identify possible flaws or inequities in the system and not to make legal or ethical judgments. We feel that your input could be especially valuable.

We recognize the considerable demands on your time, but we sincerely hope that you will consider our request to be worthwhile. We have received the full support of the Health Care Financing Administration, the Office of the Attorney General, the Department of Health Services, and the State Board of Medical Quality Assurance. Our findings could well impact upon future modifications in Medi-Cal reimbursement.

Several physicians have agreed to be interviewed in exchange for our informing the appropriate agencies of their cooperation, and we have done so. Of course, only their willingness to cooperate was noted, and the specific content of all interviews has remained strictly confidential.

For your convenience, we have again enclosed a card on which you can propose an agreeable time and place for an interview. We look forward to hearing from you, and, if you have any questions or comments, please feel free to call us at (714) 856-5574 or 856-6153.

Thank you for your consideration.

Sincerely,

Henry N. Pontell
Assistant Professor

Gilbert Geis
Professor

NY-Letter 1
Isaac

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PROGRAM IN SOCIAL ECOLOGY — IRVINE, CALIFORNIA 92717

NO ITEM TO INSERT

Dear Dr.
NO ITEM TO INSERT
:

We are writing to you in the hope that you can assist us in an ongoing research project being conducted in New York and California. The study is based at the University of California, Irvine and concerns government regulation of professionals, with a central focus on health programs and practitioners. We believe that both official and newspaper accounts of violations by health care professionals offer only a limited perspective about such occurrences. A more complete and balanced picture can be gained by listening to those professionals who have been negatively sanctioned by the government.

Your name came to our attention from lists published by the government of those persons who ve been suspended from government benefit programs. We are interested in your perceptions garding your particular circumstances leading to the suspension, your attitudes regarding problems in the programs, and your suggestions about how the programs might be improved. Given the dissatisfaction expressed by the majority of the medical profession, we want to get the views of those of you who have had problems with these regulations.

We would like to arrange a personal interview with you at a time and place of your convenience. We expect that the interview will take less than one hour. All of your responses will be kept strictly confidential. This research has been approved by the Human Subjects Committee at the University as complying with all aspects of confidentiality requirements.

We understand that your schedule is extremely limited and would greatly appreciate your talking with us for a short time. We would like to schedule an interview with you some time in October, and we will be contacting you by phone to arrange an appointment. We have enclosed a self-addressed stamped postcard with which you can indicate a convenient time for us to call you, and a number where you can be reached. If you have any questions about the study or interview, please contact us at the above address, or call (714) 856-5574 or 856-6153.

Thank you in advance for your assistance and cooperation. We look forward to meeting with you and discussing important issues which concern the medical profession and society as a whole.

Sincerely,

Henry N. Pontell
Assistant Professor

Gilbert Geis
Professor

P,GG/fr

NY-Letter 2
Isaac

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PROGRAM IN SOCIAL ECOLOGY — IRVINE, CALIFORNIA 92717

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As you may recall we wrote to you two weeks ago describing an ongoing research project we are conducting at the University of California, Irvine. The study examines physicians' attitudes toward government health benefit programs, and we are particularly interested in interviewing physicians who have had difficulties with these programs. The interviews are non-adversarial and would require only about one hour of your time. Our main objective is to identify possible flaws or inequities in the system and not to make legal or ethical judgments. We feel that your input could be especially valuable.

We recognize the considerable demands on your time, but we sincerely hope that you will consider our request to be worthwhile. We have received the full support of the Health Care Financing Administration, Special Prosecutors office, and the the Department of Social Services. Our findings could well impact upon future modifications in Medicaid reimbursement.

Several physicians have agreed to be interviewed in exchange for our informing the appropriate agencies of their cooperation, and we have done so. Of course, only their willingness to cooperate was noted, and the specific content of all interviews has remained strictly confidential.

For your convenience, we have again enclosed a card on which you can propose an agreeable time and place for an interview. We look forward to hearing from you, and, if you have any questions or comments, please feel free to call us at (714) 856-5574 or 856-6153.

Thank you for your consideration.

Sincerely,

Henry N. Pontell
Assistant Professor

Gilbert Geis
Professor

CA-Yon-Sene.

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PROGRAM IN SOCIAL ECOLOGY — IRVINE, CALIFORNIA 92717

NO ITEM TO INSERT

Dear Dr.
NO ITEM TO INSERT
:

We are writing to you in the hope that you can assist us in an ongoing research project being conducted at the University of California, Irvine. The study concerns government regulation of professionals, with a central focus on health programs and practitioners. As part of the study, we would like to hear the views of those professionals who have been actively involved in the Medi-Cal system. Your name came to our attention from a list of Medi-Cal vendors published by the state. We are interested in your perceptions and attitudes regarding problems in the program, and your suggestions about how the program might be improved. Given the dissatisfaction expressed by the majority of the medical profession, we want to get the views of those of you who have to deal with these regulations.

We would like to arrange a personal interview with you at a time and place of your convenience. We expect that the interview will take about one half hour. All of your responses will be kept strictly confidential. This research has been approved by the Human Subjects Committee at the University as complying with all aspects of confidentiality requirements.

We understand that your schedule is extremely limited and would greatly appreciate your talking with us for a short time. For your convenience we have enclosed a self-addressed stamped postcard for arranging the best time and place for a brief meeting. If you have any questions about the study or interview, please contact us at the above address, or call (714) 856-5574 or 856-6153. We will try to reach you by telephone in about one week.

Thank you in advance for your assistance and cooperation. We look forward to meeting you and discussing issues which concern the medical profession and society as a whole.

Sincerely,

Henry N. Pontell
Assistant Professor

Gilbert Geis
Professor

APPENDIX C.

GRANT PUBLICATIONS AND MANUSCRIPTS

SOCIAL PROBLEMS, Vol. 30, No. 1, October 1982

POLICING PHYSICIANS: PRACTITIONER FRAUD AND ABUSE IN A GOVERNMENT MEDICAL PROGRAM*

HENRY N. PONTELL
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PAUL D. JESILOW
Indiana University

GILBERT GEIS
University of California, Irvine

Fraud and abuse by physicians participating in government medical programs incurs physical and fiscal costs to society. This paper focuses on the enforcement process by which such behavior is detected, defined, and sanctioned. Interviews with officials in California's Medi-Cal program reveal the special problems associated with the influence of physicians' professional power on the enforcement process. In addition, the occupational status of physicians protects them against damaging interpretations of acts that may be in violation of the law.

When professionals, such as doctors, violate laws designed to constrain their autonomy—laws that, in effect, tell them how to run their practices—at least three issues are raised. First, those charged with enforcing the laws have to develop tactics to combat the expertise of the professional. Second, punishing a law-violating professional may result in the withdrawal of a crucial service from innocent parties. Third, the intelligence and social standing of the errant professional, and his or her ability to cast shady actions in a decent light, makes effective detection and prosecution of violations difficult—a problem common to white-collar crime in general.

This paper examines patterns of control over physicians who obtain funds from Medi-Cal, the state of California's Medicaid program. Medi-Cal is the second largest health-care reimbursement system in the United States, second only to the state of New York's. We look at how authorities define and identify fraud and abuse, the obstacles that hinder the enforcement of laws, the problems associated with sanctions, and, especially, how professional values and the power of medical doctors influence the control process.

When physicians engage in fraud and abuse benefit programs they violate both professional norms and the law (Lanza-Kaduce, 1980). Their behavior fits the classification that Katz has labelled "pure" white-collar crime:

> In the purest "white-collar" crimes, white-collar social class is used: (1) to diffuse criminal intent into ordinary occupational routines so that it escapes unambiguous expression in any specific, discrete behavior; (2) to accomplish the crime without incident or effects that furnish presumptive evidence of its occurrence before the criminal has been identified, and (3) to cover up the culpable knowledge of participants through concerted action that allows each to claim ignorance (1979:435).

As we show, it is easy for physicians to "diffuse criminal intent into ordinary occupational routines" while participating in government medical benefit programs. Physicians as a professional group enjoy a high level of autonomy in practicing medicine, which makes the search for evidence of wrongdoing both difficult and complex. There may be little "culpable knowledge of

* This research was supported by a grant from the National Institute of Justice, U.S. Department of Justice (82-1J-CX-0035) and a faculty research grant from the University of California, Irvine. The views expressed are those of the authors and do not necessarily reflect the position of the Department of Justice. The authors thank Mary Jane O'Brien for her comments and Marcia Bell for typing. Correspondence to: Pontell, Program in Social Ecology, University of California, Irvine, California 92717.

participants" in physician fraud and abuse cases where only a single physician is involved. Moreover, information from patients does not provide substantial proof in most cases. One doctor, who was taped by undercover agents pretending to be interested in buying his business, highlighted most of these points when he explained how he would defend himself against accusations of wrongdoing:

> I don't remember—I don't even remember what I put down for 95 percent of my patients. . .you create doubts. Who can disprove it? The nurse? Do you think she can remember any better than you? You know the type of intellect patients have. . . .I never put down for a CBC [complete blood count] or a SED [sedimentation] rate. . .if I don't draw blood. They remember if you give an injection. I don't like going through the routine, but it must be done. . . .Even if they show you the worst piece of paper you ever wrote, there is no way to prove a thing (U.S. Congress: Senate, 1976:59).

STRUCTURAL FEATURES RELATED TO FRAUD

The structure, organization, and administration of Medicare/Medicaid[1] contain an implicit fiscal incentive for physicians to overtreat and overdiagnose. The fee-for-service nature of government benefit programs provides one example. Under this policy, the doctor is reimbursed according to a schedule established by the government. Fee-for-service reimbursement is a major vehicle for fraudulent and abusive practices, such as billing for services never rendered; "upgrading" (billing for a service more extensive than that actually provided); overtreating; "ping-ponging" (referring the patient to another physician when there is no need for additional work); scheduling unnecessary visits; and "ganging" (billing for services to members of the same family on the same day. This generally occurs when one member of a family is accompanied by another, usually a mother and child. The doctor also "treats" the individual who has come with the ill person, though there is no complaint, and submits a bill for both persons.) The fee-for-service structure of medical practice, incorporated in the government-funded medical system, thus provides a "crime-facilitative environment" (Needleman and Needleman, 1979). If physicians were paid beforehand a stipulated sum for each patient on their roster, the profit from such practices would largely be eliminated.

Although the structure of the programs may encourage fraud among physicians, these incentives do not in themselves explain fraudulent practices. One doctor may cheat the government, while another may remain satisfied with a lower—but honest—income. Government regulations for benefit programs are themselves the predisposing factors, or raw materials, for fraud and abuse. One California physician defrauded the Medi-Cal program by treating many poor patients. Prior to the inauguration of Medi-Cal, he had rendered free services for those who could not afford to pay. Without Medi-Cal, he probably would have continued to offer free treatments.

Tension between the government and the medical profession over Medicaid/Medicare may go far in explaining patterns of fraud and abuse. Our interviews with doctors, as well as other studies (Davidson, 1982; Garner *et al.*, 1979; Jones and Hamburger, 1976; Stevens and Stevens, 1974), reveal widespread dissatisfaction with the repayment system. Physicians claim they receive from Medicare only one-half of what they would normally charge patients. They also complain of excessive red tape and paperwork involved in the government system.

Colombotos *et al.*, (1975) found that just over half of a national sample of physicians favored

1. Medicare and Medicaid, established in 1966, comprise two separate government medical benefit programs: Medicare is a federally-funded, national health insurance program for the aged, while Medicaid is a grant-in-aid program for the indigent in which the federal government shares costs with the states, based on per-capita income. Services provided to Medicaid recipients vary slightly among the states, but must include physician, hospital, laboratory, nursing home, and clinic services. Eligibility is determined by either the state office which administers the program or by the federal Social Security Administration. Stevens and Stevens (1974) provide an excellent analysis of the development of the Medicaid program.

national health insurance. The physicians overwhelmingly preferred that the program be administered by a private third party rather than the government, and three-quarters supported a fee-for-service form of reimbursement. Such attitudes are partly attributable to the ideology and norms of the medical profession, especially the desire to operate free of government intervention. But they also have implications for the frequency of abuse and fraud in benefit programs.

Many physicians have expanded beyond their office and hospital practice into other medical domains, including laboratories, pharmacies, medical supply stores, and nursing homes. The complexity and size of this world provides many opportunities for fraud (Meier and Geis, 1979). Hospitals performing a myriad of functions offer the most criminogenic structure.

In sum, it appears that strategies to control physicians in government medical benefit programs must deal with: (1) a fee-for-service system which invites fraud and abuse; (2) a professional environment in which physicians resent the lowered fees and additional red tape and paperwork necessary to receive reimbursement for treating the poor; and (3) a complex world of overlapping ownerships and financial involvement in medically related businesses that makes abuses and crimes difficult to detect, and, at the same time, renders it convenient for those involved to abuse the system by taking advantage of overlapping interests.

THE MEDI-CAL PROGRAM

This paper focuses on official interpretations of abuses in California's Medi-Cal program. The program was implemented in March 1966 by the California Legislature, in response to the availability of federal funds from the 1965 Title XIX amendments to the Social Security Act. The program was designed to provide health care and related services to recipients of public assistance and the elderly.

We interviewed Medi-Cal personnel and officials in the Bureau of Medical Quality Assurance, the state's medical licensing board, in 1981 and 1982. Official reports and case files provided numerical, procedural, and attitudinal information. Within the state's Department of Health Services, where Medi-Cal is administered, our interviews were concentrated most heavily in the Surveillance and Utilization Review (SUR) Branch of the Audits and Investigations Division. This office is responsible for the integrity of the Medi-Cal program. It plays a major role in detecting fraud and abuse by screening claims and determining billing patterns. This is accomplished, using computers, by comparing specific physicians to a norm established by other physicians in similar circumstances. When a large discrepancy exists and fraud is suspected, the SUR Branch refers the case to investigators who establish if a crime has been committed. If it has, the Medi-Cal Fraud Unit takes over. Located in the state's Department of Justice, this unit was established in July 1978, pursuant to Public Law 95-142, Section 17. It investigates crimes and, where it believes it is warranted, brings criminal charges against physicians.

The SUR Branch plays a major role in officially defining fraudulent and abusive practices by physicians (as well as other health care providers) in California; the unit also channels subsequent enforcement activity. SUR personnel operate in the belief that major losses to the Medi-Cal program are not due to fraud but rather to overutilization and abuse of the system. Thus, most sanctions against physicians involve administrative rather than criminal actions. The work of the SUR Branch, therefore, is central to the enforcement process.

The SUR Branch

The SUR Branch was established in 1977 with a mandate to "detect overutilization, abuse, and fraud of Medi-Cal providers and beneficiaries and to initiate appropriate corrective actions" (California Department of Health Services, 1978:1). It has two main organizational units for dealing with abuse by physicians. The Case Detection and Development Section (CDDS) identifies violations through case referrals from outside sources (patients, nurses, bookkeepers, physicians) and by computer reports which identify suspicious physicians. After an internal review of cases, commonly referred to as "desk work-ups," those believed to warrant further investigation are referred to one of two field office medical teams made up of a physician, nurse, and administrative analyst. These teams, which comprise the second organizational unit, visit the physician's office and examine his or her records to determine the necessity of services rendered, whether the services were of acceptable medical quality, and whether the physician's files meet Medi-Cal standards. Depending upon the results of this investigation, SUR officials can take any of the following actions: (1) warn the physician about incorrect billing; (2) demand reimbursement for overpayments; (3) establish a special claims procedure under which full documentation of services rendered must accompany all future bills; (4) demand that the physician seek the SUR's authorization before accepting non-emergency patients; (5) suspend the physician from the Medi-Cal program, the most difficult sanction to achieve; (6) refer the case to the Medi-Cal Fraud Unit for possible criminal prosecution; and (7) refer the case to the state licensing agency for possible disciplinary action. SUR officials said that such actions saved the Medi-Cal program about $4 million dollars in 1981, a figure equivalent to the SUR Branch's operating budget for that year.

TABLE 1

Summary of SUR Branch Activities, 1981

Provider Type	On-Site Review	Cases Closed*	Referral For Suspension/Investigation	Dollars Demanded	Spear Actions
Physician	49	52	4	508,001	24
Pharmacy	20	25	0	21,720	0
Optometry	31	64	0	7,231	1
Clinical Lab	4	11	0	71,493	0
Medical Clinic	11	9	0	224,654	1
Dental	23	20	0	32,609	0
Psychologist	2	3	0	0	0
Podiatry	1	2	0	17,117	0
Medical Group	12	7	0	8,260	0
Medical Lab	1	5	0	1,591,587	0
Total	156	217	4	$2,484,672	26

Note:

* Sometimes this category exceeds the number of on-site reviews due to the fact that some cases were opened during the previous year and thus represent carry-overs.

Table 1 summarizes SUR Branch activities in 1981. On-site investigations were carried out on 49 physicians with individual practices, 31 optometrists, and 23 dentists. Of the 217 cases closed (where some final action was taken), only four—all of them against physicians—were referred for either program suspension or criminal investigation. Requests for recoupment of undocumented program payments was the most frequently applied form of control. The only other type of control used in 1981 was SPEAR (Special Payment Evaluation and Review) action.[2] Under this sanction, the doctor must send SUR officials full documentation of services performed over a specified level. If the physician does not comply, the Medi-Cal program is under no obligation to reimburse him or her for services. This tactic was usually reserved for physicians who did not heed warning letters, and who displayed blatant disparities in billing practices.

Setting Up Shop

Before the SUR Branch was established, the Audits and Investigation Division responded to

2. This name was changed to Special Claims Review in 1982, after the SUR Branch decided that SPEAR sounded unnecessarily ominous.

complaints and referrals. These primarily involved suspected criminal fraud. The division did not employ health professionals, which hampered its ability to detect less blatant abuses of the Medi-Cal program. With the creation of the SUR Branch, officials aimed more at "systematic detection" rather than the "hit and miss" approach used previously.

Both before, and during, the early operation of the SUR Branch, the state delegated the control function to Blue Cross and Blue Shield, the private health insurance programs, whose job it was to review billing patterns against "peer group norms." (This review procedure was adopted by the Medicare system, and is still in use.) With Blue Cross and Blue Shield in charge of reviewing billing, the state was omitted from detection and enforcement activities until 1978, when increased budget allocations allowed the state's Department of Health to assume responsibility for postpayment review and to provide new contract specifications for fiscal intermediaries. The Computer Sciences Corporation took over the responsibility of fiscal intermediary from Blue Cross and Blue Shield, and the SUR Branch assumed program control functions. With this major restructuring, the state substantially increased its involvement in the control of fraudulent and abusive practices.

Establishing Procedures

The relative power of the different health care professions, as well as the influence of the medical societies, are both evident in the evolution of specific procedures used to detect fraud and abuse. Although random on-site audits were, at the time of this research, conducted in California for pharmacists and optometrists, for example, such reviews were ended for physicians in mid-1977, soon after the SUR Branch began functioning. Officials cited three reasons for this surveillance selectivity: (1) Initial attempts to use this tactic against physicians produced no results: nine randomly selected reviews uncovered no abuses of the program. (2) Organizational resources could be better deployed elsewhere. (3) "Medical societies objected to [on-site review] and strongly urged that it be used only where there is apparent cause" (California Department of Health Services, 1978:2).

Local medical societies neither strongly support nor greatly resent the activities of state control agencies. Most societies cooperate with authorities, though this is not always the case. One successful method employed early on by state officials for gaining the support of uncooperative medical societies was to present them with the most glaring and blatant cases of abuse by physicians in their geographic areas. Medical societies usually do not report suspected cases of fraud and abuse to authorities, though they sometimes counsel members who have administrative charges brought against them and refer them to legal assistance. The medical societies are notoriously reluctant to decertify physicians and rarely view even criminal violations of Medi-Cal regulations as grounds for removal from the profession. Nonetheless, investigators constantly court the medical societies; their cooperation, however lukewarm and marked by inertia, is regarded as necessary for the adequate operation of the Medi-Cal program.

Government control units need the cooperation of medical societies to inform physicians about program policies and guidelines and to help insure that regulations are taken seriously. Officials believe that if they "go too far" in regulating physicians in the program, they are likely to forfeit the support of medical societies, and that this would result in a lowered rate of participation by physicians in the Medi-Cal program. This in turn could further restrict the sources of health care for the population served by Medi-Cal. It could also raise costs, since patients would likely go for care to more expensive facilities, such as the emergency department of hospitals, if a Medi-Cal physician was not available.

