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Page 7 Madam Chair and distinguished committee members, I wish that you could hear firsthand the compelling experiences former patients have shared with our Senate Interim Committee on Health and Human Services over the past six months. Since time and distance make that impossible, I want to speak to you today not only in my capacity as chairman of the committee, but also on behalf of hundreds of Texas citizens who have written, called or provided testimony at our public hearings. It is largely through their assistance that our committee has been able to expose and document widespread abuse in the private psychiatric and substance abuse delivery system. There is no question in my mind that corporate profits have taken priority over patient care in many instances and that some care providers have compromised their principles and their professional codes of ethics in pursuit of the almighty dollar. Early on in our examination, I received a pamphlet in the mail from an anonymous source promoting books and other materials published by a particular corporate chain of psychiatric hospitals called "Books as Hooks." The pamphlet claimed that these items were inexpensive marketing tools that could increase a hospital's patient census. It contained the following quote from a substance abuse program director, and I quote, We've been using these books for three years. Families love these books and they do help fill the hospital. In Texas, we have uncovered some of the most elaborate, aggressive, creative, deceptive, immoral and illegal schemes being used to fill empty hospital beds with insured and paying patients. Probably the most widely known case and the one that really started the investigation involves an adolescent boy who was apprehended at his grandparent's home in San Antonio by employees of a private security firm who were not even certified peace officers, although they flashed large police badges. The firm was being paid between $150.00 and $450.00 for each patient delivered to certain private psychiatric hospitals in the area. This young man was admitted to the hospital for a substance abuse problem without ever being examined by a physician. His records show that he wasn't even given a drug test until four days after admission and the results of the test were negative. Unbelievably, it took the involvement of a local state senator and a judge's order to obtain this young man's release from the hospital. The grandmother described the entire incident as reminiscent of her childhood in Nazi Germany. Fortunately, our state legislature met in special session last summer and passed a bill prohibiting anyone but an on-duty police officer from apprehending people. In addition, we made it illegal for health care providers to pay or except payment for patient referrals. However, not long after the bill went into effect we learned it wasn't broad enough to cover all of the avenues for abuse. What was once thought to be a very serious local problem in San Antonio quickly exploded into a statewide problem and then became national and even international in scope. At approximately the same time we started holding our public hearings, the Canadian government started cracking down on excessive charges it was being billed by private psychiatric hospitals

8 in the United States. Many Canadian patients were enticed by the prospect of complimentary air fare, limousine services and luxury accommodations in treatment programs in sunny California, Florida and Texas. Claims from United States hospitals for Ontario patients alone increased from $5.4 million in 1988 to $51.3 million just two years later. In 1990, approximately 2,500 Ontario residents were brought to the United States for treatment. One man was referred to as a half million dollar man. He reportedly received over 20 months of treatment in five different Houston hospitals and returned to Canada a cocaine addict. After the Canadian government put strict limits on reimbursement to United States hospitals, we were told that dozens of Canadian patients were dumped and stranded at the Houston airport with no return tickets. Bounties paid for Canadian patients also were extraordinary, ranging from $1,500 to $4,000 per patient. While these headhunting fees are a despicable practice and a probable

violation of certain state and federal laws, the problem is even more insidious than it appears on the surface. We discovered instances where social workers, school counselors, probation officers, crisis hotline workers and even ministers were paid to refer paying patients to private psychiatric hospitals. These are people in our communities we have all been taught to trust, not avoid. Since I mentioned crisis hotlines, let me share with the committee one of the extremes. A 1-800 suicide hotline advertised in the San Antonio telephone book, Congressmen, refers callers to a 1-900 number where they make $2.00 a minute off of your call while you're deciding whether or not to take your life. Time and time again, throughout almost 80 hours of public testimony, witnesses gave accounts of how they were cured miraculously on the day their insurance benefits ran out. Twenty-eight days seemed to be the magic number. Others related horrifying experiences of having voluntarily sought treatment for such conditions as an eating disorder or chronic back pain and then found themselves being held against their will. Still others told of having their diagnosis falsified by hospital personnel so it would match their insurance benefits. No one, I repeat no one, presented evidence to us that patients are abusing their insurance coverage, but I have seen convincing evidence where providers have milked every dollar and used up every day of coverage the patient was entitled to receive. Fortunately, some of the former patients obtained itemized copies of their hospital bills, which they submitted to the committee. I wanted to share just a few samples with you which show exorbitant fees, charges for services never rendered, over medication, excessive therapy, duplicate billing and other blatant abuses. Once you have had the opportunity to review some of the bills more closely, I think your committee also will be convinced that this is a major factor contributing to the out of control health care cost in this country. The examples I have submitted to you show one young woman being billed for eight, ten and 12 hours of group therapy each day. Now, the psychiatrists and psychologists in Texas don t agree very often on many things, but when they analyzed these bills it was unanimous, the excessive number of hours of therapy would not benefit the patient and could actually be quite harmful