Medi-Cal officials learned that they had to be very careful in working up allegations against physicians. The first few cases brought before an administrative hearing officer were turned away for lack of sufficient evidence. Without a foolproof case, officials found that court procedures

proved futile, given the resources accused physicians can bring to their defense. Officials decided to pursue cases only in the most blatant instances of wrongdoing, and where full documentation was available.

ENFORCEMENT PATTERNS

Fraud and abuse are hard to identify in medicine because of the technical nature of the field, the different treatment styles of physicians, and the relative ease with which offenses may be covered up, given the privileges and status of physicians. Such privileges include a large amount of professional autonomy, which makes it difficult for officials to determine whether abuse or fraud actually took place. One high-ranking Medi-Cal official, himself a physician, said:

> Our major problem is not fraud in terms of dollars or impact on the program. Our major problem is abuse, and I would prefer to say that it's nonfraudulent abuse. That is, where a provider or physician does more tests than he would if the patient were paying the bill, it becomes very difficult in most cases to say what is or is not abuse. There is a tendency to practice medicine more as an ideal, more complete, more thorough when you are not inhibited by the patient's ability to withstand the cost (Personal interview).

No one has yet proven this proposition, nor has a general consensus been reached on what practicing medicine as an "ideal" means; at the same time, the foregoing quotation represents an important official stance concerning the control of Medi-Cal violations. That more acts are designated abuses rather than frauds likely has to do with the way official definitions affect enforcement activities. These definitions in turn can be influenced, both blatantly and subtly, by the power of the medical profession. For example, when officials responsible for producing evidence against physicians are themselves physicians, they are more prone to regard violations as abuses. This becomes especially pronounced when the officials learn that attempts to label acts as fraud without impregnable proof—where such level of proof is difficult to come by—will be fruitless.

Organizational Goals

The formal organizational goal of the SUR Branch is to assure the integrity of the Medi-Cal program. In some respects it is a policing institution which detects and sanctions improper activities. Because it oversees recoupment of excessive payments, it is also a revenue-producing system. And, insofar as it helps to redesign regulations and administrative methods of control, it is involved in planning and managerial efficiency.

The obstacles to pursuing cases of fraud and abuse help shape the SUR's official position in policing Medi-Cal. Officials did not see their most important function as punishing errant physicians but as recommending better management of the Medi-Cal program. They realized that to be effective they had to accommodate powerful professional groups which could be aroused by the threat of increased government control. Thus, the SUR Branch had to earn the acceptance of the medical societies. Not surprisingly, its administrative approach was designed "to prevent fraud and abuse rather than to merely punish it after it happens," an official said. He continued:

> We don't measure our success by how much money we get back for the state of California. We think that a large part of what we do should be educational and working with the profession to eliminate practices which should be eliminated. We're really not interested in putting all doctors behind bars, or sending them into bankruptcy. We're interested in correcting a situation where it needs correction and doing that in as professional a manner as we can, providing that we are not dealing with crooks. That's something else. They [crooked doctors] need everything we can throw at them. Most doctors are not crooks (Personal interview).

Even while adopting this basically non-punitive stance, officials expressed frustration with the nature of the organization of the medical profession and the vagueness of the basic goals of the control body. One administrator reflected the teleological uncertainty of his unit in the following terms:

When we discover irregular practices that don't look like outright fraud, where there are practices which should be controlled or curbed so the program, the taxpayers, and the patients can be protected, we have to ask ourselves: "Well, what are we trying to accomplish? Are we here primarily to deprive them of their livelihood for a while, or are we here to get as much money back as we can? What are we here for?" (Personal interview).

The Production of Fraud and Abuse

The serious practical difficulties in proving intent on the part of the physician in cases of fraud accounted in some measure for the higher proportion of abuses than frauds. Limited resources precluded any serious official attention to cases which might border on fraud, though blatant cases of fraud were sure to be met with formal action. Administrators, however, tried not to get involved in "the gray area of medical practice," the area where professional opinions could differ.

Charging for more complex and/or time-consuming services than were actually provided was the most frequent abuse uncovered. Such acts were not usually regarded as abuses, and almost never as frauds. Categories of treatment were vague, which made attempts to label such practices as fraud difficult. Even when the evidence seemed to clearly indicate that the doctor billed incorrectly for services, the matter may have become questionable later. Reliance on audits of patient records, for example, often proved unsatisfactory. An investigator explained why this was so:

All we have to do is go into the office and we see something, a note, a two-liner, and maybe it's a brief one—and we say, "Doctor, you billed us for a big one, we paid for it, but we checked your records, and all they show is a brief one." And then the doctor says, "Look fellows, I'm too busy taking care of patients to spend all my time writing down a lot of crap for you bureaucrats. I've got to take care of these people." What he is saying is that he did a complete physical, but didn't have time to put it all down. Do you call that fraud? No way. How are you going to prove it?"

The same official added:

It is a great challenge to say what is or is not abuse and/or fraud of the program. For example, we know of instances of "overuse," but how much of it is due to a physician's genuine desire to do whatever he or she can for a patient without any financial obstacles and how much of it is due to his or her personal desire to gain wealth? (Personal interview).

The legal dividing line between abuse and fraud, which officials were keenly aware of, is the legal doctrine of intent (Edwards, 1955). Establishing intent was virtually impossible in most Medi-Cal cases. Abuse was relatively easier to prove since no evidence of intent was necessary. Abuse itself, however, was not always as clearcut as first appeared. Computers sometimes alerted investigators to cases which in fact showed sound reason for departing from the usual pattern.

You may, for example, find somebody who does far more opthalmology consultations than anybody else and looks suspicious. But, you check into this and find the opthalmologist is the only one within two hundred miles. With good reason, you close that case [and go on to] something else (Personal interview).

On other occasions, what originally looked like potential fraud was ultimately designated an abuse. For example, a California psychiatrist, sanctioned for Medi-Cal abuse, was paid approximately $9 per patient for one-and-one-half hour sessions of group psychotherapy. He signed 16 false claims for services rendered as the provider; in fact, his wife, a psychiatric nurse, led the sessions. Taken before the licensing agency for discipline, the psychiatrist argued that he had performed the services, although he was not present, since his wife worked under his supervision. He claimed that he thought the rules permitted him to do this. The licensing agency rejected his defense and suspended his license. The administrative report suggested that the psychiatrist was unfamiliar with the agency's requirements of the Medi-Cal program.

Medi-Cal bulletins sent to his office. . .were discarded by respondent without reading them. Respondent did not deliberately seek to defraud Medi-Cal; he simply lacked interest and was indifferent in keeping abreast of Medi-Cal rules and regulations. He casually concluded that since his wife was a qualified

psychiatric nurse and rendered group psychotherapy under his supervision, that he qualified as the Medi-Cal provider for billing purposes. It appears that respondent's indifference was due, in part, to the fact that Medi-Cal patients constituted a minor portion of his professional income (California Department of Consumer Affairs, 1979).

Physicians generally did not have to fear that SUR investigators would seek information from patients. An official explained why:

We have some highly intelligent, sophisticated, and well-educated patients on Medi-Cal. Generally, though, they're medically unsophisticated, and it is very difficult for them to make these kinds of determinations. It's difficult for them to say whether they were in the office at all on a specific date, rather than how long the doctor saw them. Relying on the patients' memory is not too good (Personal interview).

Sanctions

Suspending a doctor from the Medi-Cal program for abuse was very difficult to accomplish. It usually took a year or more to prepare a case, another year or two for a hearing, and yet another year to allow for appeal. Officials had to be certain that their cases were airtight, given the amount of time and resources involved and the uncertainty of the outcome. Thus, only the most flagrant instances of abuse and/or carelessness were pursued. One official noted:

We better have a very strong case. We discovered that through experience—we lost some. We've backed off some and we've won a couple. But it's extremely difficult. We produce very few program suspensions. It's a tough process. The courts are not always in agreement as far as overwhelming evidence (Personal interview).

For these reasons, program administrators emphasized actions that could be taken without formal legal proceedings. For example, a physician was sometimes asked to supply copies of records and other program reports to substantiate patient visits over a certain amount.

That's our single most effective tool. It acts rapidly, gets the message across quickly, curbs the abuse, and protects the program (Personal interview).

Program officials believed that enforcement activities had had a substantial impact on the Medi-Cal program: they were at least partially effective in identifying fraud and abuse, and in earmarking millions of dollars for recoupment. Yet officials did not know whether their actions had deterred abuses by other physicians.

SUMMARY

The work of the SUR Branch in policing the Medi-Cal program reflects a variety of crosscurrents that bear upon its mission. For one, the very organization of the program invites fraud. The fee-for-service delivery system in California offers physicians the chance to amass considerable gain with little risk. Diagnostic tests that have not been performed can easily be billed to the state, as can a variety of other spurious costs. The professional background of the physician affords strong protection against discovery. If such discovery does occur, there are a range of defensive tactics to safeguard against effective sanctions.

An alternative to the existing program would be prepaid health services for Medi-Cal recipients. Under a prepaid program, the state would have fixed costs, and the onus would be on the practitioner to deliver services within the price range for which he or she has contracted with the government agency. The problem here, of course, is that any reduction in the quantity and quality of care redounds to the financial benefit of the practitioner. It is not unlikely that fraud and abuse under such circumstances would take the form of substandard delivery of services, much as was true at the turn of the century when county sheriffs were paid by the number of prisoners under their care and skimped on food for their charges in order to save funds.

Authorities charged with policing the Medi-Cal program exhibit a number of behaviors that

can be tied to the structure of the program. They are, for one, caught between literal interpretation of their mandate to maintain the program's integrity, and the practical goal of keeping their powerful constituents at bay. They cannot offend the medical societies by moving too forcefully against too many practitioners. Otherwise, they risk forfeiting the societies' help in circulating and endorsing Medi-Cal guidelines. Nor can they adopt tough investigative tactics that physicians might regard as a violation of personal autonomy; physicians might simply refuse to participate in the Medi-Cal program. The use of false identity cards by undercover investigators to police physicians—a practice known as "shopping"—is not encouraged in California, though it is common in other states.

The evidence needed to win a court conviction for a criminal offense inhibit prosecution in all but the most blatant kinds of Medi-Cal fraud. Physicians have wide discretion in regard to the way they practice medicine; and few of their peers are wont to state publicly that they regard a given referral or diagnosis as patently unacceptable. The element of intent, essential for criminal action, is extraordinarily difficult to prove beyond a reasonable doubt.

The quality of medical care available to both the wealthy and the poor truly involves matters of life and death. Fraud and abuse in a medical benefit program likely deprive some persons of the satisfactory treatment that they otherwise would receive. To fully understand this phenomenon, research is needed into the traits and behaviors of individuals who violate Medicaid laws and regulations, and the success of various tactics that have been employed in an attempt to control such behavior.

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PRACTITIONER FRAUD AND ABUSE IN MEDICAL BENEFIT PROGRAMS:

Government Regulation and Professional White-Collar Crime

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This research was supported by a grant from the National Institute of Justice, U. S. Department of Justice (82-1J-CX-0035) and a grant in-aid from Indiana University, Bloomington. The views expressed are those of the authors and do not necessarily reflect the position of the Department of Justice. An earlier version of this paper was presented at the annual meeting of the American Society of Criminology in Toronto, November, 1982. The authors thank Mary Jane O'Brien and Herbert Edelhertz for helpful comments and Marcia Bell and Doris McBride for typing. Correspondence to: Pontell, Program in Social Ecology, University of California, Irvine, CA 92717.

(FORTHCOMING, LAW AND POLICY)

ABSTRACT

Physicians who defraud and abuse medical benefit programs provide a unique group of lawbreakers for scientific study. They could be considered to epitomize white collar criminals given their exceedingly high socioeconomic status and power as a professional group. Using official reports and documents, as well as interviews with enforcement and program personnel at both state and federal levels, this study examines the problem of physician fraud and abuse in Medicare and Medicaid. Major areas relevant to understanding this phenomenon and its control are presented and policy implications of present knowledge in the area are discussed.

PRACTITIONER FRAUD AND ABUSE IN MEDICAL BENEFIT PROGRAMS:
Government Regulation and Professional White-Collar Crime

Fraud perpetrated by practitioners in the health and allied professions takes a heavy toll on the well-being and integrity of human life in the United States. Medical care is one of the most costly aspects of contemporary life. It has been estimated that it costs in the U.S. $285 billion a year for "curing the ill and diagnosing the diseased." (Time, 1982:54). The toll exacted by fraudulent practices is both fiscal and physical. Unnecessary surgery, performed only because a government insurance program will pay the cost, sometimes results in maiming and death, so that medical program fraud, besides entailing economic losses, can fall within the realm of crimes against the person and crimes of violence. Note, for example, the case of an opthamologist who performed cataract surgery on persons with healthy eyes only because Medicaid paid $584 per eye for the operation; in the process the doctor "blinded a lot of people" (Personal Interview).

Poor health and inadequate access to medical aid particularly victimize minorities. In this regard, the record of the United States in the world community is not one of which to be proud. On major indices of health, such as infant mortality, the United States ranks behind a dozen western nations (U.S. Bureau of the Census, 1980:247-487). Fraudulent practices also undermine attempts to upgrade and equalize access to decent medical treatment. Proposed national insurance schemes are beset with concerns about how to control what is anticipated as enormous fraud (Stotland, 1977).

Joint hearings in 1975-1976 by the U.S. Senate Subcommittee on Long Term Care and Health of the Elderly underlined concern about fraud and abuse in regard to government-funded medical benefit programs. Testimony suggested that as much as 10 percent of the money paid to medical practitioners under state benefit programs was obtained in violation of program guidelines. Abuses included charging for services never rendered, ordering superfluous laboratory tests, encouraging unnecessary office visits and surgery, and charging for physician service where nonlicensed personnel performed the task (U.S. Senate, 1976). A report by the newly formed Inspector General's Office in the Department of Health and Human Services indicated that up to two billion dollars may be lost to fraud and abuse in the Medicare Program alone (U.S. House of Representatives, 1980).

The federal Medicare-Medicaid Anti-Fraud and Abuse Amendments, enacted in October 1977, require that HEW suspend practitioners convicted of crimes against the government's health programs. In 1979, the Secretary of the Department of Health, Education and Welfare suspended 40 health practitioners. Almost all cases involved billing Medicare or Medicaid for services not rendered. The public announcement by HEW was intended to serve as a general deterrent. All told, there had been 115 suspensions by mid-1982. Also, activities of the Federal Bureau of Investigation and the Department of Justice produced 112 indictments, 89 convictions and 684 active investigations in 1979 for medical benefit program violations (New York Times, 1980).

It is believed that a majority of physicians comply with benefit program regulations, though a very large number of fraud and abuse cases undoubtedly remain unknown. As Lee (1978:30) notes: "It is generally accepted by persons closely associated with the programs that only a small percentage of Medicaid fraud and abuse is detected and/or sanctioned."

Professional White-Collar Crime

Physicians are members of the most highly regarded professional group in society (Hodge, Siegal and Rossi, 1964; Reiss, 1961). As an FBI supervisory agent we interviewed put it: "What other stranger would you go in and take your clothes off in front of? It's that kind of trust" (Personal Interview). Physicians are expected to adhere to lofty standards of conduct and to place patients' welfare above their own interests (Parsons, 1951). They enjoy exceedingly high socioeconomic status as individuals and exercise considerable power both in their professional role vis a vis patients and as members of a group jousting for economic advantage. That their ethical codes demand high standards of conduct does not mean, of course, that all practitioners meet such standards (Mechanic, 1978). Some physicians may sacrifice for their patients more than others (e.g., make house calls, over look fees), while some may take unfair or illegal advantage (see e.g., Burgess, 1981).

The social position of physicians, when combined with their law violations, inevitably leads to initial ambiguity on the part of the rule-enforcers and subsequent attempts to reshape their initial image of the professional. A high-ranking state medical officer, for instance, noted the following in regard to fraud among doctors:

> I think that percentage-wise the overall amount of fraud is quite low, but when it [fraud] does come out, it's sobering because you don't expect that of this kind of profession. But you know, the more I deal with things, I begin to realize that we're the same kind of population as any other kind of population. As a population, it [medical doctors] is better educated, well trained,

and with valuable resources, but along with that doesn't mean you don't have your bad guys too (Personal Interview).

The redefinition satisfactorily permits actions against defined deviants while allowing the prevailing view of the larger group of doctors to remain relatively intact.

In this paper we concentrate on five major areas relevant to understanding how and why physicians break the law and the official policies in regard to their abuses. Specific areas to be addressed are: (1) structural features of the programs and medical practices; (2) motivations and mechanisms (reasons) for violating program guidelines; (3) patterns of control in terms of official interpretation of regulations and subsequent actions against physicians; (4) prevention and deterrence of violations; and (5) policy implications.

Data for this study were obtained from official reports and documents, and face-to-face interviews with Medicaid/Medicare administrators and enforcement officials in four states and in Washington, D.C. who are responsible for the integrity of the programs. These persons included health department officials and investigators, federal agents in the Office of Inspector General (OIG) and the Health Care Financing Administration (HCFA) of the U. S. Department of Health and Human Services (HHS), state prosecutors who handle medical fraud cases, officials and investigators in special Medicaid Fraud Control Units (MFCU), and officials of state contracted companies ("carriers" or "fiscal intermediaries") who administer payments for the benefit program. Respondents are identified only when we have secured permission to do so. Otherwise, their remarks are cited as from personal interviews.

Background of the Programs and Early Enforcement Efforts

The Medicare/Medicaid programs were signed into law by Lyndon Johnson in 1965. Medicare aimed at filling the health care needs of a growing elderly population. Funds for the program came from federal revenues, and the administration was housed in the U.S. Department of Health, Education and Welfare. To enlist the support of the medical profession the Medicare law avoided prescribing a fee schedule for physicians, but mandated instead that doctors of Medicare patients be paid their usual and customary fee, provided that the fee was "reasonable" (Marmor, 1970).

Medicaid provides access to medical care for the poor. The administration of the program is the responsibility of the states, but HEW (now Health and Human Services) monitors the state programs since they are partially financed with federal dollars. Not all states have medicaid; Alaska, for example, has been unwilling to pass legislation since projected costs of the program are said to be too great for the state to bear, given the high indigency level among the Eskimo population.

The Medicaid population included 28.6 million persons in 1980. Program expenditures are heavily weighted toward institutional services, especially long-term care. Individual physicians (not including those who billed through hospitals) received about 10 percent of medical expenditures, or about $2.45 billion in fiscal 1981 (U.S. House of Representatives, 1980:5).

Fraudulent and abusive practices by health care providers were not articulated concerns of administrators or policymakers during the early years of the medical programs. Participation by physicians in the programs was a primary consideration. Enhanced medical care for the elderly and indigent would have been impossible without the support of the medical profession.

Besides the aid of organized medicine, public confidence in the programs

was another necessary element for the success of Medicare/Medicaid. Officials felt that to highlight questions of fraud and abuse early on might undermine that confidence. An official in the Health Care Financing Administration, which sets regulatory policy for Medicare/Medicaid, was told, "The more we came up with fraud and abuse, the worse it was. So what they did was try and stop this fraud and abuse work" (Personal Interview). A high ranking enforcement official noted:

> It seems as though when all of this was originated they said let there be a program. They felt they were dealing with a community group that was full of integrity and would not violate the precepts of the program. From 1965...until about 1968 there was no such thing as fraud and abuse. (Personal Interview).

This benign notion altered as the cost of Medicare/Medicaid quickly escalated. The 1965 price tag of 1.9 billion dollars had grown to 37 billion dollars by 1977 (Brown, 1979:203). Both governmental and private interests now saw a need for cost containment; the heady rhetoric extolling a new era of medical treatment was abandoned in the face of fiscal concerns.

The characterization of fraud and abuse as a "non-problem" by early Medicare/Medicaid policymakers had affected the manner in which program control efforts were organized. Early enforcement efforts were thwarted by the absence of satisfactory legal tools and adequate program regulations with which to control the abuses beginning to be uncovered. An official noted:

> You could identify it [the fraud case] but there weren't laws and regulations to support it...The controls weren't built in and I find that to be the largest problem of

> anything, whether it's General Motors or IBM or whatever. You build this magnificent edifice but you don't build in any security precautions at all (Personal Interview).

Moreover, there was no integrated system specifically designed to uncover, investigate, prosecute and sanction errant providers. Gardiner and Lyman (1981:4) argue that even today no "coherent 'policies' or 'systems' regarding fraud control exist" because of the lack of planning. Rather, the "system" grew "topsy-turvy" (Gardiner and Lyman, 1981:4).

Enabling Structural Features for Benefit Program Fraud and Abuse

The nature of laws and regulations for administering Medicare and Medicaid are held by some persons we interviewed to "cause" the problem of abuse and fraud by health providers. Regulations are said to be too loose to provide an adequate basis for criminal or administrative investigations, and too restrictive of medical practice, leaving doctors little choice but to violate program rules. The reimbursement mechanism in Medicaid which provides doctors with about one-half of what they usually would charge is a major structural feature of the program which appears to encourage fraud and abuse. In addition, the fee-for-service billing mechanism offers great temptation through the seemingly unlimited ability of the system to pay the billed costs of health care delivery. Physicians are "encouraged" to overbill and overtreat patients by fee-for-service reimbursement.

A recent survey of California doctors has shown that many considered inadequate levels of reimbursement, bureaucratic interference, and denial of reimbursement for services already provided as "critical" problems in the state's Medicaid (Medi-Cal) program (Jones and Hamburger, 1976). Another report notes that reduced levels of reimbursement to health providers actually

increases overall costs. Some physicians drop out of the program, leaving patients to seek care at more expensive facilities (e.g., hospital emergency departments) (Leighton, 1980). The structure of government benefit programs has no rewards for economy. But it is not clear that changing regulations will eliminate abuse and fraud. Some officials believe that there would merely be different types of frauds. As one experienced investigator noted:

> For the next ten years you fellows could think of schemes and these devils will think of how to beat it in 15 minutes (Personal Interview).

But a veteran federal official noted that "cleaning up" regulatory policies would at least leave a clearcut group of criminals to contend with rather than the person who get caught up in regulations and those who are "marginal conformists":

> If government cleaned up its act...you would be left with a group of providers that really would be thieves no matter what walk of life they got into (Personal Interview).

The same official noted that under the current structure he "wouldn't be surprised that 85 to 90 percent of all practitioners...nickel and dime from time to time." Another administrator noted in the same vein:

> Overutilization [abuse] is destroying the Medicare and Medicaid programs. There are no two ways about it. If you could get all the frauds tomorrow...and put them on a ship someplace the program would still go broke because the people who are killing us are the overutilizers (Personal Interview).

The medical benefit system whose rules and regulations allow fraud

and abuse to flourish is fundamentally a construct of the medical profession itself. Both the American Medical Association and state medical associations exerted a major influence on the laws and regulatory policies concerning control mechanisms in government benefit programs. The medical groups fiercely resist any attempts to reduce autonomy in the practice of medicine. The use of undercover agents to "shop" providers under investigation for fraud is extremely limited in some states, for example, due to the efforts of medical groups to block such tactics. Program officials also are aware that "too much" of a crackdown might result in a lowered rate of physician participation, denying services to those the system is expected to service. At the moment, about one-quarter of all primary care physicians refuse to accept Medicaid patients, allegedly because of low reimbursement rates (Buchberger, 1981). The drop in the number of physicians who accept medical benefit programs assignment is said to be "alarmingly high" (Levin, 1980:22). Another important area involves access to physician records, for which no federal legislation exists, making investigations more costly and cumbersome if the physician refuses to allow auditors to examine patient records. Such structural features of the programs handicap effective policing, which, according to most officials, results in additional program violations due to the extremely low likelihood of detection and sanctioning.

Doctors, the records of medical program fraud indicates, are not very different from other people; in fact, they may be even more sensititve than most of us to economic and material considerations. One investigator noted her re-evaluation of the medical profession after beginning her duties.

> When I first became an investigator with the Department of Health, I felt a little bit intimidated about going

to a hospital and dealing with doctors. The first time I walked into a hospital I remember looking at the parking lot and seeing the doctors' cars; Porsches, Mercedes, a Ferrari. I thought they're not quite what I think they are. It showed me a playboy image that I wasn't thinking of before. I had been thinking of doctors as very conservative. They have more of a flashier, money image (Personal Interview).

Motivations and Mechanisms for Engaging in Fraud

Overcharging for services and overordering tests is a way for some physicians to "make back" what they feel they would be earning if it were not for government reimbursement schemes. Such practices appear to be particularly widespread among doctors whose clientele is largely indigent. These doctors may engage in fraud as the only means they see to maintain adequate health care for the poor among their patients. Other physicians may see their participation in the government program as a game to be played and won. In these instances, it does not matter how fair the guidelines are; the doctors would look for means through which to gain an upper hand.

A pair or cases illustrate this idea of game playing, which may entail participation of other professionals. In the first instance, two individuals agreed to bill Medicaid fraudulently for x-ray services. One of the conspirators did the x-rays without meeting government performance requirements. A physician in another city would then bill Medicaid for the work and falsely describe it having been performed by himself. In a similar case, a physician signed and submitted false claims stating that pap smear evaluations were performed in his office, when, in fact, they were done in a pathology laboratory

located in another city. In both instances, the physicians had established a mechanism to bill Medicaid for services other than their own.

The odiousness of government regulations to physicians who enjoy "professional dominance" (Friedson, 1970) supports informal professional norms which encourage some doctors to exploit benefit programs. The behavior which enables a doctor to engage in fraud probably is at least partially learned from others in the profession in most instances, and professional values may effectively neutralize the doctors' conflicts of conscience.

Physicians' decisions to commit fraud are also partly due to how they view themselves in terms of being professional persons versus business people. Many individuals undoubtedly become doctors because of anticipated high fiscal rewards. Quinney (1963) found that pharmacists with a "business view" were more likely to be prescription violators than colleagues who had a "professional view."

Doctors who engage in fraud and abuse can also rationalize that sanctioning is impossible because of their social position and the inadequacies of program policing. A supervising investigator notes that doctors may be unaware of the government's capabilities and activities in policing the program, and that even when such knowledge exists, they may still feel that they are beyond reproach due to their high social status.

> A lot of doctors don't believe that we have computer records that will show one whole year's history right in front of us. I don't think they believe we have that or they wouldn't cheat the way they do. The bottom line is that they have egos, and they think that welfare recipients are stupid. That's their biggest mistake because there are a lot of bright people on public

assistance and we go out and interview these people... They feel that those people pitted against them in the courtroom are never going to be believed. But they are believed. That's the part they don't understand. These recipients will go into the courtroom...tell their simple little story, and the doctor's going to fall. They just don't believe that (Personal Interview).

It is arguable whether or not this attitude on the part of some doctors is due to arrogance or naivete or some combination of the two. Arrogance may have a lot to do with committing fraud, an arrogance that high-handedly dismisses the violation of program rules as insignificant behavior on the part of a doctor. One case, involving a California psychiatrist, illustrates this point. The doctor was convicted of stealing about $5,000 from the Medi-Cal Program. He had served time in jail when a license revocation hearing was held. The following transpired at the hearing, according to the state investigator who handled the case.

I was called to testify and he brought defense witnesses who testifed for him. He was on the Board of Directors of the major local hospital here. The deputy attorney general would ask these people from the hospital, "You mean you have reelected him to the board of directors of the hospital even though he's pled guilty to a felony?" And they said "Sure." And [the deputy attorney general] said, "Don't you realize that he pled guilty to Medi-Cal fraud?" And this physician on the board said, "Yeah, but you know Medi-Cal doesn't pay very much anyway." And that was the response that was actually

right at the hearing. They didn't revoke the license (Personal Interview).

Patterns of Control and Enforcement

Medicare.

Current policing efforts in Medicare are in no small part shaped by prosecutors. Reiss notes that "by legal theory and by practice, prosecutors have the greatest discretion in the formally organized criminal justice network (1974: 690)." Prosecutors' definitions of what constitutes "fraud" help to shape the actions of federal investigators who must work up cases. The necessity of proving criminal intent is paramount in control agents' working definitions of fraud and abuse. A universal view exists among agents that fraud cases must involve "something willful." As one puts it:

There is some intent to defraud or cheat the government and there is no question but that it's willful... Abuse, on the other hand, is just basically giving people more than they need in terms of medical service--excessive treatment, treatment that is not necessary, billing for more services that are needed--anything that is above and beyond what the diagnosis calls for but doesn't involve a willful intent. The difference between fraud and abuse, as far as I'm concerned, is in the case of fraud, services aren't rendered. In abuse cases the services are rendered but there is more given than is necessary based on the diagnosis (Personal Interview).

Official attempts to define "overutilization" as fraud are frustrated by prosecutors' needs for proving intent. One high ranking official

complained:

> An internist in the city of Pittsburgh will see a patient with a certain condition six times, and I'll identify a guy who sees a patient with that condition 20 times. And now I think that somebody should tell us that this guy has seen him 14 times too often and we should get out money back. When we put this before a medical review group they say, "Hey, how bad is this?", or they'll say, "Oh well, you know, it's malpractice time and I can understand why he might have ordered unnecessary tests" (Personal Interview).

It is part of medical practice folklore that physicians are unwilling to label the actions of other physicians as wrong. Also, lacking total agreement among physicians regarding diagnosis and treatment, as well as specific regulations in benefit programs that clearly define treatment categories, criminal prosecution of overutilization would be futile, since it would not be possible to show "willful intent" beyond a reasonable doubt.

The Office of Inspector General (OIG), the agency that investigates fraud by Medicare providers (as well as all crimes committed against Health and Human Services), will normally take on only those cases that prosecutors agree to. As one agent noted:

> Very early on in the investigation, before we expend a lot of investigative resources, we'll go directly to the prosecutor [and make a] presentation... We'll set forth the allegations and facts as developed preliminarily and then ask the prosecutor, "If we substantiate these allegations, given the dollar amounts, the proofs and so forth,

> will you prosecute this case?" So we are right up front in our system of priorities whether nor not to make a commitment of our resources or end it right there (Personal Interview).

In many respects an agent has to sell a case to the prosecutor. Medicare provider fraud must compete with other federal offenses which account for most of the time of the U.S. attorney. An investigator commenting on prosecutors in one federal district noted:

> Their priorities are bank robberies, drugs, immigration, and terrorists. The workload of the assistants is huge. Somebody goes and blows up nine airplanes and then you come in the next day with a doctor who is [stealing] from Medicare or Medicaid. Where are their priorities? They will be more concerned with violent crimes (Personal Interview).

Because of such priorities, prosecutors usually consider the absolute dollar amounts involved and the amount of resources necessary to prove a case in assessing whether or not it is worth pursuing. An investigator explained:

> The first thing they always looked at is money. You can get a guy whose [fraudulent] Medicare bills are $3,000 or $4,000 a year. No matter how good the complaint is, it's probably not going to warrant federal prosecution. Then you get into other questions. How much work are we going to have to do on this case? Are you talking about a guy adding an injection where he's getting an extra $2 per claim so that you're

> going to have to interview 1,000 or 2,000 people? If that were the case, he may feel that it's better [to pursue] civil action. The fact is that there is going to be a lot of work. Just because there's going to be a lot of work shouldn't be a criteria, and it usually isn't. But there are times where you have somebody bucking for one to two dollars per claim. The amount of evidence you need to prove it beyond a reasonable doubt...just becomes burdensome (Personal Interview).

The same respondent went on to point out that the U.S. attorney will also consider the weight of the evidence:

> If it's an open and shut case where this guy is obviously committing a fraud and the intent is there, and the evidence is there...it may not be a lot of money, but the evidence is going to outweigh it and so they may prosecute it. Usually if you get patient abuse, that may not overwhelm the assistant, but a lot of times that may be the one extra thing. Say the guy's taking x-rays with no film in it, or he's allowing his secretary to prescribe drugs, then sometimes that will outweigh some of the other factors. It's kind of a scale. The amount of dollars is taken into effect, the amount of work, or what you're going to have to prove. On the other side is what is the evidence going to show? Is it going to be overwhelming; is he really fooling around with patients' welfare? (Personal Interview).

U.S. attorneys' decisions not to prosecute means that Medicare cases originally identified as fraud will be dropped or treated as abuses.

Medicaid

Medicaid fraud cases are investigated by state Medicaid Fraud Control Units (MFCU). There are currently 30 states with such units, which began to operate in 1978. Their total number changes as some states start up units, while other states end participation. New units receive 90 percent of their funding from federal revenues and are certified by HHS. The state's share of the cost is increased to 25 percent after three years. New York's unit is the largest with well over 100 positions, including investigators, auditors and prosecutors. California has 60 people in its unit. Units usually are housed in the state's Attorney General's office, making prosecution less burdensome. An attorney's opinion is immediately available, and in-house prosecutors handle only Medicaid cases. Smaller state units rely on prosecutors located in the criminal justice system. The chief investigator in a smaller MFCU commented:

> We will have two attorneys. They're not going to be prosecutors, primarily. They're going to be "prosecutive consultants"--a name I like to give them. We're going to rely on the county prosecutors and we're going to have these guys available to advise and recommend and everything else. And if a county does neglect a case or refuse a case for frivolous reasons, we have authority under the Welfare Act to prosecute it ourselves...and every one of these cases is a federal case also and we've got good liaison with the U.S. Attorney's office so there's nothing stopping us from going in

there (Personal Interview).

In addition, some attorneys in MFCU units have been given courtesy appointments as U.S. Attorneys, which allows them to prosecute medical benefit fraud cases in U.S. courts.

A major force affecting sanctions against errant providers in medical benefit program cases are the financial resources of the investigative units. The capacity of the system to enforce laws and mete out punishment is in no small measure related to the "production" of fraud and abuse by authorities. It has been observed that:

> Environmental demands on organizational resources and the distribution of those resources in the criminal justice system may be largely responsible for what the system actually "produces" in terms of reported crime rates, arrests, convictions, and sentences (Pontell, 1982:131).

Similar constraints on health care enforcement agents affect whether a provider's behavior will be treated as an abuse or a fraud. The first level of the control process is housed in the carrier--an insurance company under contract with a state or the federal government to administer payments to providers. The carrier is required to perform basic program integrity functions involving both pre- and post-payment reviews. Physician billing patterns that are highly abberant are "flagged" by computer for further investigation to determine if the program is being abused or defrauded:

> The carrier will then start to screen invoices and usually what that involves is that they will pick 10 to 15 claims of an individual provider and contact the patients by mail or by phone and say, "Did you get or

> did you not get the service?" If enough of those people did not get the service or in some way don't verify what this provider has billed for, that package is then referred for possible fraud investigation (Personal Interview).

The ability of carriers to conduct these preliminary investigations ("work-ups") is limited by budget constraints. Recent cuts in Medicare and Medicaid programs have reduced the number of investigations that carriers can conduct. This has greatly reduced the ability of the system to detect and sanction fraudulent health care providers. One administrator gave the following characterization of the situation:

> Take the universe of 15,000 doctors such as in New York. They can still identify 450 aberrant doctors every year. It hasn't decreased. However, they can only work each year on less and less as the budget calls for less and less. But because they're working on 50 cases this year, while last year they were working on 100, doesn't mean there are 50 less aberrant doctors out there (Personal Interview).

Cases that are not "worked" are treated as abuses and are handled within the carrier, or may be referred to the state health department for administrative sanctioning. In such cases, "Sometimes they decide they're just going to get an overpayment back and send an educational letter to the doctor. Usually they meet with the doctor and try to give him an opportunity to explain," an agent notes. State health department units responsible for program integrity, for example, may do any of the following: (1) warn the physician about any incorrect billing; (2) demand reimbursement for overpayments;

(3) establish a special claim procedure under which full documentation of services rendered must accompany all future bills; (4) demand that the physician seek prior authorization before accepting non-emergency patients; (5) suspend the physician from the program, which is the most difficult sanction to achieve; (6) refer the case to the MFCU for possible criminal prosecution; or (7) refer the case to state licensing agencies for possible disciplinary action (Pontell, Jesilow and Geis, 1982).

Current OIG budget levels make the likelihood of sanctions rather low. The capacity of the system to generate and administer punishments (aside from the complexities involved in detection, investigation and acquiring evidence) in medical fraud cases seems to exceed the problems involving common crime (Pontell, 1982; Pepinsky, 1982).

Deterrence and Prevention

A major set of propositions regarding prevention of fraud and abuse can be found in the criminological literature on deterrence. The basis of the deterrence doctrine is that crime rates are negatively related to properties of punishment; particularly the perceived certainty of legal punishement. The literature suggests that white-collar criminals such as physicians acting illegally may be more sensitive to deterrence efforts. "[I]t seems likely," Zimring and Hawkins (1973:127) write, "that those who attain high status will possess many of the characteristics that may be associated with maximum threat influence, such as a sense of the significance of the future and a strong loyalty to a social system that has been responsible for much of their success." Similarly, Geerken and Gove hypothesize that "the effectiveness of [a] deterrence system will increase as the individual's investment in and rewards from the social system increase (1975:91)." In regard to deterrence, the high occupational status of physicians would suggest that

they are among the most "rational" element in society. Physicians should likely learn the lesson intended by punishment.

Some qualitative and quantitative evidence regarding deterrence and physicians does exist. Lindesmith (1965) argues that the government was able to deter physicians from dispensing heroin to addicts. Prior to 1919, physicians often would prescribe narcotics for those addicted. In their medical opinion, addiction was a disease and the addict was a patient to whom they could prescribe drugs to alleviate the distress of withdrawal. The Treasury Department, however, interpreted the existing law regarding the dispensing of opiates to prohibit a doctor's prescription for an addict. In addition, law enforcement efforts drove narcotic usage into slum areas (Ball and Cottrell, 1965:475). Doctors soon found narcotic addicts to be unrewarding patients, with a high degree of intransigency and a low rate of payment (Geis, 1979:111). Most doctors simply stopped having anything to do with addicts and the few who did not do this found themselves threatened by prosecution (Lindesmith, 1965:7). The flow of narcotics from doctor to patient addict abruptly ceased.

Similarly, Andenaes suggests that physicians were easily deterred in regard to illegal abortions. He argues that the reason for this was that "the medical profession on the whole is quite susceptible to the threat of law and the censure of society" (1971:545).

A survey of 388 obstetricians undertaken prior to the amendment of many state laws on abortion, however, found 10 percent admitting that they referred patients to abortionists. They also believed that 14 percent of their colleagues did so. For the majority of those making such referrals, there were four or five cases each year, though a few said that they referred from 30 to 40 cases annually (Lader, 1965:46, 59). Zimring (1972:715), in a

study of the change in abortion practices after Hawaii liberalized its abortion law, reached a similar conclusion. "Physicians were intimately involved in prechange abortion practice at least in a referral capacity." It is not easy to interpret these figures. Perhaps it can be said that for at least a minority of physicians there proved to be a willingness to violate the law if: (1) a patient's welfare was involved; and (2) the physician did not have to take direct and brazen illegal action himself or herself.

In a more recent test of the effects of deterrence in regard to medical practitioners, an official carrier reviewed the claims data of pharmacies of Lake County, Indiana before and after the criminal conviction of one of their number. He found "a sizable decrease after all the publicity" (Personal Interview). A more sophisticated technique was used by a high ranking enforcement agent in HCFA. He examined the claims data of the 20 largest providers (dollar amounts) in one medical specialty in the New York City area. Again, billings were compared for a time period before and after a "highly publicized" conviction of members of the specialty in the City's area. The official reviewed HCFA's records of the providers to eliminate any who might have had a structural change in their business (for example, relocation), as well as those who had been included in the prosecution. The agent reported a 52 percent drop in billing charges following the conviction (Bailey, 1982). Similarly, a regional enforcement office noted that "doctors' earnings go down when they realize they're being investigated" (Howard, 1982). In short, if such results can be generalized, efforts to deter physicians from abusing and defrauding medical benefit programs might reasonably be regarded as likely to be successful.