9 This same patient was billed on one day for 36 prescription drugs. Her itemized statement shows 8,400 milligrams of Lithobid, or lithium. The PDR, Physicians Desk Reference, lists the maximum dose at 1,800 milligrams. This amount of lithium alone or in combination with the other drugs would have been lethal if it had actually been given to the patient. I've also provided copies of a bill for another patient that showed the same drugs being billed at different costs on different days. For example, the charges for a ten milligram tablet of Mellaril ranged from $6.60 up to $44.55. Another example we wanted to share involves a 16 year old female whose father indicated the private psychiatric hospital called his insurer almost daily to determine exactly when the insurance benefits would run out. His daughter was admitted for substance abuse treatment and was discharged after only 13 days, precisely on the day insurance benefits were exhausted. Like so many other patients, this teenager's bill reflected an excessive amount of therapy each day, sometimes as many as eight hours, even though school age patients are supposed to be receiving academic instruction too. On one particular day, she received $482.00 worth of "projective testing," and $482.00 worth of psychological evaluation; and five additional hours of group therapy at a cost of $80.00 per hour for a total of $1,364.00 worth of testing and therapy in one day. Her $625.00 a day semi-private room brought the grand total for that one day to right at $2,000.00. This is not just unreasonable, it's outrageous and it's fraudulent. I urge you to consult mental health experts in your communities and ask them whether it's possible to conduct that much testing and therapy in one day. I also brought with me a copy of this paperback book, Broken Toys/Broken Dreams, which can be purchased for $10.95 at any bookstore. I presume a hospital that buys large quantities can get it at an even lower cost. The teenager we have been talking about was charged $84.00 for her copy. Her bill showed a $42.00 charge for an $11.00 book, not just once, but two times. I don't want you to believe for one minute that only health care providers are at fault. Let me also mention that the insurance industry has not offered any acceptable explanations for their failure to monitor and investigate these claims for potential fraud. One possible explanation, as reported last October in the Houston Chronicle, is that

several major health insurance companies own large quantities of stock in the corporations that in turn own private psychiatric and other health care facilities. In my opinion, this is a blatant conflict of interest. What possible incentive is there for an insurer to help hold down costs if by paying these exorbitant claims the company will improve the return on its investment and just raise the policyholder's premium to adjust for the escalating health care costs? By focusing my remarks primarily on the financial aspects of our examination, I hope I have not diminished the impact these deplorable abuses have on human beings. It is extremely difficult for grown men and women, much less children, to step up to a microphone in a public setting with cameras and newspaper reporters all around and discuss very private information about a mental illness