Policy Implications

The government's capacity to control program violations is clearly

limited by organizational resources, the structure of the law, and the state of current reactive, post-payment technologies for detecting such abuses. It is also limited by social, political, economic, and professional factors present in the organizational environment of such programs. "Get tough" policies might produce more violations and return public monies (cost-benefit ratios would need to be calculated), but at the same time, they might: (1) reduce physician participation in programs making it more difficult for the needy to obtain health care; and (2) further alienate the medical profession and related groups without whose support program and control efforts become more difficult.

The most obvious problem area is the fee-for-service nature of government medical programs which enables, and sometimes encourages, abusive and fraudulent practices. Such violations are difficult to detect, and can be easily incorporated into physicians' ordinary occupational routines. Moreover, other physicians are not likely to assess negatively any but the most dramatic cases of fraud, which seriously hampers efforts to impose certain and severe sanctions. The fee-for-service reimbursement system operates in an influential and at times unsupportive and conflict generating environment of organizations, professional groups, regulations, and law. The assumption in the formulation of the benefit programs--that doctors could by and large be trusted under circumstances of almost limitless opportunity to enrich themselves--has not been borne out by experience. The fee-for-service nature of the programs provides no incentives at all for economy.

Prepaid Health Benefit Programs

One alternative to the current fee-for-service structure is a reimbursement system based on capitated costs on a per-patient basis. This is similar

to the Health Maintenance Organization (HMO) concept which currently exists in other health insurance programs. Under such a framework providers would be paid a set amount per patient for all health care needs. California is currently initiating such a system for hospitals. Institutions are negotiating confidential contracts with the state for rendering services to Medi-Cal patients. Some officials anticipate that the new payment system will reduce hospital costs for patients and remove structural incentives for abusing the Medi-Cal system. It will take years, however, before a definitive assessment can be made of this new approach.

HMO's have "shown that they can provide a rather comprehensive set of services at costs ranging from 10 to 40 percent less than the cost of the same benefits under an indemnity program" (Leighton, 1980). Under a prepaid system, the quality of care rendered to patients would have to be closely monitored. This is currently not a prime concern of program enforcement, which focuses on rising costs. Prepaid systems remove incentives for excess billings but, at the same time, they can enrich providers who skimp on patient services. Program officials fear that by changing the system, fraud and abuse will not be prevented, but that different means will be employed. New control techniques would have to be developed and tested by government agencies who are just beginning to settle into a comfortable and an increasingly productive pattern of enforcement practices.

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

> The old HMO 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 they are, have you had any diseases, all the good questions. Then, if it turned out that this was a person/family that statistically was not likely to produce medical problems, the second person who came through would sell them on joining the HMO--sign them up for it. So they got a higher proportion of well people at their HMO than the payments contemplated and they made out. 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 margin by that much more. When it began to look as if they were going to get caught, they declared bankruptcy and walked away... (Personal Interview).

HMO's also have in the past enrolled fictitious persons in order to increase their prepayment fees (Personal Interview).

Officials believe that <u>regardless</u> of the payment structure of government medical programs, members of the medical profession must be encouraged to be more responsible in labeling aberrant services, abusers and defrauders. Doctors are extremely reluctant to assess treatments as unnecessary or to label care as inferior. Determinations of necessary services and adequate levels of patient care necessarily fall back on the expertise of medical professionals. Strict norms need to be created and vigorously enforced.

In light of the partially false assumption on which Medicare and Medicaid programs were structured, namely, that doctors could be trusted under a

fee-for-service system, a related issue needs to be resolved if prepaid systems are to succeed. If some doctors overtreat under a fee-for-service system, what evidence is there that they would not undertreat in a prepaid system? New control mechanisms would be needed to ensure that patients receive adequate medical care. Cost control under a prepaid system would not be as serious a problem as the quality of patient care. Perhaps more importantly, the medical profession would have to define carefully what "acceptable medical care" entails under a broad range of circumstances in order for such a system to succeed in providing for the needs of the poor.

Further Strategies

There are other strategies short of restructuring of the reimbursement system that probably could help to control fraud and abuse. Heavy publicity for cases involving program suspension and, more importantly, criminal conviction likely could achieve general deterrence. This might also serve as a mechanism which would educate physicians regarding enforcement activities. Publicity, while perhaps of little or no consequence to outright thieves, could influence marginal conformists and those who skim small amounts of money from aid programs. It might also produce beneficial results by making the population more aware of criminal and abusive practices in medical programs and thus generate new cases. Such effects are likely to be temporary, however, following directly after major newspaper coverage. Constant publicity may, in fact, reduce the effects of the intervention by making such cases so commonplace that they no longer serve as eye openers to either providers or the general population. Moreover, some providers may feel that it is safer to cheat following a "big case," since the government may have already depleted its resources. Time-series analyses of the

possible effects of publicity using weekly or monthly billing patterns both before and after highly publicized cases would be useful for assessing publicity as a control tool.

Lastly, government agencies could be given greater sanctioning capacity through restructuring regulations and increasing their powers for investigation. "Shopping" providers is currently hampered in many states by laws which allow it only under special circumstances. In addition, access to provider records is oftentimes problematic and cumbersome. A recent government report (U.S. House of Representatives, 1982:102) which examined state Medicaid Fraud Units recommended that the Congress should enact legislation requiring the states and providers to give Medicaid Fraud Units access to provider records as a condition of receiving Medicaid funds.

There are no unqualified solutions to the problems of fraud and abuse in government medical programs, just as there are no true solutions to the problem of crime in general. Policing the medical programs involves a complex and delicate set of both intra- and interorganizational relationships. The preceding discussion has suggested major areas that need to be more fully explored by systematic research. More definitive conclusions concerning the efficacy of legal and organizational interventions could then be drawn.

Conclusion

In his initial statement of the concept of white-collar crime, Edwin H. Sutherland used medical professional practices as one of the bases of his theoretical work. Sutherland (1940:3-4) noted:

> 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.

It is arguable today (and perhaps it was then) that the medical profession displays less violation of the law than other professions. For one thing, the fees of doctors are extremely difficult to trace, and it is suspected by the Internal Revenue Service that there is widespread tax cheating by doctors, largely in the form of unreported income (Stern, 1964). 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 has failed to report as much as half of the amount on their tax returns (Stevens and Stevens, 1974).

Focus on the fraud perpetrated by medical practitioners highlights a well-educated group of persons whose violations cannot be laid to the malaise created by poverty, inadequate socialization (though medical school training might be found deficient in the inculcation of adequate ethical standards) or similar "explanations" of more traditional kinds of criminality. Recent studies of white-collar crime have been entangled in attempts to dissect the symbiosis between organizations and their executive employees. There are analytical problems involved in differentiating between, say, an automobile manufacturer and its vice presidents when the company is accused of the perpetration of white-collar crime. Are organizations, the issue goes, something other than a mere combination of their operating personnel, or should the analysis focus exclusively on the actor, as if he or she were operating in a less embracive contextual environment? Doctors, as individual entrepreneurs, allow for easier comprehension of personal acts in regard to

laws relating to white-collar crime.

Deviance among professionals has not been a major area of research in sociology or criminology. Lanza-Kaduce (1980) has recently defined professional deviance in terms of violating the "public service norm." In this sense, physician abuses in government programs constitute a clear example of professional deviance. We have discussed this form of professional deviance in terms of factors which may contribute to its occurrence, particularly the law governing the structure and control of the behavior. We have also discussed remedial policy options. 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," one official we interviewed noted, "that the one who is defrauding the program is also defrauding the patient because he does not provide the services that are needed or does so only perfunctorily at best" (Bailey, 1982).

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FRAUD AND ABUSE BY PSYCHIATRISTS AGAINST GOVERNMENT MEDICAL BENEFIT PROGRAMS

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The research for this paper was supported by a grant from the National Institute of Justice, U.S. Department of Justice (82-IJ-CX-0035). The views expressed are those of the authors and do not necessarily reflect the position of the Department of Justice. We want to thank Carol Wyatt for typing help, William Grenner for interviewing assistance, and Dr. Edwin S. Robbins for providing access to APA materials.

(FORTHCOMING, AMERICAN JOURNAL OF PSYCHIATRY)

FRAUD AND ABUSE BY PSYCHIATRISTS AGAINST GOVERNMENT MEDICAL BENEFIT PROGRAMS

Psychiatrists constitute a particularly large proportion of medical practitioners in the United States who are convicted of charges involving fraud against government medical benefit programs. There are about 378,000 practicing physicians in the country; of these approximately 8 percent are psychiatrists (1). Since the advent in 1967 of Medicare and Medicaid, the nation's major health benefit programs, through 1982, 147 physicians have been suspended from program participation because of fraudulent and abusive practices (2). Checking the names of suspended doctors with state licensing boards and the American Medical Directory, we found that psychiatrists represent 18.4 percent of that total. The largest number of suspensions have involved general family practitioners (27 percent), but this total is approximately the same as their representation in the practitioner population. The same is true for the three specialities which follow psychiatry in suspensions: General surgery (11%); Internal Medicine (7.5%); and Obstetrics/Gynecology (7%).

Fraud and abuse have never been definitely distinguishef by government authorities in regard to suspension policies (3). In general, fraud relates to a criminal offense which involves "intent" on the part of the offender. Program abuse entails a violation of rules, and does not have to be intentional, or to involve criminal wrongdoing. In practice, both forms of behavior generally have to be egregious before they will elicit official action.

The disproportionate number of sanctioned psychiatrists is underscored when physician involvement in the benefit programs is examined. Medicare, which is designed

to assist those 65 years of age and over, certain disabled persons, and individuals with renal diseases requiring dialysis or organ transplants, severely restricts psychiatric services. Medicare recipients themselves must pay 50 percent of the costs associated with mental health treatment received on an outpatient basis up to an annual limit of $500. In their lifetime, Medicare recipients are eligible for only 190 days of government-paid psychiatric care in a hospital.

Medicaid also discriminates against clients who might seek long-term and expensive psychiatric care. This program primarily provides assistance for poor persons. Medicaid is partly federally-funded, partly state-funded, and administered through state governments. There is considerable procedural variation among jurisdictions, but the usual rule is that when they deal with Medicaid patients psychiatrists can expect payment from the government for only limited periods of treatment time. It is against Medicaid that most recorded psychiatric fraud takes place, and it is to this program that the largest number of observations in the present paper refer.

Given the foregoing, it is not surprising that psychiatrists treat very few benefit program patients. In a comprehensive review, Mitchell and Cromwell (2) found that almost two-fifths of the psychiatrists across the nation who are engaged in private practice reported that they did not treat any Medicaid patients. By contrast, less than one-fourth of the total physician sample did not deal with Medicaid patients. In only in 2 of the 15 medical specialties surveyed by Mitchell and Cromwell was the participation rate lower than that of psychiatrists: for allergists and for cardiologists.

Given their relatively low rate of participation in government medical benefit programs, the discrepant proportion of psychiatrists discovered and sanctioned for defrauding and abusing the government benefit programs becomes even more pronounced. But these figures require both interpretation and explication. The goal of the present paper is to place them into their proper context.

Scrutinizing the Statistics

The statistical data available proclaim that psychiatrists are the objects of successful government fraud actions disproportionately more often than other medical practitioners. But how poor actually is the specialty's record? It might be maintained that 27 cases of fraud and abuse during the 16 years since the benefit programs have been in existence constitutes a rather inconsequential violation rate, one that members of the profession might find "reasonable." The difficulties with this position are that enforcement of the benefit program fraud and abuse control laws has always been regarded as rather slack, and that there undoubtedly is a great deal more fraud going on than is discovered (5). The lax monitoring effort in part reflects early fears, when the programs were inaugurated, that if too much control were maintained against the medical community, doctors would balk at participating. Wilbur Cohen, who had been instrumental in the enactment of Medicare, recently disclosed some dimensions of this early concern:

> President Johnson...talked with me nearly every day before we inaugurated the system, about what I was going to do if aged persons were lined up outside of hospitals with physicians refusing to admit them...[A]s Commander in Chief [he] authorized me...to utilize any veterans' hospital or armed services hospital if any aged person was not able to get into a hospital...when [Medicare] became effective (6).

Another factor that has inhibited vigorous enforcement efforts is that government authorities generally regard their primary purpose as the disbursement of funds in an expeditious manner to ensure that providers and beneficiaries remain content. Control of fraud is clearly a minor, secondary interest (7). It was not until the fiscal integrity of the programs began to be threatened by the recent escalation in medical costs, coupled

with the economic recession, that any serious attention was turned to combatting fraud. In addition to the creation of the Office of Inspector General in 1977 (P.L. 94-505), the Anti-Fraud and Abuse Amendments in the same year provided federal subsidies for the establishment of state Medicaid Fraud Control Units (P.L. 95-142). These units have largely been responsible for the concerted campaigns against fraud which have resulted in the sanctioning of such a high proportion of psychiatrists. Since the creation of the special fraud units, the yearly rate of cases involving psychiatrists has risen significantly; one-third of the total number sanctioned was in 1982. In addition, many fraud investigators insist that the violation figures for psychiatrists reflect only the bare minimum of such behavior. In the three-dozen personal, in-depth interviews we conducted with field supervisors and investigators throughout the country it was not uncommon for the practice of psychiatry under Medicare and Medicaid to be vehemently condemned as "thievery."

Such remarks, of course, must be interpreted with great caution. Law enforcers are notoriously cynical, and often perceive themselves as innocents inundated by encompassing evil. The disproportionate number of cases they process involving psychiatrists may well produce self-fulfilling and tautological conclusions about the general practice of psychiatry.

Slightly more damning, though hardly conclusive, are the results of an internal study conducted by the Health Care Financing Administration (8) of psychiatrists in New Jersey and Metropolitan New York who showed conspicuous patterns of service and reimbursement. Thirty-nine psychiatrists (about one percent of the relevant areas' total) were studied in regard to their benefit program work in late 1978 and through 1979. The investigation conclusion reads: "Overall, the study resulted in significant findings of apparent fraud, abuse, and waste, indicating the possibility of approximately $1.3 million [of a $33 million total] overpaid to the subject physicians." The authors were careful, however, to emphasize that since the selection of cases was not random, "the findings,

therefore, do not reflect activity of the entire psychiatric community in the geographic area studied or elsewhere."

A response to the report was prepared by the APA Area II Third Party Payment and Insurance Committee. The response criticized the study on a number of grounds, maintaining that (1) it did nto fully disclose its methodology and the pitfalls of its approach; (2) it was not a scientifically designed investigation; (3) it was misleading and inaccurate at a number of points; (4) it produced inflated estimates of psychiatric fraud and abuse; and (5) it represented more of an attempt to publicize fraud and abuse than to study it.

Members of the review committee had participated in the HCFA study, but issued their response because they maintained that their views had not found their way into the final report.

The major problem with available materials certainly is that found in virtually all studies of crime and deviant behavior. Little is known about the so-called "dark figure" (9), those cases that do not, for whatever reason, come to the attention of the authorities. This lacuna makes generalizations and extrapolations hazardous: any conclusion must be advanced with considerable caution. Nonetheless, what is actually known and what is believed about fraud by psychiatrists against government medical benefit programs reflects unfavorably on the practice of psychiatry. In the remainder of this paper, we will offer some extentuating evidence that suggests that the relatively high degree of fraud by psychiatrists (compared to physicians in other specialities) is in large measure a function of their particular susceptibility to discovery and successful prosecution.

Psychiatrists as Easy Targets

Cases of fraud are generated in a variety of ways. Some of the methods are standard for detecting crime, while others are unique to the medical benefit programs. Investigators receive and encourage tips from disgruntled or distressed present or former

employees of a doctor, and from his or her colleagues. Such sources have been of quite limited utility, however, in part because of the traditional reluctance in the medical field to turn against a fellow practitioner. Some cases are generated from forms that are mailed to at least a portion of a doctor's patients, indicating the charges that had been submitted for payment. It is hoped that patients will report to the authorities bills for services they have not received. Most importantly, cases of fraud are discovered by blatant discrepancies in billings between what might be reasonable and what appears impossible or unlikely. Doctors who submit bills for hysterectomies for male patients, or circumcisions for female infants, are obvious targets for closer investigation. The widespread installation of MMIS [Medicaid Management Information System] computers enhanced the detection process by flagging cases which varied by a specific number of standard deviations from the norm of practitioners in the area. Substantial deviation from the norm, however, does not prove fraud. Further investigation often reveals legitimate explanations.

Investigation of practitioner fraud, by whatever means, is apt to be an arduous and intricate paper chase whose results often are unlikely to convince overburdened prosecutors that it is worthwhile to go forward with the case. Questions concerning the establishment of criminal intent bedevil enforcement efforts; so does the matter of gaining access to the files of physicians, who may be immune to record searches and seizures as a part of their doctor-patient privilege.

It is against this background that the high percentage of convictions of psychiatrists must be examined. Similarly, the kind of opportunities available for fraud, and the manner in which particular illegalities are carried out by particular kinds of medical specialists needs to be noted.

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 the practice actually was 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. Only if the illegal behavior is notably egregious, both in behavioral and financial terms, is the investigation and prosecution likely to be conducted with some ease and some prospect of success.

At least two major branches of medical practice, however, are marked by a distinctively different form of service and billing than that for others. These are anesthesiology and psychiatry. In both, the unit for compensation as measured by the benefit programs is not a service alone, but rather a service that has been rendered over a specific period of time. Anesthesiologists are paid for what is called "table time," the amount of direct contact they have with the patient during an allowable period. They often are not paid, for instance, for any time they might spend monitoring a patient being transferred from the operating to the recovery room, though their sense of professional responsibility may dictate their management of the case at this point. An unknown but perhaps sizeable number of anesthesiologists are believed by investigators to add extra minutes to the allowed time in order to get what they think they have legitimately earned. Obviously, it would prove very difficult to detect such fraud: the patients are not able to contradict doctor claims, and site undercover work is an unlikely strategy.

Psychiatrists also are paid in terms of both time and service. States vary somewhat in Medicaid reimbursement details, but the approach in California can be taken as typical for the nation. In California, a psychiatrist can bill for having seen the patient for (a) 15 minutes; (b) 20 to 30 minutes; or (c) 45 to 50 minutes. The payment rate is $40 for a 50-minute session.

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 resources on psychiatrists' fraud against the government medical benefit programs. The investigators employ a variety of tactics: they can themselves secure spurious Medicaid cards and pose as patients [For moral objections to such

practices see (10,11)]. In this way, after identifying the patients, they can determine how long they are seen by the psychiatrist compared to the length of the period for which the payment agency is billed. They can also clock the movement in and out of the waiting room by other patients. Equally readily, investigators can photograph traffic to and from the 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 what he billed for. A field investigator notes wryly how a patient's panegyrics about a therapist can provide crucial fraud evidence:

> I have strong testimony from patients who sit there and say this guy is really great. I saw him at least 50 minutes and I saw him regularly once a month. Well, that's fine, but he billed us for an hour once a week.

Also, a surprising number of convicted psychiatrists bill for periods of service far in excess of the number of hours in a day (12), a matter readily spotted by the computer controls.

Psychiatrists, then, are particularly easy enforcement targets because of the criteria involved in their billing for reimbursement. It becomes impossible to state, therefore, whether it is because they are significantly more dishonest than other medical practitioners or whether it is because they are more readily apprehended that they constitute so large a proportion of the fraud cases.

Cases of Psychiatrist Fraud

Cases of fraud against medical benefit programs by psychiatrists can be divided into a number of types. The most common forms by far involve charges for inflated amounts of time with patients who had been seen for lesser periods. But there also are cases of billings for fictitious patients, and for situations in which someone other than the psychiatrist carried out the therapy for him or her. Psychiatrists also have been apprehended for dispensing drugs to patients and charging the government for therapy

time. There also are instances of psychiatrists involved sexually with patients or former patients and charging the benefit program for such dalliances.

Illustrations of different kinds of cases are presented below.

A. Bogus Billings

In order to qualify for payment, psychiatric treatment has to have been a one-on-one relationship. Psychiatrists sometimes will see groups of persons as a unit and then bill the state as if the group members had been treated individually. The details of one such case are provided by the investigator who had worked on it:

> I interviewed one particular patient who was seeing him along with her five children. She would see him for an hour alone. The following Wednesday the five kids would see him as a group. The next Wednesday she would see him; they would alternate. He was billing us for one hour individual psychotherapy every week on each of them. So that amounts to $240 per session and would take about five or six hours to compete. She was never there more than an hour. That over the period of a year and a half amounts to a lot of money; just on that one family, about $15,000, $16,000.

In a similar kind of case, the psychiatrist would visit an alcohol facility twice a month. He would talk to half the residents on one visit, the remaining half on the other. But he billed the state for separate one-hour sessions for all the facility residents, resulting in an illegal gain of $40,000 during the nine-month period before he was charged with fraud.

As a final example, there is the Report of Investigation of a case which summarizes the testimony of an employee of the suspected psychiatrist in these terms:

> She was employed by Dr. A, from June, 1976 to March, 1977. Her responsibilities were that of billing clerk, secretary, and receptionist...While so employed she noted the following which she believed to be violations of law:
>
> Dr. A. had used B. and C. to visit his hospital patients and perform psychiatric therapy, and then billed for this service under his Medicaid provider number. B. and C. are not licensed to perform psychiatric services on Medicaid patients. Dr. A. had ordered her to transpose the names of his patients in her appointment book from one day to the following day and to continue to do so until the patient was discharged from the hospital. She was further instructed to bill for each of these patients as long as they were still hospitalized.

B. Drug-Related Deception

Details of a case in which a psychiatrist pretended that he had given psychotherapy to persons to whom in actual fact he was dispensing various kinds of medications were provided to us in an interview with an investigator:

> We're finding psychiatrists that are doing vitamins, holistic stuff, and billing psychotherapy numbers. We just did a case on a psychiatrist who'd come in and give vitamins. He'd say a Medi-Cal sticker is worth $20 and you have vitamins that are worth $40 so give me two stickers [The sticker system has since been eliminated in the state, except for special cases].

C. State-Supported Sex

Two cases of psychiatrist involvement in sexual affairs with patients that included defrauding the government benefit programs illustrate dimensions of that genre of law-breaking. These cases obviously involve malpractice as well as fraud.

In the first, the psychiatrist had been seeing a female patient since she was 16-years old. She terminated treatment with him when she was 22, but returned four years later, and they became involved sexually. He placed her under heavy sedation during sexual episodes, and told her that intercourse with him was essential to her treatment. The exploitation of his position by the psychiatrist is perhaps best captured by a statement of the woman during a civil suit that resulted in her being awarded punitive damages: "If [he] would have told me the grass is blue and the sky is green, no matter what I would have seen, I would have believed him."

The affair terminated when the patient discovered that the doctor was sexually involved with another patient as well as with her. She reported him to the state licensing board on the advice of a policeman she knew. The psychiatrist maintained that he had billed the Medicaid program for time spent in the liaison because his wife handled his accounts, and he did not want her to learn that he was spending unreimbursed time with the women.

In another case, a psychiatrist attached to the military fathered a child by a patient, then kidnapped the infant and took it overseas with him to where he was stationed. The publicity surrounding the case caused the Medicaid fraud unit to examine his billing practices. It was learned that he had been charging the government for the sexual affair time. The psychiatrist received a one-year jail sentence, an unusually stiff punishment. The investigator, discussing the case, could not decipher its dynamics:

> Why would Dr. D., who is a Colonel in the Army, married to another psychiatrist, why would anybody like him do anything like that? It certainly couldn't be for the $5,000. Maybe for the thrill of it.

The same investigator suggested that many medical law-breakers appear to possess a feeling of invulnerability, built on an assumption that they were not answerable to anybody who might want to challenge their conduct. She pointed out that they tend also

to underestimate the competence of welfare patients: "They think welfare recipients are stupid. That's their biggest mistake because there are a lot of bright people on public assistance and we go out and interview these people." On the other hand, it was noted that cases against psychiatrists sometimes prove particularly difficult to prosecute because their patients can be especially vulnerable courtroom witnesses.

Conclusion

We have documented in this paper that psychiatrists are sanctioned disproportionately more often than other physicians for fraud perpetrated against government medical benefit programs in the United States. There are a variety of forms that their violations take, but by far the most frequent ones for which they are apprehended involve billing for longer periods than those for which they provided therapy or billing for patients they did not in fact see.

It remains arguable, however, whether psychiatrists truly are more dishonest than their colleagues in other branches of medicine. There are reasons to hypothesize that they may be so. These would include possible differences in the kinds of persons recruited to various medical specialties (13,14). There is also the possibility that work as a psychiatrist brings out in some persons behavior which leads to the kinds of illegal acts documented in this paper. Certainly, there must be impacts upon the therapists as well as their patients from the form of treatment administered. Psychiatrists also may cheat more than other doctors because they find the benefit system particularly unresponsive to what they consider to be their fiscal due (15,16). Among those apprehended, a common self-defense is said to be that what they were doing was worth so much more than the government was paying that they felt they were justified in adding time to their bill. Note the observation of a program official:

> I had a doctor tell me—I had monitored 3 to 7 minutes per patient—that he figured his work was quality, not quantity. I said what we're talking about is individual psychotherapy. So

> he said, well, I give the best I know how. I used to be a surgeon and I could do a surgery in 15 minutes where it takes another doctor an hour and a half. I said we're not talking about apples and oranges, we're talking about psychotherapy.

It is also possible that the standing of psychiatry relative to other specialties is tied to the rate of violations. Studies report that psychiatry has a rather low position among medical branches (17), in part because it is not regarded as "real" medicine, and in part because income from psychiatry tends to be less than that from most other forms of practice.

On the other hand, equally persuasive ideas can be found to support the suppositions that psychiatrists are likely to be more honest than their colleagues in other fields. For one thing, they presumably entered the field with a certain disregard for particularly high earnings. In addition, psychiatry notably appears to be a field with a strong commitment to people in contrast to material things. There is also, finally, some likelihood that psychiatrists are much like other medical practitioners in terms of their honesty, and that the opportunity structure for fraud, the temptations, are what condition the outcomes.

Our study clearly has indicated that the recorded high rate of apprehension of psychiatrists undoubtedly is closely tied to the fact that they are the easiest targets for investigation and apprehension. This is because they bill in terms of time, and because the manner in which they spend their time is readily subject to accurate determination. A major area that requires examination is whether in fact control agencies disproportionately review claims by psychiatrists, or tend to follow up on them more frequently than claims from other medical specialists. A variety of factors influence whether or not a case is pursued by investigators. Such factors include the nature of corroborating evidence, workloads, dollar amounts involved, persistence of billing aberrations, likely appeal of the case to the prosecuting attorney, and availability of

patient testimony. There are no available databases which reflect how many physician cases are reviewed and what review practices are followed. Such information would be necessary for an accurate determination of whether psychiatrists are in fact more frequent targets for investigation than other specialists. Whatever the true violation rate may be among all physicians involved in government benefit programs, it seems obvious that the disproportionately high level of established fraud by psychiatrists is creating a poor reputation for its practice among persons concerned with these programs.

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MEDICAL CRIMINALS:

PHYSICIANS AND WHITE-COLLAR OFFENSES

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This work was supported by a grant from the National Institute of Justice, U.S. Department of Justice (82-1J-CX-0035). The views expressed are those of the authors and do not necessarily reflect the position of the Department of Justice. The authors thank Gertrude Pontell, Mary Jane O'Brien, Constance Keenan and Stephen Rosoff for helpful comments, and Carol Wyatt for typing aid.

(FORTHCOMING in T. Hirschi and J.E. Scott, CRITICAL ISSUES IN CRIMINOLOGY, SAGE PUBLICATIONS.)

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"Now sickening Physick [Medicine] hangs her pensive head
And what was once a Science, now's a trade (Garth,
1697/1730:14).

Sir Samuel Garth's mournful observation about the commercialization of the practice of medicine in England in his time—nearly three hundred years ago—pinpoints a basic structural conflict that to this day marks the position of physicians in the United States: they are at one and the same time scientists engaged in a vital humanitarian endeavor and free enterprise businessmen operating in a capitalistic marketplace in which their skills and knowledge can be of enormous financial significance and value. "Your money or your life!" a thief commands Jack Benny, that master of comic timing of America's 1940s. The audience laughs when Benny, who assumed the radio and television persona of a tightwad, hesitates, apparently unable to decide which option he prefers (Benny, 1978). We, the viewers, of course immediately know what our choice would be—no amount of money is worth death. And therein lies a basic source of physician power, an important correlate of medical crime.

That such power has aroused strong feelings of anger and frustration among those at its mercy, particularly when it is employed ineptly or is abused, is not surprising. Envy and frustration are regular precursors of hostility. Ovid (43 B.C.-18 A.D.), the Roman poet, in the second book of Metamorphoses, describes how Ocyrrhoe was transformed into a mare as punishment for her prediction that Asclepius, the Greek god of medicine, would by means of medical science save

mankind from death (Jones, 1951). The Constitutio Criminalis Carolina of 1592 provided in section 134 for the punishment of physicians whose patients died because of their doctoring (Langbein, 1974). In the 17th century, Sir Thomas Browne, a country doctor in Norfolk, and author of the philosophical treatise Religio Medici, was castigated for his unorthodox religious views, his critics maintaining that Browne and other medical people downgraded religion because they were threatened by the fact that Christ and his disciples were superior healers. A patient "got more good by one touch of Christ's garments than by all the physicks she had received from those of your profession," one of Browne's critics argued (Wise, 1973:152). Antagonism to doctors in that period is captured by the title of a book of the time: The Conclave of Physicians, Detecting their Intrigues, Frauds, and Plots Against their Patients (Harvey, 1686).

A sample of medical practices that aroused public indignation in the 17th century—and does so today—is put forward by the same Sir Thomas Browne who had been accused of resenting theological competition in the practice of his trade. In the tirade below, Browne berates fellow practitioners who dupe patients into believing that analysis of their urine is the diagnostic wherewithal:

> Physicians...besides diverse less discoverable ways of fraud, have made [patients] believe there is a book of fate...in urines. They have recourse [to urine tests] as unto the oracle of life, the great determiner of virginity, conception, fertility, and the inscrutable infirmities of the whole body....They foolishly conceive we visibily behold therein the anatomy of every particle [of the body], and can thereby indigitate [determine] their diseases (Browne, 1646/1981:19).

Browne then raises a point closely related to some of the stresses associated with contemporary medical practice. Patients, he points out, come to

believe all physicians should be able to make proper judgments on the basis of urine tests because some physicians claim such skill: "they expect from us a sudden resolution in things wherein the devil of Delphos would demur, and we know hath taken...some days to answer easier questions." Thereafter, Browne deplores the fringe practitioners of his profession, those he calls "saltimbancoes, quacksalvers, and charlatans." (Browne, 1646/1981:19).

Finally, to place into context our review of crime in the practice of medicine, we can set down observations of Sir William Osler, generally acknowledged as the preeminent medical practitioner of the past century. Osler, it is said, "had the greatest contempt for the doctor who made financial gain the first object of his work" and "even seemed to go as far as to think that a man could not make more than a bare living and still be an honest and competent physician" (Cushing, 1940:177). Nonetheless, though he pointed out that there were doctors "who serve for shekels," Osler stressed that these were the "exceptions": the rank and file of practitioners was said to be "self-sacrificing" and to "labor earnestly" for the good of patients (Cushing, 1940:408). But at the same time, Osler located one of the primary sources of medical crime, the isolation and arrogance that can accompany medical pretice unattended by leavening influences. He wrote:

> No class of men needs friction so 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 (Cushing, 1940:447).

These age-old themes, then, form the background for our inventory and discussion of some of the major forms of law-breaking by physicians as part of their professional and vocational work. The conflict between service and self-serving behavior, the autonomy and power, and the structural form of medical practice all contribute to the nature and extent of the medical violations we will discuss below.

SUTHERLAND ON DOCTORS

The study of "white-collar crime," of which medical offenses form a part, was begun by Edwin H. Sutherland in 1939. In a path-breaking book on the subject, published ten years later, Sutherland accorded only passing mention to doctors. Interestingly, he maintained that he was focusing on physicians primarily because he believed they probably were more honest than most other professionals: therefore, he implied, their violations provided particularly important information for the formulation of an answer to the question of why persons who seemingly have no "real" or "true" need to enrich themselves illegally nonetheless do so. Sutherland also was interested in decimating theories of the time which insisted that Freudian complexes, immigrant status, and poverty "caused" crime: Doctors and other white-collar criminals, he noted, rarely manifested such traits. Sutherland then put on record a roster of the nature of some of the violations committed by doctors:

> ....illegal sales of alcohol and narcotics, abortion, illegal services to underworld criminals, fraudulent reports and testimony in accident cases, fraud in income tax returns, extreme instances of unnecessary treatment and surgical [illegible] restriction of competition, and

This litany of offenses is made more specific in a recent overview of medical law-breaking. It points out that 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, under which referring physicians receive an illegal kickback from the doctor performing the surgery. A 1966 government lawsuit alleged that the 4,500 doctors who own medical laboratories overcharged the public for tests and conspired illegally to keep everyone but themselves out of the medical laboratory business. In 1970, the Internal Revenue Service reported that about half of the 3,000 doctors who received $25,000 or more in Medicare and Medicaid payment failed to report a substantial amount of their income. A 1976 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 believed that at least two million or more were unwarranted. A later survey found that the rate of surgery on the poor and near-poor—financed by Medicaid—is twice that for the general population. It was estimated in this survey that the cost of unnecessary surgery in the United States is $3.92 billion (Meier and Geis, 1979:436).

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 (Lanza-Kaduce, 1980). In a 1984 case described as "shocking" by the judge, a California opthalmologist 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 programs 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 astounding how they could write these 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 in this case, the uneducated, Spanish-speaking people, some of whom will never see a sunrise or sunset again" (Welkos, 1984).

In the month of April 1984 alone, three major stories appeared in the national media which focused on episodes of physician improbity. A New York Times article (Lyons, 1984a) captured its theme in the opening paragraph: "Increasing evidence of widespread cheating and fraud involving the basic examination that doctors must pass before they are allowed to practice medicine is being reported by medical educators, state and federal officials and professional groups." Prices as high as $50,000 a copy were said to have been paid for examinations before they were to be officially administered. Copies of "Flex" [Federation of State Licensing Examiners] tests had been found on the person of students coming to take the exam in New York City. Later in April, it was reported by a news syndicate, based on a study by the Senate Subcommittee on Governmental Affairs, that "nearly one of every four medical school graduates who accepted millions in federal scholarship money broke their pledge to practice in small towns or inner cities where health care is scarce." ("Doctors, Dentists Not Keeping Word," 1984). And two weeks later, documents indicated that 2,000 fraudulent medical degrees had been granted to North Americans in schools operated in the Dominican Republic. At least "several

dozen" of these persons were found to be practicing medicine in the United States (Lyons, 1984b).

How widespread, then, is law-breaking by doctors as part of their work? We are far from knowing at this time because the violations are often extraordinarily difficult to detect, and intent almost impossible to demonstrate to the satisfaction of the law. An estimate by the past president of the Federation of State Medical Boards seems as accurate as any we are apt to get. He believed that:

> ...at least one physician in 20 is a severe disciplinary problem, that between 15,000 and 20,000 private practitioners (as many as one in nine) are repeatedly guilty of practices unworthy of the profession. Most of these physicians commit offenses that are unethical rather than prosecutable: substandard care, abandonment, overcharging and the like...If anything, [the figures] are too conservative (Lewis and Lewis, 1970:25).

CATALOGUING MEDICAL CRIMES

Few textbooks on deviance or criminology attend to offenses by physicians, probably because of the respect, power, and trust that the profession engenders. In addition, there has been little systematic investigative or social science work on the range of illegal medical acts. In part, this is because access to information is difficult to achieve since the strength of the profession has served to protect it from close scrutiny. In addition, doctors are essential for the public well-being and there is an understandable reluctance to antagonize a group upon whom all of us depend. The medical profession itself, represented by organizations such as the A.M.A., might have elected to move against its

malefactors forcefully—to clean up its own act—but has instead opted for profession-wide self-protection on the arguable assumption that publicized wrongdoing by any of its members reflects unfavorably on the image of all of them.

Below, we will set out a brief inventory of some of the forms of medical wrongdoing, paying particular heed to acts of fraud and abuse against Medicaid and Medicare, the two largest government medical benefit programs, because these offenses illustrate how new legal systems can offer new illegal opportunities and temptations and thereby "create" a contingent of wrongdoers. We might note in passing that doctors, of course, like the rest of the population, sometimes commit "traditional" kinds of offenses, things such as rape, robbery, and murder. There seems little doubt that occupational expertise at times plays a part in such acts: the general belief is that doctors, using knowledge and skills germane to their work, are literally able to get away with more murder than other persons. What is surprising are those instances in which physicians have been convicted of singularly inept slayings, particularly of their wives, such as in the case of Sam Sheppard (Holmes, 1961) and Jeffrey MacDonald (McGinniss, 1983). Such cases are apt to gain media notoriety, undoubtedly because of the professional status of the accused. Doctors also have on occasion incorporated traditional offenses into their office practice: in a notable study, Burgess (1981) reported how a gynecologist used his physical examinations to masturate patients, who were humiliated but uncertain about how to properly deal with such an assault, knowing, but not absolutely positive, that what was happening to them was not part of the regular examination protocol.

DRUG AND ALCOHOL ABUSE

The practice of medicine can be an intensely demanding form of work. General practitioners often are exposed to all forms of sickness—and catch some

of them themselves—work long and erratic hours, and see more human misery that anyone ought reasonably be exposed to. They are expected to make accurate decisions, often on less than adequate information: the consequences of error are liable to be much more serious for them than for most of the rest of us—unless, of course, we are the patient who is misdiagnosed or inadequately treated.

It is not surprising therefore that overuse of alcohol and drugs has been marked among physicians (see e.g., Wallot and Lambert, 1984). Only since the 1970s, however, has the problem of "sick" doctors been widely considered in professional and public forums.

Writing phony prescriptions for oneself and for friends may seem relatively harmless, but it can seriously affect a doctor's ability to handle his work satisfactorily. In addition, drug addiction can become a consuming passion, and the physician user can be drawn into black-market transactions, where his easy access to pharmaceuticals makes him notably important. The relationship of "pill" or "script" doctors and Medicaid fraud has been described in a vignette by Goldstein. Pete, a New York Bowery alcoholic, decided that he needed something to calm his nerves:

> He...walked three blocks to visit a doctor on Bleeker Street. The doctor's "office" was equipped with a desk, a chair, a stack of Medicaid forms, and a prescription pad. He handed the doctor his Medicaid card. The doctor wrote down that he had just given Pete a complete physical, four x-rays, a blood test, a urine-sugar test, and a test for venereal disease..."I'll take 300 Valium," Pete said after signing the form (Goldstein, 1982:42).

ABORTION

Involvement of physicians with abortion offers a particularly striking documentation of the relationship between legal codes and their bearing on the imperatives involved in the practice of medicine. The law in the United States until the Supreme Court decision in Roe v. Wade (410 U.S. 113, 1973) decreed that abortion was illegal. In England, interestingly, a doctor arrested for deliberately defying a similar statute was vindicated by the appellate court which declared that had he not performed an abortion for the woman he believed required one to save her life, he would have been prosecutable under the criminal law for negligent manslaughter (Rex v. Bourne, 3 All Eng. Rep. 615, 1938).

A recent study by Luker (1984) points out that the abortion controversy in the United States began in the 19th century. It had its roots in the successful efforts of physicians to establish a professional monopoly over medical services. In order to put their rivals out of business, the doctors found it tactically valuable to mount a campaign against abortion, which was widespread at the time. Abortion was targeted because its main practitioners—midwives and herbalists—could be branded as incompetent and immoral. The doctors were not particularly moved by the religious and philosophical disputation that now surrounds abortion; indeed, within Roman Catholicism, the stronghold of the antiabortion movement, the church had been divided for millenia over the issue. In early times, Catholic church authorities held that abortion during the early months of pregnancy did not constitute an ecclesiastic offense. The dividing line between "early" and "late" pregnancy was 40 days after conception for a male fetus and 80 days for a female fetus. In practice, since it was impossible to determine the sex of the fetus, 80 days became the latest time for sanctioned abortions. This early church position was abandoned in 1869, when Pope Pius IX put forward the doctrine of "immediate animation" of the fetus and declared

that both early and late nonspontaneous abortions were acts of homicide (Geis, 1972:94). In the United States, a physician campaign between 1850 and 1890 led to every state in the union enacting a law stipulating that abortions could be carried out only by medical doctors and only when a pregnancy threatened the mother's life.

Despite the pre-1973 legal prohibition in the United States, a study of 388 obstetricians found that 10 percent admitted that they referred patients to abortionists, an illegal act, and they guessed that 14 percent of their colleagues did so too (Lader, 1965). A later study by Zimring (1972), done in Hawaii after abortion had been liberalized (and therefore more honest responses about earlier behavior might have been forthcoming), found that about half the potential demand for illegal abortions had been satisfied on the island. Zimring offers the following interpretation of his finding:

> Part of the explanaton for the high rate of referrals by physicians in Hawaii was the availability of foreign abortions [in Japan], referral to which rendered the physician free of criminal liability. But [the data] shows a high rate of in-state and unexplained referrals as well as referrals abroad. It seems likely that the doctors did not fear criminal liability for referral as much as one might expect, and it may well be that these doctors were correct in thinking that they ran few risks in the referral process (p. 720).

No information is available on the number of doctors who themselves performed abortions on their patients, persons they might have known for some time or whose families they were acquainted with. Such procedures could be carried out, sometimes even unbeknownst to the patient, as part of a routine D &C (dilation and curettage) process. In the instance of abortions, we see the

ideological and humanitarian impulses of physicians pushing them into law-breaking. They may have felt that, despite the law, they "owed" the referrals to patients, or they may have sympathized with the patients' interests.

FEE-SPLITTING

Fee-splitting is a widespread medical practice, though illegal in many states. It involves a kickback, usually to a general practitioner who refers patients to a surgeon or a specialist. Fee-splitting grows out of the market conditions in the practice of medicine; it apparently was even more common in America at the turn of the century than now (Myers, 1960). Sutherland made the following points about fee-splitting as white-collar crime:

> The physician who participates in fee-splitting tends to send his patients to the surgeon who will split the largest fee rather than the surgeon who will do the best work. The report has been made that two-thirds of the surgeons in New York City split fees and that more than half of the physicians in a north central state who answered a questionnaire on this point favored fee-splitting (1949:12).

Besides lowering the quality in the performance of operations, and tending to increase those that are unnecessary, fee-splitting obviously raises the cost of medical care. It restricts competition, works against excellence, inflates health costs, and increases the number of unneeded operations, inevitably maiming and killing some patients. As Whitman (1953:24) has noted, the best financial arrangements—which tend to dictate fee-splitting choices—are those apt to be associated with the worst care:

> In areas where fee-splitting is rampant, kickbacks range as high as 60 and 70 percent. The less skilled the surgeon, the higher the kickback he must give in order to get business.

> Thus split-fee cases gravitate to the highest bidders, the worst surgeons (p. 24).

A patient is merely a pawn in such arrangments, involved for the purpose of enriching both physicians. Fee-splitting, nevertheless, remains alive and well in the practice of medicine today, is carefully camouflaged, and usually surfaces only when a repentant or conscience-stricken doctor comes forward and speaks to authorities.

MEDICARE AND MEDICAID FRAUD AND ABUSE

Another area of physician violative behavior that has come to the fore recently is that involved in fraud and abuse directed against government medical assistance programs (U.S. Senate, 1976; Lee, 1978; Pontell et al., 1982). Medicare is the federally funded program designed primarily for the elderly, while Medicaid is predominantly state funded and administered largely for the benefit of the needy. These programs created new medical malefactors. There would be no point, for instance, in performing extensive diagnostic tests upon a poor person unable to meet their cost: but if an insurer will pay the charges there is a great deal to be gained by doing as much work, needed or not, and doing it as cheaply as possible. Bills have been submitted for payment by doctors which proved on investigation to be for x-rays done without film, blood and urine tests never analyzed, and treatments much different—and more expensive—than those that were actually carried out.

Psychiatrists, who constitute 18.4 percent of the Medicare and Medicaid violators, the most disproportionate number for any medical specialty, have been caught charging for individual therapy for patients seen as a group, for analytical treatment which proved to be sexual dalliance between patient and doctor, for "therapy" when what was done was only the writing of drug prescriptions. The high rate of apprehended psychiatrists seems to stem in particular from the fact

that they bill for time rather than services, and therefore are easier to catch when they inflate charges. Indeed, several psychiatrists have been caught because they billed the government for therapy sessions for hours far in excess of those in a day (Geis, et al., 1984).

The fee-for-service structure of the benefit programs, built upon typical medical payment procedures, makes it easy to overcharge, double-bill for services, pingpong (send patients around to other physicians for additional treatment), family gang (request to see members of a patient's family, even though unnecessary), to prolong treatments, and to carry out additional fraudulent schemes. Fee-for-service can contribute to the disintegration of ideals and altruism among physicians, as Keisling (1983) has noted:

> ...fee for service medicine subtly corrupts its own practitioners. Motives for entering medicine are many and complex but the strongest is the desire to be a healer....Unfortunately, the feelings of dominance that inevitably accompany the healer's role frequently overpower whatever native idealism a doctor might have brought to his profession. The grueling 100-hour weeks spent as a resident encourage him to feel unappreciated for his important work. As he gets older, he also begins believing that the same power and respect he commands in the office or operating room should extend into the community, where the badges of success and status, instead of centering on the value of one's work, center on material possessions and social standing. And as the fee-for-service system combines with the doctor's revered status to make these things so accessible, what increasingly becomes important are not the satisfactions of

> medicine itself but the benefits that result from practicing it. For these doctors, stories of million-dollar incomes do not provoke outrage, but envy (p. 30).

Besides the conflict created by the physician's role as both "healer" and "entrepreneur" under the fee-for-service system, there is also a conflict between the dictates of government regulation and the desire of the profession to remain autonomous. It is maintained that "outsiders" never can adequately appreciate the way physicians act, and that these outsiders impose rules that handicap treatment. In addition, government programs are apt to have relatively low reimbursement rates, payment delays, and what are considered to be excessive red tape and paperwork requirements. Officials insist what they do is necessary for proper accountability; doctors prefer private health care where the marketplace and their own interests operate more freely (Waitzkin, 1983). The inability of the aged to bear unaided the costs either of adequate private insurance or, assuredly, of uninsured medical expenses was largely responsible for inauguration of programs such as Medicare. These programs have contributed to the escalating income of doctors, well in excess of inflation rates, but they also have allowed the government to bring its enforcement arm to bear on unearthing medical violators and to tarnish the image of a profession already undergoing a decline in esteem.

The extent of fraud associated with benefit programs is believed to be extremely high. A recent case involved overpayment of more than half a million dollars to three California physicians (Los Angeles Times, October 20, 1983). Officials believe that between 10 and 40 percent of programs monies are lost to fraud and abuse—a sum that would be in the range of $10 to $40 billion dollars annually.

ISSUES OF CONTROL

Many of the same issues that generally confront efforts at control of white-collar crime apply as well to physician violations. The transgressors are usually highly intelligent, and able to manipulate the system cleverly for their own gain. They have resources to allow them to hire excellent attorneys for their defense if they are apprehended. Their acts are of such a nature that it often becomes difficult to demonstrate to the satisfaction of the law and beyond a reasonable doubt that they were done with criminal intent. Juries often to not like to convict doctors, particularly in small towns, where their services may have built up a grateful clientele.

In the government health care field, criminal sanctions have come to be regarded as possible only in cases of the most egregious nature. These would involve very large sums, or injuries or death, many cooperative witnesses, and a paper trail that implicates the doctor beyond any possibility of rebuttal. Much more often recourse is had to civil sanctions, and more recently, the federal government has authorized the imposition of triple money penalties for doctors who abuse benefit programs. As yet, no systematic research exists on the efficacy of these newer penalties: it remains arguable whether the greater likelihood of their imposition outweighs the fact that they will be seen as milder than criminal proceedings.

Pre-paid health care systems would likely reduce costs of medical care significantly, and there now are underway efforts to restrict the reimbursement permissable to the hospitals for particular kinds of medical services. The ingredients of violative behavior would be reversed under a prepaid regimen. Doctors would be rewarded for skimping on services, since they would receive the same payment whether they did a great deal of work or very little. This would then require strict monitoring of the quality of care, a difficult matter

involving considerable personal judgment, if the new approach were to become an improvement over fee-for-service arrangements (Luft, 1982).

CONCLUSIONS

The current roster of physician offenses as part of their professional activity include overcharging, absence of adequate care for patients, needlessly prolonged treatment, incompetence, fee-splitting, and the ordering of unnecessary and expensive tests, to name but a small part of their law- and rule-breaking.

The discovery of such behavior, as with most white-collar crime, tends to be complicated and highly uncertain. The status of doctors precludes the rough and insensitive treatment often accorded to street offenders. As a federal agent has noted:

> U.S. attorneys are extraordinarily kind to doctors, because even if they are crooks, theoretically they're still providing some useful services for the community... . There's a double standard for doctors because there aren't many other categories of white-collar criminals that are looked upon as a community of people who save lives (Personal interview).

It is believed that the practice of medicine is marked by an esprit d' corps that limits effective discovery of medical aberrance. Doctors are reluctant to testify against fellow practitioners, though such reluctance itself may violate ethical norms. Medicine also has a requirement of confidentiality, designed to protect patients, and this demand can inhibit taking action against wrongdoing, as Stone has observed:

> ...psychiatrists have an ethical obligation to expose colleagues who sexually abuse their patients. However this

> obligation often conflicts with the ethical obligation of confidentiality.... When a psychiatrist is publicly exposed because of such abusive conduct, it often turns out that a substantial number of his or her colleagues acknowledge (usually in confidence) that they had long known of this unethical conduct (p. 185).

An obvious question concerning medical criminality is "Why, given selection procedures, training, and fiscal rewards associated with medical practice, are there deviant and criminal physicians?" There is no one answer to this question, just as there is not one kind of medical crime, nor one kind of doctor who practices medicine. Explanations will vary depending on the case at hand.

Some doctors believe that a growing number of individuals chosen for medical school may not be endowed with altruistic motives for practicing medicine. A director of pediatrics residency at a large hospital presents his feelings in the following way:

> Because of my personal background and my professional feelings, I still put in sixty or eighty hours a week. But I have a very difficult time finding responsible people who feel the same way I do to help me take care of my patients. By my standards, most practicing physicians and young physicians in training—regardless of what the new youth are saying—are primarily interested in ripping off the public and getting power.... In the residency program, it's exhilarating to see the brilliance, concern and conscientious output of the same percent of residents now as there were when I started twenty years ago. On the other hand, twenty years ago, I would have

> one, two, at the most three people whom I would consider avariciously motivated monsters. My experience is that this group is now five to ten times larger than it used to be—comprising 25 to 30 percent of the trainees. These people are taking advantage of the system, of their colleagues, of the nurses that work with them, and of their patients. Some of them are just peculiar nuts who want to go to medical school and get some kind of graduate degree because they want to prove they can do it. The system has created a challenge for these people—they go into medicine as "the highest profession" (Rabinowitz, 1981:60).

The seeds of many medical crimes probably are sown early on during medical training. As Becker (1961) and his colleagues have observed, idealism inevitably gives way to cynicism during medical education, partly as a means of survival. Becoming a doctor also involves nurturing a great degree of self-confidence, which can also manifest itself as a feeling of invulnerability. Given the tremendous amounts of illegal money at stake and the relative ease in obtaining it, simple greed undoubtedly influences law- and rule-breaking.

Therefore, as physician power and authority have increased during the past half century, both in absolute terms and vis a vis other social groups (Starr, 1982), professional transgressions may also have increased. The doctors' enhanced power serves to protect the practice of medicine from adequate supervision. Physicians are likely to be more deterrable than most offenders—they have much more to lose. The need is to inaugurate a fair and effective method to monitor and punish their behavior in a manner that will be conducive to first-class health care, honestly delivered. We noted earlier that Sutherland had chosen to examine physician offenses because he believed that medical

practitioners were probably more likely to be honest than members of other professions. The verdict is not yet in on that issue, but we have provided evidence suggesting that, while Sutherland's observation probably was correct fifty years ago, it may no longer be accurate today.

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A DEMOGRAPHIC PORTRAIT OF PHYSICIANS SANCTIONED BY THE FEDERAL GOVERNMENT FOR FRAUD AND ABUSE AGAINST MEDICARE AND MEDICAID

Running Head: Aid Program Fraud and Abuse

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The authors wish to thank the National Institute of Justice, U. S. Department of Justice, for a grant which made the work upon which the paper is based possible. They also want to thank Carol Wyatt for typing assistance.

(SUBMITTED FOR PUBLICATION)

ABSTRACT

Characteristics of 147 physicians sanctioned by the federal government for Medicare and Medicaid violations were tabulated by use of the American Medical Directory and correspondence with state licensing boards. Statistics indicate an escalating enforcement effort. Black and foreign-medical school graduates are overrepresented among the sanctioned physicians, possibly because, as inner-city practitioners, they represent the easiest enforcement targets. Psychiatrists were most overrepresented among specialties, seemingly because, by inflating time rather than services, they are more easily apprehended than other specialists.

Both state and federal authorities recently have stepped up their efforts to police the Medicare and Medicaid programs. An Office of Inspector General has been created in the Federal Department of Health and Human Services (DHSS)[1] to fight fraud and abuse[2] in government aid programs. Also, thirty states have established Medical Fraud Control Units to monitor Medicaid.[3] Tougher civil recovery statutes also have been enacted to aid in the recoupment of monies lost through fraud.[4,5]

There is no reasonable method for determining the precise extent of fraud and abuse involved in the two major medical benefit programs. As with all law-breaking, the "dark figure" of unknown violations can only be estimated by extrapolation from events which come to the attention of the authorities.[6] For street crimes, such estimates are informed by Census Bureau surveys of households which inventory victimization.[7] For white-collar crimes, such as fraud against benefit programs, calculations prove much less satisfactory, in large part because victims—patients and carriers—themselves typically remain unaware of the violations.[8] Government authorities sometimes suggest that from 10 to 20 percent of the $87 billion combined cost of the Medicare and Medicaid programs is lost to fraud and abuse, but such guesses cannot be accorded much credence. Two different federal investigators in interviews with us used piscatorial images to convey what they believed to be the large amount of violative behavior unreached because of limited enforcement personnel. One said that his agency's detection work, particularly in earlier days, was as simple as "fishing in a barrel,"[9] while another insisted that the providers detected are only the most egregious, "the ones who jump into the boat."[10] Fraud, whatever its true extent and cost, deprives patients of needed care by draining off resources. On occasion, too, physicians in pursuit of Medicaid funds have injured patients: early in 1984, for instance, a California opthalmologist was convicted of

performing unnecessary eye operations in a scheme to defraud the state that left 14 patients with impaired vision.[11]

This paper provides information about physicians found to have violated the laws regulating practice under Medicaid and Medicare. The names of 358 providers appear on the lists issued since November 1977 by the Federal Health Care Financing Administration of persons excluded from participation in Medicare or Medicaid because of fraud or abuse. The law requires that any physician or other health care professional convicted of a crime related to participation in Medicare, Medicaid, or other social services programs will be suspended from participation in the programs. Of the total of 358 providers, 147 were identified as physicians.

Table 1 indicates the number of cases from late 1977 through 1982, the last full year for which figures were available. Except for 1981, the number of suspensions and expulsions has been rising each year, with the 49 cases for 1982 higher than for any other 12-month period. The increase is believed by enforcement authorities to be related to stepped-up efforts rather than to changes in physician behavior.

METHOD

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. All states responded except New York. We had been able to obtain information from the Directory about all but four of the 25 New York doctors sanctioned.

RESULTS

Of the 138 physicians for whom we were able to determine where they had received their training, 50 (36%) were foreign medical school graduates. They had attended 41 different schools. Six schools had more than one graduate among the sanctioned

doctors. Three physicians had graduated from the University of Havana, and two came from each of the following schools: Central University of Manila; Far Eastern Institute of Medicine, Manila; University of Innsbruck; University of Bologna; and the Medical University of Neuvo Leon in Mexico.

Among the 88 domestically-trained doctors, Meharry Medical College had trained six, followed by the University of California, Irvine (5); Loma Linda in California (4), and the University of Louisville (3). Fifteen other schools had two graduates on the list. These included such preeminent institutions as Johns Hopkins, the University of Wisconsin, UCLA, Tulane, New York University and Columbia.

California accounted for 41 sanctioned doctors (28% of the total), followed by New York with 25 (27%). Thereafter came Maryland with 8, Florida and Pennsylvania 7 each, Texas 6, and Michigan 5.

Family or general practitioners, as Table 2 shows, accounted for the greatest percent of violators (27%), followed by psychiatrists (18%), general surgeons (11%), internists (8%), and obstetricians and gynecologists (7%). The "other" category includes 13 specialties with only one or two offenders.

DISCUSSION

This is the first profile of physicians sanctioned for practices in violation of Medicare and Medicaid laws and regulations. Like most statistics portraying law-breakers, the results undoubtedly tell 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 by computer checks 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 high degree of discretion about what cases will be accepted. Overutilization cases, for instance, because they are apt to involve a labyrinthic "paper

chase," receive much less attention than cases in which bills are submitted for services never rendered. These are the kinds of mattters that influence the nature of the persons apprehended by the authorities.

That Meharray Medical College, with its very high black student enrollment,[12] accounts for six violators is striking. Black doctors now make up about 2.6 percent of the 400,000 physicians practicing in the United States.[13] The disproportionate number of foreign graduates is also notable: they constitute about 25 percent of doctors at work in the U.S.,[14,15] and 34 percent of the violators.

These results seem to reflect in some measure the heavier concentration of black and foreign graduates in inner-city work, where Medicaid mills are apt to flourish,[16] and where practitioners may be most apt to feel the need—and possess the self-excusatory rationalizations—for cheating in order to compensate for the lower fees offered to those who treat aid program patients. In New York City, foreign trained doctors outnumber domestically-trained.[14] U. S. Senate investigators, "shopping" some of the City's "mills" with feigned ailments, usually described as a cold to the physicians, found themselves subjected by 85 different doctors they visited to 18 electrocardiograms, 8 tuberculosis tests, 4 allergy tests, hearing and glaucoma tests, and three electroencelphalograms. They found that 7 percent of all doctors participating in New York's Medicaid program were receiving 50 percent of the funds going for physicians' services in the city.[16]

Nonetheless, other studies indicate that by no means can large Medicaid practices be regarded as necessarily fraudulent.[17] It may be that they are more vulnerable, or that greater enforcement resources are focused upon their work. In street crime statistics, black and ethnic minorities constitute a heavily disproportionate segment of the offending population. But this is because they commit the kinds of acts that are more readily detected, and which find their way into the numerical tabulations of criminal activity.[18] White-collar offenses, such as antitrust violations, toxic waste disposal offenses, and similar kinds of acts, are believed to impose higher costs and more

serious injuries on the population than the street offenses, but their perpetrators are less rarely acted against because, among other things, the cases are more complicated, tougher to win and intent is difficult to establish.[19] It remains arguable, then, how truly those doctors snared represent the universe of physicians violating against Medicare and Medicaid.

Psychiatrists are by far the most heavily overrepresented among the specialties, and this again may indicate something about enforcement tactics and, perhaps, something about psychiatrists as well. Psychiatrists constitute about 8 percent of American medical practitioners,[20] and participate less than almost all other specialists in aid programs.[21] Nonetheless, they account for 18 percent of the violators. This undoubtedly is partly a function of the fact that their cheating takes the form of inflating the amounts of time spent with patients (rather than in regard to services performed), and that such kinds of cheating on time are much easier to detect than other forms.

Government medical benefit programs represent a significant exposure of physicians to public scrutiny and control. As Thompson notes: "Medicaid...has...provided an entree for greater government regulation. Medical providers have been compelled to accept greater assessment and review of their services. The playing of the easy money game by some providers has tended to undermine claims that the medical profession should regulate its own house."[22] The indications are that escalating health care costs, combined with budget-consciousness at all government levels, will lead to increased attention to detection of fraud against benefit programs. Such resources might better be used to expand access to health care, but they obviously will not be so employed until there is compelling evidence that the fraud levels are minimal.

Table 1

Physician Suspensions/Exclusions From
Medicaid and Medicare Under Sections 1128,
1160, 1862(d) and 1862(e) of the Social Security Act

Year	Suspensions/Exclusions
1977*	3
1978	22
1979	23
1980	30
1981	20
1982	49
Total	147

*November and December only

Table 2

Physician Suspensions/Exclusions From
Medicaid and Medicare by Medical Specialty
November 1977 Through December 1982

Medical Specialty	Suspensions/Exclusions	Percent
Family, General	40	27.2
Psychiatry	27	18.4
General Surgery	16	10.9
Internal Medicine	11	7.5
Obstetrics/Gynecology	10	6.8
Specialized Surgery	5	3.4
Pediatrics	4	2.7
Osteopathy	3	2.0
Anesthesiology	3	2.0
Other	18	12.2
Not Known	10	6.8
Totals	147	100.0

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MEDICAL STUDENT ATTITUDES TOWARD PHYSICIAN FRAUD AND ABUSE IN MEDICARE AND MEDICAID

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This research was supported by a grant from the National Institute of Justice, U. S. Department of Justice (82-IJ-CX0035). The views expressed are those of the authors and do not necessarily reflect the position of the Department of Justice. An earlier version of this paper was presented at the annual meeting of the Western Society of Criminology, San Diego, February, 1984.

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ABSTRACT

This paper reports the findings of a survey of medical students at the University of California, Irvine, regarding their views toward Medicare and Medicaid, and toward the problem of fraud and abuse in government medical benefit programs. Students were questioned about four main issues: (1) the quality of government benefit programs; (2) the seriousness and prevalence of physician fraud and abuse; (3) the punishment of violators; and (4) the causes and prevention of fraud and abuse in government programs. They viewed fraud and abuse as serious but not as widespread. They believed that physicians who violate program regulations are not likely to be sanctioned by official agencies. Students favored moderate penalties for violations. Explanations for fraud and abuse focused on physician attitudes and motivations as well as on the structure of government benefit programs. Suggested strategies for prevention included better monitoring of billing claims as well as modifications in program structure which would more effectively address concerns of physician providers.

MEDICAL STUDENT ATTITUDES TOWARD PHYSICIAN FRAUD AND ABUSE IN MEDICARE AND MEDICAID

Medical school is regarded as the most intensive phase of professional socialization (1), and as a major influence on the career paths of physicians (2,3). Research has examined a number of aspects of the medical schooling, including career choices and specialty emphases (1), student culture (4), development of a professional self image (5), and the effects of medical education on student values and professional orientation (6). The studies tend to focus on general attitudes held or acquired by medical students, such as their degree of "idealism" or "cynicism." The present inquiry instead focuses on student views concerning a specific aspect of government regulation of the professions--fraud and abuse by physicians who participate in Medicaid and Medicare. The results reflect both medical students' professional orientations and the attitudes that will help shape the behavior of a number of them as providers of government-subsidized health care.

Research is only beginning to focus on offenses committed by physicians participating in Medicaid and Medicare (7). Pontell et al., (8) describe two types of physician violations. The more serious is fraud, which involves the intentional stealing of government program funds. It would include, for instance, billing for services not performed. Regarded as less serious, but believed to be more widespread, are abuses by physicians who use government benefit program structure to maximize their economic gain. Program abuses often take the form of overutilization, such as performing unnecessary tests and treatment or sending patients from one specialist to another, called "ping-ponging." The effects of such practices on the patients' health are at

best arguable, and their impact on government program budgets is clearly negative. New enforcement efforts have been launched at both the state and federal levels to curb fraudulent and abusive practices by health care providers (9).

The present paper explores how violative behavior patterns might develop during formal medical training. It is based on the idea that physicians may first learn about professional norms and ideologies concerning government health programs during their professional socialization. Lanza-Kaduce (10) used such a "learning framework" to explain how physicians adopt deviant behaviors in the course of their medical practices, asserting that "definitions and behaviors are learned in...groups comprised of colleagues in medical school, hospitals and practices" (352).

We were interested in the following issues as they relate to the problem of fraud and abuse by physicians in Medicare and Medicaid: (1) how much students know and have developed opinions about government health programs; (2) what they felt were the causes of fraud and abuse; (3) how they rated the seriousness of such behaviors; (4) their views about the prevalence of the problem; (5) how familiar they were with official sanctioning processes; (6) what sanctions they felt were needed and/or proper; and (7) how they assessed the overall quality of government health programs.

DATA AND METHOD

Surveys were distributed to 350 medical students enrolled at the University of California, Irvine, during the spring of 1983. Two methods of implementation were used to adjust for differences in students' academic schedules. First and second year students completed the questionnaire on the medical school campus between classes. Third and fourth year students, who

were involved in clinical training at several area hospitals, received the questionnaire in their mailboxes, located at the UC Irvine Medical Center. Reminders were placed in the mailboxes both one week and two weeks after the initial mailing, urging students to return the completed survey to a "drop box" in the mailroom.

The questionnaire contained both open- and closed-ended items. Open-ended items asked students to state what they felt to be the causes of physician fraud and abuse, and possible ways to prevent such practices. Closed-ended items asked students to rate the quality of government health benefit programs, the seriousness and prevalence of fraud and abuse, and the likelihood that physician violators would be sanctioned by various agencies. An additional set of items asked students to select from a list of eight possible penalties what they felt to be the most appropriate penalties for three hypothetical cases of fraud and abuse.

Frequency distributions and other descriptive statistics were used to create a profile of students' views, and Pearson product-moment correlations to examine interrelationships among students' responses. The views of students from different years in medical school were compared to see if any changes were apparent between first and fourth year students.

One hundred and forty-four students responded to the survey, producing an overall response rate of approximately 36 percent. The rate of return presents some problems for internal validity that will be addressed later. The response rate was considerably higher for first and second year students who completed the survey in a more controlled group setting. Fifty-eight percent of the respondents were male, and 37 percent were female.

RESULTS

(1) The Quality of Government Health Benefit Programs

Students rated the aspects of the programs on a 5 point scale, with 1 being "poor" and 5 being "excellent." The program components rated were: (1) overall quality of care delivered; (2) ability to reach all those in need of services; (3) cost effectiveness; (4) reimbursement scale; and (5) program efficiency. The scores ranged from 2.95 for "quality of care delivered" to 1.73 for "program efficiency." Administrative aspects of the programs (cost effectiveness, reimbursement scale, and program efficiency) all received lower ratings than both "quality of care delivered" and "ability to reach all those in need of services." Students showed the greatest consensus in their ratings of "program efficiency," the lowest rated aspect of the program. An additional item asked students to rate the relative overall quality of Medicare versus Medicaid on a 5 point scale, with 1 being "Medicare much worse," 3 being "Same," and 5 being "Medicare much better." The mean response for this item (3.35) indicates that students viewed Medicare as slightly better in overall quality than Medicaid. Program ratings were consistent between classes and sexes, with the exception of the reimbursement scale item which was rated significantly lower by fourth year students than by first through third year students (fourth year = 1.93, first through third year -1.46, $p < .05$). Fourth year students also saw a greater difference in the quality of Medicare and Medicaid (rating Medicare as better in overall quality) than first through third year students (fourth year = 3.90, first through third years = 3.22, $p < .05$).

Table 1 about here

For all program ratings listed in Table 1, between 1% and 28 percent of the respondents indicated that they "didn't know" how to rate the program. In each case, more than 80 percent of the "don't know" responses came from first and second year students.

(2) Seriouness and Prevalence of Fraud and Abuse

Students rated the seriousness of these violations on a scale from 1 (not serious) to 5 (very serious). The results show that both types of violations are rated relatively seriously, with fraud rated as slightly more serious than program abuse (fraud=3.84, abuse=3.44, $p < .05$).

Students rated the prevalence of physician fraud and abuse on a four-point equal internal scale ranging from 1 (less than 20%) to 4 (61-80%) Most students estimated that the percentage of physicians engaging in some type of program violation is less than 20 percent. Mean estimates of involvement were significantly higher for program abuse than for fraud (abuse=1.72, fraud=1.29, $p < .05$). Taken together, these two findings indicate that students view physician fraud as more serious but less prevalent than program abuse.

(3) Sanctioning of Physican Violators

As Table 2 shows, students gave consistently low ratings to the likelihood that program violators would be negatively sanctioned by some official agency. Students viewed the programs themselves as the most likely to impose sanctions (2.32), followed by civil authorities (2.10), state licensing boards (2.04), criminal authorities (1.96), and local medical societies (1.95).

Table 2 about here

Students also were presented with three hypothetical cases representative of actual case histories, and were asked to select the three most appropriate penalties for each case. Case #1 involved billing for services that were not performed ($4,000 worth over a one-year period). Case #2 involved overutilization of program services, that is, billing for unnecessary laboratory tests and x-rays ($21,000 worth over a three-year period). Case #3 involved a psychiatrist who billed Medicaid for $5,000 worth of psychiatric treatment for a patient with whom he was involved in a sexual relationship.

Table 3 contains the response frequencies for the eight possible penalties imposed for program violations. The total frequencies for each penalty represent the total number of times that penalty was selected as a first, second, or third choice over the three cases. These frequencies appear to form four clusters. Monetary penalty (n=298) and suspension for the program (n=248) were selected far more often than any other penalty. Community service and warning from the program form a second cluster with total frequencies of 148 and 134 respectively. A third cluster consists of criminal probation (n=109) and loss of medical license (n=91). Finally, incarceration and no penalty were selected least often, each showing a total frequency of 31.

Table 3 about here

Some significant variations are noted in the response frequencies for the three hypothetical cases, Monetary penalty and community service were

selected far less often in Case #3 (the psychiatrist) than in Case #1 or Case #2. In addition, Case #3 showed considerably higher response frequencies for loss of medical licence, incarceration, and no penalty, and three times the number of missing responses than for either Case #1 or Case #2.

While the response frequencies for most penalties appear to be quite similar for Case #1 and Case #2, an analysis of students' first two penalty choices for each case resulted in significant differences between these two cases. Students gave significantly harsher sanctions for Case #1 which involved billing for services not performed (fraud) than for Case #2 which involved overutilization of program services (abuse), or for Case #3 (the psychiatrist). Penalty selections for Case #2 were also more severe than for Case #3, but the difference here was not significant. Students were consistent in their penalty selections over classes, with the one exception that fourth year students selected "warning from the program" (the least severe penalty) more often than first through third year students.

(4) Possible Causes of Fraud and Abuse

Factors that contribute to fraud and abuse by physicians can be grouped under four headings: (1) the structure of the programs; (2) the nature of the violations; (3) the violators; and (4) the recipients. Statements referring to the structure of government programs constitute the largest category of responses (35.2%). Students specified four structural features which they believed "promote" fraud and abuse among physician providers: low reimbursement rates (n=19), inefficiency and red tape (n=18), lack of adequate monitoring procedures (n=10), and program rules which are too restrictive (n=5).

Almost a third of students' causal explanations referred to some aspect of the violation itself; that is, they explained "how" rather than "why" fraud

and abuse occur. Thirteen students cited charging for services not rendered as "causes" of fraud and abuse. Eleven students pointed to "overuses of lab tests and treatments." Twenty-three students stated that fraud and abuse occur because such acts are "easy to get away with" in the context of government programs. While this response refers to the act itself (i.e., it is easy to get away with), it also refers to the structure of the programs (i.e., they provide opportunities for abuse), and to the sanctioning process (i.e., it provides no effective deterrent to such acts).

A little over a quarter of the students mentioned physicians' motivations, attitudes, or deficiencies as causal factors leading to fraud and abuse. "Greed" was the most frequently cited factor in this category (n=20), followed by "lack of ethics and responsibility" (n=9), and "feeling justified in cheating because the program abuses physicians" (n=9).

Seven students cited abusive behavior or ignorance on the part of the program recipient as a cause of fraud and abuse in government programs.

Eighty-eight out of 144 respondents suggested at least one strategy for preventing fraud and abuse in government programs. The most frequently suggested preventive measure was "increased surveillance of physician billing claims" (n=28), followed by "increase the rate of reimbursement for physician services" (n=19), "better enforcement and prosecution (n=14), "harsher penalties for confirmed violators" (n=14), and "simplify the billing procedures" (n=9). Other suggestions included "increasing program regulations" (n=8), "patient verification of services rendered by physician" (n=7), and "discontinue the programs altogether" (n=6).

DISCUSSION

What can we infer from these findings about medical students' attitudes toward physician fraud and abuse in government health benefit programs?

First, it can be noted that the students view government programs in the same unflattering light as practicing physicians. They give Medicare and Medicaid low ratings, especially on administrative dimensions (program efficiency, reimbursement scale, and cost-effectiveness). The tendency to rate Medicare as better in quality than Medicaid is also consistent with practicing physicians' views (11,12).

Students' mean ratings were fairly consistent between medical school classes, suggesting that medical education has no significant effect on views or the issues considered here. This conclusion must be qualified, however, by the fact that a significantly larger percentage of first and second year students responded "don't know" on all scaled items. This suggests that students learn something about government programs during medical school, even if their general views do not change drastically. Amidst this pattern of consistency, however, we find that fourth year students provide significantly lower ratings for government program reimbursement scales. This could be due to the fact that students have little knowledge of program reimbursement scales until their final year of medical school, or to a change in students' attitudes toward government fees for service. Certainly, the fee schedules are apt to have more imminent personal meaning to the fourth year students than to members of other classes.

Students viewed physician fraud and abuse as relatively serious problems, but not as common practices. Most students estimated that less than 20 percent of physician providers engage in fraud or abuse. Students

distinguished between fraud and abuse, rating fraud significantly more serious and less common than abuse. They sanctioned a hypothetical act of fraud (Case #1) significantly more severely than an act of program abuse (Case #2). This was true despite the fact that the hypothetical fraud case involved only one fifth the amount of money as the case of program abuse.

Respondents explained the causes of fraud and abuse in terms of psychosocial, structural, and situational factors. While roughly 20 percent of students' responses cited "greed" or "lack of ethics and responsibility" on the part of the physician as causes of fraud or abuse, more than 50 percent pointed to situational or structural factors as contributing to the problem. Many students believe that violations occur simply because they are easy to get away with. Several students maintained that physicians may feel justified in their actions because they perceive the programs as being unfair and abusive to the profession. It is interesting to note that in citing several program features (e.g., reimbursement scale, red tape, and inefficiency) as "causes" of physician fraud and abuse, medical students shifted the responsibility for these acts from the individual perpetrator to the organizational context within which they are committed.

Students reported that physicians were unlikely to be penalized for program violations, which corroborates their view that violations occur because they are easy to get away with. While very few students supported the idea that physicians should not be sanctioned for program violations, the majority favored moderate penalties for such acts. Although the dollar amounts cited in the hypothetical cases were significant (ranging from $4,000 to $21,000), most students felt that monetary penalties, suspension from the program, community service, or simple warning were sufficient punitive responses. These penalties were selected far more often than others which would clearly involve either criminal labeling (e.g., probation), deprivation

of liberty (e.g., incarceration), or interference with work (e.g., loss of license). It remains an open question whether students would support similar penalties if they were dealing with cases of fraud and abuse perpetrated by program recipients.

Suggestions for preventing fraud and abuse focused on deterrent measures and program structure remedies. Students advocated both general and specific deterrents, including increased monitoring of physician billing claims, better enforcement and prosecution, and harsher penalties for confirmed offenders. If physicians perceived a greater risk of suffering severe consequences, it is believed, they would engage in fraud and abuse less often. The discrepancy between a general advocacy of tougher measures and support of milder sanctions for particular cases is not uncommon, especially in regard to offenses in the so-called "white-collar crime" area (13).

In addition to deterrent measures, students cited specific structural changes in government programs which could help prevent fraud and abuse. These changes would address the focal concerns of physician providers by increasing reimbursement rates and simplifying billing procedures.

Interestingly, only one out of 144 respondents cited education as a means for preventing fraud and abuse, calling for courses in medical ethics during medical school. While past research has cast considerable doubt on the efficacy of programs that attempt to change students' values or professional attitudes (14), it is still surprising to find that students do not view medical education as a potential vehicle for change in this area. Perhaps students already identify so strongly with the physician's role that to advocate formalized training in medical ethics might seem to imply that they believe that physicians are somehow deficient in their ethical standards.

SUMMARY

The validity of these survey findings is somewhat marred by the low response rate, especially among third and fourth year students. Differences in the response rate of medical school classes may be attributed to variation in students' willingness to participate in the study and to the methods used to administer it. The final sample is unevenly distributed between medical school classes, and this may distort the results so that they reflect the views of first and second year students more accurately than those of third and fourth year students. In addition, there may be a response bias due to self selection among third and fourth year respondents. Students who responded to the mail survey may have gained more firsthand exposure to government benefit programs in their clinical training and, as a result, may have been more willing to state their views. Responding students may also hold distinctly different views toward government programs or toward medical practice in general than non-responding students.

As in other research using surveys, it is impossible to determine the extent to which these reservations may be accurate. The information obtained nevertheless provides an initial picture of how medical students feel toward government medical programs and the crimes and abuses that take place within them.

The findings have a number of policy implications. There is an indication in the results that students form attitudes toward government medical benefit programs while they are still in medical school. Such attitudes are likely to affect their behavior as physicians. The fact that a rather small proportion of students knew anything specific about Medicare and Medicaid seems to indicate an educational deficiency. A full understanding of the purposes and processes of Medicare and Medicaid, as well as the

responsibilities of participation and the consequences for wrongdoing, may go far in reducing fraud and abuse. Prior education seems a more desirable method for producing conformity than punishment after violation.

While our study documents students' views on government medical benefit programs, it provides little information on how these attitudes are developed. Future research could focus on the roles of classroom and clinical instructors, hospital personnel and peers in the formation of students' attitudes. It would also be useful to compare the views of students who had to complete a course in medical ethics with others who did not. Finally, a longitudinal study of students' attitudes during medical school and possibly through their internship and residency period might offer more specific information on how and when attitudes toward government programs are developed and their subsequent influence on physician behaviors as participants in Medicare and Medicaid.

TABLE 1

Means, Standard Deviations, and Rank Order Scores for Five Dimensions of Government Health Benefit Programs, as rated by 144 Medical Students at the University of California, Irvine, in May, 1983*

Program Dimension	Mean	S.D.	N
Quality of Care Delivered	2.95	.85	124
Ability to Reach all Those in Need of Services	2.40	1.02	123
Cost-effectiveness	1.90	.90	114
Reimbursement Scale	1.81	.82	104
Program Efficiency	1.73	.73	121

*Programs were rated on a scale ranging from 1=poor to 5=excellent

TABLE 2

Means, Standard Deviations, Rank Order Scores for the Perceived Likelihood that Physician Violators will be Sanctioned by any of Five Different Agencies, as rated by 144 Medical Students Irvine, in May, 1983*

Sanctioning Agency	Mean	S.D.	N
The Program Itself	2.32	1.18	134
Civil Authorities	2.10	.94	132
State Licensing Board	2.04	1.04	132
Criminal Authorities	1.96	.90	132
Local Medical Societies	1.95	.96	132

*Likelihood was rated on a scale ranging from 1=very unlikely to 5=very likely

TABLE 3

Response Frequencies for 8 Penalties Imposed in 3 Hypothetical Cases of Physician Fraud or Abuse, from 144 Medical Students at the University of California, Irvine May 1983*

	Case Frequencies			
	Case 1	Case 2	Case 3	
Penalty Type	Billing for services not performed)	Over-utilization of services)	(False billing involving secret sexual relationship with patient)	Total Frequencies
Monetary Penalty	121	114	63	298
Suspension from the Program	85	95	63	243
Community Service	71	53	24	148
Learning From the Program	48	51	35	134
Criminal Probation	38	34	37	109
Lose Medical License	21	20	50	91
Incarceration	6	7	18	31
No penalty	3	9	19	31

*Response Frequencies are based on three preferred penalties selected for each case.

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PECULATING PSYCHOLOGISTS: FRAUD AND ABUSE AGAINST MEDICAID

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The research upon which this paper is based was supported by a grant from the National Institute of Justice, U. S. Department of Justice (82-IJ-CX-0035). The views expressed, however, are not necessarily those of the funding agency.

The authors wish to express their appreciation to Carol Wyatt for typing assistance.

(UNDER REVISION FOR PUBLICATION IN THE PROFESSIONAL PSYCHOLOGIST)

ABSTRACT

Fraud and abuse by providers of Medicaid services remain a largely unexplored area of scientific inquiry. This study presents information on psychologists who have been either criminally or administratively sanctioned for violatons of laws governing the Medicaid program. Mental health practitioners are disproportionately sanctioned compared to their numbers in the program, a situation at least partly due to the fact that they bill according to time spent with patients, making them easier enforcement targets. Interviews with eight sanctioned psychologists and forty state and federal officials involved in administrative and enforcement activities found that sanctioned psychologists were commonly charged with filing false claims, felt that they were treated very unfairly by the system, and resented the low reimbursement rates and paperwork involved with Medicaid. Almost all violators strongly denied personal blame for their behavior. These and related findings are discussed within the context of increased official scrutiny of professionals who participate in government medical benefit programs.

PECULATING PSYCHOLOGISTS: FRAUD AND ABUSE AGAINST MEDICAID

Medicaid, established in 1966, has extended medical benefits to indigent persons who in some cases otherwise would not have been able to obtain such care (Buchberger, 1981:xii). At the same time, on the darker side, the program has "created" a group of malefactors who, absent Medicaid's existence, presumably would not have strayed outside the bounds of the laws or rules regulating their professional behavior. Charging five patients each for an hour's individual therapy when in fact they had been seen for only ten minutes is an unlikely violative tactic unless a third-party insurer is going to pick up the bill. Nor would it have been likely, without benefit programs, that a male therapist would bill the state for time spent in sexual dalliance with a patient: Medicaid, however, has been charged for such "treatment" on a number of occasions.

In the foregoing sense, the laws establishing the government medical programs are responsible for the appearance of the law-breakers. The programs created new rules which can be sidestepped by practitioners with considerable prospect of relatively safe self-aggrandizement (Pontell, et al., 1982). The impersonality of the administrating bureaucracy also insulates wrongdoers against feelings of guilt (Smigel, 1956), and the sometimes complex rules and low payments provide therapists, as we shall see, with rationalizations to deflect any moral obloquy that might accompany acts of fraud and abuse. In short, Medicaid offers a context in which persons who are inclined, for whatever reasons, to enrich themselves by ignoring proper and lawful regulations, can readily do so.

By some counts, mental health practitioners appear to be the worst offenders against government medical benefit programs. From 1967 through 1982, 147 physicians

were placed by the federal Health Care Finance Administration (HCFA) onto a list of persons extruded from further participation in Medicaid and/or Medicare because of acts of fraud or abuse. Of these, 27 (18.4%) were psychiatrists. Yet psychiatrists make up only about 8% of the physician population (Harris, 1981); besides, their rate of participation in Medicare and Medicaid is notably low compared to that of almost all other specialists (Mitchell and Cromwell, 1982). This large overrepresentation of psychiatrists on the list of sanctioned doctors was by far the most disproportionate among medical specialities.

It is more difficult to ascertain with any precision the level of law- and rule-breaking by psychologists involved in medical benefit program work. Ten psychologists have appeared on the HCFA list. If psychologists are involved in the programs less than one-third as much as psychiatrists, as seems to be the case[1], then they can be said to be heavily overrepresented in the ranks of wrongdoers. On the other hand, the numbers are too small to support a definitive judgment, though they assuredly can be said to imply the existence of a worrisome condition.

What is certainly known, however, is that enforcement in the area of benefit program violations is highly selective, and that there is a very large "dark figure" of unknown offenders (Biderman and Reiss, 1967). Besides, it must be appreciated that therapists probably constitute so disproportionate a segment of apprehended violators because their illegalities most often involve manipulation of time rather than of services, and that because of this they are much easier to catch. A provider, for example, who charges for an hour's therapy, but sees a patient only ten minutes can be more readily apprehended than one who conducts a series of unnecessary tests or who takes x-rays without bothering to put film into the machine.

While the record of psychologists sanctioned for offenses against Medicare and Medicaid, viewed in perspective, cannot readily be generalized to conclusions about the ethical standards of the profession, it nonetheless seems clear that the government

benefit programs have provided a milieu and an ethos which have tempted a number of clinical psychologists into what can at best be regarded as rule-violating behavior and at worst as criminal acts. The remainder of this paper will examine the records and views of a sample of sanctioned psychologists.

METHOD

Background materials on fraud and abuse against Medicaid by psychologists was initially obtained by a series of interviews with 40 state and federal officials involved in the administration and enforcement processes of the program. Thereafter, we carried out an analysis of statistical and case records, some of which were obtained by recourse to the Freedom of Information Act.

To supplement these materials, we conducted interviews during October and November of 1983 with psychologists who appeared on the lists of sanctioned practitioners. Their names were obtained from the HCFA roster and from a list kept by the California Department of Health Services. The HCFA list showed the following geographic distribution: California (5); New York (2); Utah (1); Hawaii (1); and Indiana (1). Of the 11 names on the California list, four were repeats, making a total sample of 17.

Letters were sent to each psychologist in the sample requesting permission for an interview, either in person or by telephone. To spell out our mission and to increase the likelihood of cooperation, the following items were emphasized in the letters: First, that we were interested in learning from respondents about problems that appear to exist in government benefit programs; second, that we wanted to provide an opportunity for sanctioned practitioners to put forward their view of what had happened in their cases; third, that we would guarantee personal confidentiality; fourth, that our project represented a university-based scholarly endeavor with no ties to the health administration forces; and, finally, that respondents by participating could help both the mental health profession and society in general.

The psychologists were requested to return an enclosed stamped postcard, indicating a convenient time and place for an interview. Persons who responded were contacted by phone to confirm an interview appointment, and to answer questions that they might have. Two weeks after the first mailing, a followup letter was sent to all those who had not originally replied, again stressing the value of their participation. After another week, an attempt was made to contact non-respondents by telephone. Of the 17 psychologists who made up our original sample, 8 agreed to be interviewed, 8 refused to participate in the study, and one could not be located either by mail or by telephone. The final sample of 8 persons showed 7 from California and one from Utah. Three of the interviews, all in California, were carried out in person, while the remaining 5 were done by telephone.

RESULTS

The eight psychologists we interviewed may not be truly representative either of all sanctioned practitioners nor, more assuredly, of the unknown contingent of violators. It seems possible (though not necessarily probable) that the persons who refused to be interviewed might have differed in significant ways from those who agreed to cooperate. And, of course, it appears reasonable to suspect that the persons apprehended, like all those caught in wrongdoing, are different in meaningful ways—if only perhaps in their ineptness—than those who were not snared. Our sample can only be regarded as a group of practitioners who were caught for violations of Medicaid regulations. They do represent a sizable portion of sanctioned psychologists, and some of their views about benefit programs seem to reflect those of a larger and important segment of the practitioner community.

All members of the the sample were men and they proved to be relatively old: the average birth date was 1927, making 56 years their mean age at the time of our interviews. Four were in their sixties when we interviewed them, three between 49 and

51, and the youngest was 44. These, then, were not "newcomers" to the field who might by definition have been pressed to earn a livelihood. They were largely (five of the eight) involved in solo practice, and they had been working as psychologists for an average of 22 years. They were not notably mobile either: most had been at the same site through almost their entire career.

Five of the respondents were married at the time of our interviews, two divorced, one single and living with a woman. All had children; four, indeed, had four children.

Medicaid work had constituted an average of 41 percent of their work for the group, with a range from 12 to 95 percent. Only one psychologist reported participation in Medicare, and for him that involved only 10 percent of his work.

The Cases.

The official investigative files offer additional details of the particular nature of Medicaid violations involving psychologists. We examined these files to expand our interview material beyond the cases with which we had personal contact. In one case, two women had complained to the authorities that a clinician had asked for their Medi-Cal (California's name for Medicaid) stickers, in addition to those of their child, though only the child was in treatment. The investigator checked the psychologist's claims for payment and then randomly selected for interviews nine additional families in which a similar pattern appeared to exist. The following segment of a Report of Investigation conveys information about the offense and also indicates other possible harmful effects; in this instance, depriving a person of access to needed medical care by unlawful commandeering of her Medi-Cal stickers. The investigation report summarizes an interview with one of the mothers (names have been changed to camouflage identities):

> My daughter Susan has never received any services rendered by Dr. Allen. Athough I had taken my daughters Ellen and Jean to Dr. Allen, I have never been present in any of their

> therapy sessions. I only went in so he could tell me when their next appointments would be. At the end of the last session, Dr. Allen personally took from me both "Medi" labels from my card and from the cards of Susan, Ellen, and Jean. Dr. Allen usually took all of our "Medi" labels.... He told me to make sure I brought Susan's labels to the last session of each month. Susan complained to me that she could not see one doctor from whom she needed services because Dr. Allen had taken her "Medi" labels. I asked Dr. Allen why he took Susan's labels but he did not answer me. I told my social worker what Dr. Allen was doing, but I never received any feedback from her.

Interviews with the other nine families uncovered essentially the same tactics. Dr. Allen was charged with 24 counts of filing false claims and one count of grand theft. He plead guilty to one count of filing false claims, a felony, and was put on three years' probation, ordered to pay $3975 in restitution, given a $5000 fine, and required to perform 300 hours of community service. He also was suspended from participating in the benefit program during the term of his probation.

A case that received considerable public attention involved a psychologist who had charged the state for therapy performed by his wife, who was not licensed and had billed for services at a residential facility far in excess of the number of working hours in the day. He also had taken stickers from family members of patients he was treating. He plead guilty and received a sentence much like the psychologist in the case described above. In this instance, however, California State University, Sacramento, where he was a tenured professor, fired him for immoral conduct and dishonesty. He maintained that the violations were inadvertent, representing sloppy bookkeeping, and a failure to understand the regulations adequately. The appellate court was unpersuaded by this

defense: it found that the evidence "was not equivocal; it was convincing." It believed that "on the record it appears that the appellant was in fact guilty of the crime of which he was convicted and his honesty was significantly impugned." The court concluded, therefore, that "the penalty of dismissal was not an abuse of discretion" (Samaan, 1984).

The cases against the eight psychologists we sampled arose from a variety of sources. Two came from investigations by their state Medical Fraud Control Units (MCFUs), probably as a result of aberrancies discovered in computer checks of billing practices. A third began from an anonymous patient tip to the authorities, another was said to have resulted from work by an unnamed "state agency," and the fifth began from a Department of Defense mail fraud investigation connected with the federal civilian Health and Medical Program of the Uniformed Services (Champus) (see generally Morton, 1982) and ended with a Medicaid violation charge. The remaining two cases were initiated by patients.

The most common charge was for filing false claims; in two instances, this was accompanied by grand theft and conspiracy allegations. We could not obtain information from three of the respondents, but of those who answered, four had settled their cases by plea bargains while the fifth had been convicted after a court trial.

Sanctions against the psychologists covered a wide range. Two received probationary terms of 60 months and fines between $1,000 and $4,999, and one of these in addition had to perform 700 hours of contributed community service. Two others were fined in the $10,000 to $24,999 range, and one of these had the further penalty of 36 monnths of probation, $676 in restitution, and a mandatory 960 hours of community service. The only incarceration involved two months in a halfway house for a psychologist who was also ordered to pay $73,000 in restitution.

Administrative sanctions included suspension of five of the group from participation in Medicaid, generally for three years. Two had had their licenses revoked for three months, one withdrew voluntarily from practice. Five of the seven who

responded believed that the sanctions were too severe; two disagreed. Virtually all thought the likelihood for sanctions was high "for some" practitioners, but not high in general.

There was almost universal disapproval among the survey participants of officials involved in the sanctioning process. On a five-point scale, five respondents rated investigators at the extreme end, as "very unfair." Only one thought that they were fair. Attorneys were judged in the same way; so too were judges. The unfairness was by and large said to be manifested in the use of intimidation by investigators, and by their rote assumption of guilt. The last item was also named by all respondents but two as notably characteristic of the adjudication process. Several extended comments on these issues illustrate the views behind the ratings:

(1) The investigators irritated my patients. I thought they were very crude because they asked my patients why they were coming to see me, and it was none of their damned business.

(2) I think that they should notify the person immediately that they are off cycle and that, if they continue, there will be legal proceedings brought against them. I would prefer that approach rather than saying: "You're a criminal and we're going to catch you."

(3) Two people, one from MCFU, came to my office.... Like a couple of junior G-men, they yanked out their badges and said: "You're under arrest! Goddammit, do you understand, you're under arrest!" I opened my desk drawer and got my wrists slapped. They thought I was getting a gun.

(4) What happened is that they [enforcement agency] had $1.5 million to spend....They didn't find that many people so they looked into the computer for anyone who is slightly deviate.

(5) The officials are just out there to put a notch on their gun stock or their totem pole that "I've won this victory."

The interviewers talking to members of the sample were asked to categorize the attitude of the psychologists in relation to their cases. In all but one instance, they coded response as "self as victim of unfair system." In the single exception, they believed that the respondent saw himself as "guilty of an intentional wrong."

It is impossible (and it would be unjust) to try to adjudicate the accuracy of the psychologists' excusatory statements. Certainly, in virtually all cases they felt intensely that they had been unfairly picked on, as the following quotations illustrate:

(6) They found a person who was disgruntled. She had been a nurse in the clinic...and they gave her immunity. I swear before my Maker that she lied....She was guilty of forgery.

(7) In my case, there was maybe six or seven hundred dollars involved. They contend it was about $150,000....Where that figure came from, I have no idea.

(8) This was a travesty of justice. I don't feel that everybody has equal rights under the law. I think that we were set up. And I'm positive that somebody said, "Get him," because somebody stepped on somebody's toes.

(9) They brought in some patients we had seen previously. One of these girls I had seen, and the mother got on the stand and swore we had never seen the girl....I think they paid her off.

(10) It's a little bit like the McCarthy era.

The immediate consequences of their involvement with the authorities was reported by respondents to have been highly traumatic. Four of the seven who responded to our question said that there had been a reduction in the size of their practice, and three mentioned associated financial difficulties. Three also noted a decline in their professional status, and two specified personal and emotional problems in the wake of their troubles. One pointed out that the publicity surrounding his case had been unnerving, while another respondent summarized the entire matter by saying that he had been "totally ruined."

Long-Term Outcome.

However baneful, many of these immediate consequences appear to have had only transient impact. At the time of our inquiry, all but one of the psychologists were in practice; the exception was on disability status. They averaged 80 percent of their working time engaged in therapy, with additional time devoted by several of them to teaching and writing.

Of the seven back in practice, four, rather surprisingly, reported a growth in their clientele. Of the three who quantified for us the extent of this growth, one put it at 100 percent, and two at 50 percent. On the other side, one respondent noted a decline in his practice, while two others specified such a decline at 30 and 75 percent. Given this situation, it is less surprising that three of the seven who responded said that they were "much more satisfied" with their practice than before the case against them had been mounted. The remaining four said that they were as satisfied as they earlier had been.

Attitudes Toward Medicaid

There was an almost universal condemnatory attitude toward the Medicaid program as it currently is operating. Six of the eight respondents thought the program "unfair"; only one believed it to be "fair," while the eighth thought it was "fair for some, unfair for others."

The major element of unfairness was said to be the low reimbursement rates, a matter cited by seven of the eight respondents. Six mentioned that the programs were also unfair because they would not pay for all services. Three objected to the policy of not paying for patients who miss appointments, while there was a single mention of "too much paperwork," and a lone reference to the idea that the programs "discriminate against psychologists...and are medically dominated." Asked to specify "the most unreasonable" regulation in the program, five of the six who responded pointed at the restriction on the number of visits to a psychologist allowed by Medicaid.

Every one of the respondents believed that the rules are biased against certain specialties. Undoubtedly, what the respondents had in mind in this regard are rules such as that in Hawaii which requires that services provided by clinical psychologists for Medicaid be "limited to eligible patients referred by a physician" and must be only for "that service requested by the physician." In California, a rule that likely irritated respondents is one that stipulates psychologists doing diagnostic tests may bill only for

time personally spent with a patient, and that they will not be reimbursed for any time that the patient was alone completing test protocols (see generally Sharfstein, Frank, and Kessler, 1984). Nonetheless, respondents were rather evenly divided in their overall evaluation of the underlying rationale for Medicaid. Three viewed Medicaid favorably, though they believed it needs reform; three said they moderately favored it, but that it required a major overhaul; while two opposed the program, and thought that county welfare responsibility for medical aid had been a better system. The group was also divided in its belief about the extent of fraud in the program. None thought there was very little fraud; two believed that the amount of fraud was a bit higher than "very little"; one thought it moderate; three thought it was very high; and one said that he simply did not know enough to be able to estimate properly. As to their personal goals since their difficulties, by far the largest number indicated that they had vowed to keep a low profile, and stay out of trouble.

Some of the respondents combined criticisms of the program with what appear to be justifications for their violative behavior. The following represent some of their comments on Medicaid:

(10) I felt I was getting raped in terms of fees. They were paying $27 a session when the going rate was something like $75. It was a farce because they didn't want anyone to do therapy with Medicaid.

(11) I think we spend more time trying to figure out the right computer number to put down and an inordinate amount of paperwork to prove that we've done it.

(12) When seeing cases that are very close to psychotic breaks, I think that there should be at least a minimum

of four visits a month, usually eight....Two sessions a month are not even bandaid therapy. Why even give them?

(13) A lot of us are more interested in treatment than in the business side of our office. I don't even know what goes on in my outer office. I don't want to drain my energy doing that.... Now, they've [state authorities] got us all paranoid.

(14) I think if you're not paid enough there's a tendency to feel you're being taken advantage of and wanting to make amends for it a little bit.... People do feel they have to make up for all the hell they go through.

(15) Your creativity gets lost in so darn many details. Medi-Cal drains you with all its regulations and details. You spend so much time on the clerical work that you would prefer to put into more creative work.

(16) There should be more controls over the recipient and less over the professional, and I think they would be saving more dollars and doing themselves a justice.

DISCUSSION

Evidence indicates that psychiatrists and clinical psychologists are apprehended by enforcement authorities for government medical benefit programs considerably more often than their numbers would have predicted. To a large extent, this appears to be because therapists charge for time, and it is an easier enforcement task to catch violators who fraudulently report the length of their treatment than those who might defraud the programs in other ways, such as charging for unnecessary treatments or providing unneeded referrals.

Interviews with eight psychologists who had been sanctioned for violations of Medicaid regulations indicate strong resistance to accepting personal blame for their behavior. Whether their attitudes are fictively or factually based we cannot, of course, adjudicate. But it does not appear unfair to point out that investigators, neither with benefit programs nor with street crime, are notably apt to "frame" innocent persons with false charges, though, of course, this sometimes happens. In the present cases, it seems that a subtle process of self-image protection is sometimes at work, and that the sanctioned psychologists protect themselves from assuming a full measure of guilt by quarreling with the justice of the rules under which they worked and with the decency of the enforcement process. That so-called white-collar offenders tend to be skillful in projecting onto others blame for their own situation is one of the common findings of work in that field (Geis, 1982; Rothman and Gandossy, 1982).

The litany of complaints against the Medicaid program seem to us to have an element of justice in them. The programs do pay poorly, and they do tend to be bogged down in bureaucratic rules that sometimes lack therapeutic justification, however well they may serve fiscal priorities (Davidson, 1982; Garner et al., 1979). It can be argued, of course, that when a therapist agreed to participate in the program, that agreement constituted a contractual acceptance of the terms of work; and that none of us function

in a perfect world or one that altogether meets our standards. This is the law enforcement position, and it seems to us that there is a great deal to be said for it.

It is interesting that the psychologists we interviewed report, by and large, having a greater number of patients now than before they came into conflict with the authorities. It may be that the financial setbacks of their fines and restitutive payments forced them to increase their caseload. But perhaps we have further support for the finding by Schwartz and Skolnick (1962) that medical doctors who had lost malpractice suits notably increased their practices therafter. In that instance, the cause was believed to be a rise in the number of referrals from other physicians who were sympathetic to the plight of what they saw as beleaguered colleagues.

Government medical benefit programs have established sets of laws, rules, and guidelines which to a much greater extent than ever before can place therapists under intense scrutiny in regard to their professional behavior. The present article indicates some of the dimensions of this situation as exemplified by a survey of psychologists sanctioned for Medicaid violations.

FOOTNOTE

1 Officials we interviewed believed that psychologists probably participated less than one-third as much as psychiatrists, but we were constantly told that no official figures are kept at either the federal or the state level on program involvement by members of different provider groups.

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