10 or an alcohol or drug problem. There is still a stigma in this society attached to such illnesses and I can't think of a more courageous act. In closing, let me share just one more case that was reported to our committee by the chief of police of Shenandoah, Texas, a small city outside of Houston with a large 150 bed private psychiatric hospital. The chief said his department had responded to numerous complaints about this facility. One particularly memorable incident involved a four year old girl who was admitted to the hospital for evaluation after a physician concluded she may have been sexually molested by a family member. The child's mother was persuaded to check into the hospital with her young daughter for a few days, just to help the child get adjusted. Both were covered by CHAMPUS. Promptly, after checking in, mother and daughter were separated and were only allowed to see each other at mealtimes. When the mother demanded to be released, she said that several hospital employees over powered her and gave her an injection. Mother and daughter were finally released, but only after she contacted the Shenandoah Police Department. It might interest you to know that the facility has since been converted to a rehabilitation hospital, which is the next priority for our committee. I'll give you fair warning. There are so many more individual stories that should be told. But hopefully you have a good picture of what kind of practices have been occurring in Texas and what we are relatively certain is happening nationwide. I don't want to leave you with the perception that Texas is not a safe place to seek treatment. To the contrary, we have many excellent health care providers who uphold the highest ethical standards. On top of that, we have a state legislature that is committed to passing tough new state laws and I assure you, when we are finished there won't be a more difficult place than Texas to try to take advantage of a person with mental illness or chemical addiction. Thank you again for this tremendous opportunity to share the results of our examination with you. Madam Chair, we are all public servants and we are responsible to those who are most vulnerable in our society. We need to find some permanent and meaningful solutions to these problems, not just plug our finger into the dike and wait for it to break loose somewhere else. A lot of people all over this country are depending on us. I'd be happy to answer any questions the committee has at the proper time. Thank you. Chairwoman SCHROEDER. Thank you very much, Senator Moncrief. We really appreciate that. [Prepared statement of Senator Mike Moncrief follows:]

11 PREPARED STATEMENT OF SENATOR MIKE MONCRIEF, CHAIRMAN, TEXAS SENATE INTERIM COMMITTEE ON HEALTH AND HUMAN SERVICES, AUSTIN, TX Madam Chair and distinguished Committee members, I wish you could hear firsthand the compelling experiences former patients have shared with our Senate Interim Committee on Health and Human Services over the past six months. Since time and distance make that impossible, I want to speak to you today not only in my capacity as Chairman of the Committee but also on behalf of hundreds of Texas citizens who have written, called, or provided testimony at our public hearings. It is largely through their assistance that our Committee has been able to expose and document widespread abuse in the private psychiatric and substance abuse delivery system. There is no question in my mind that corporate profits have taken priority over patient care in many instances and that some health care providers have compromised their principles and their professional codes of ethics in pursuit of the almighty dollar. Early on in our examination, I received a pamphlet in the mail from an anonymous source, promoting books and

12 other materials published by a particular corporate chain of psychiatric hospitals called "Books As Hooks." The pamphlet claimed that these items were inexpensive marketing tools that could increase a hospital's patient census. it contained the following quote from a substance abuse program director: "We've been using these books for three years, families love these books and they do help us fill the hospital." In Texas, we have uncovered some of the most elaborate, aggressive, creative, deceptive, immoral, and illegal schemes being used to fill empty hospital beds with insured and paying patients. Probably the most widely known case, and the one that really started the investigation, involves an adolescent boy who was apprehended at his grandparents' home in San Antonio by employees of a private security firm who were not even certified peace officersalthough they flashed large police badges. The firm was being paid between $150 to $450 for each patient delivered to certain private psychiatric hospitals in the area. This young man was admitted to the hospital for a substance abuse problem without ever being examined by a physician. His records

13 show that he wasn't even given a drug test until four days after admission, and the results of the test were negative. Unbelievably, it took the involvement of a local state senator and a judge's order to obtain this young man's release from the hospital. The grandmother described the entire incident as reminiscent of her childhood in Nazi Germany. Fortunately, our state legislature met in a special session last summer and passed a bill prohibiting anyone but an on-duty peace officer from apprehending people. In addition, we made it illegal for health care providers to pay or accept payment for patient referrals. However, not long after the bill went into effect, we learned it wasn't broad enough to cover all of the avenues for abuse. What was once thought to be a very serious local problem in San Antonio, quickly exploded into a statewide problem, and then became national and even international in scope. At approximately the same time we started holding our public hearings, the Canadian government started cracking

98 There was a tremendous amount of pressure put on everyone within the PIA network that we had to meet or exceed our budgets. There was no question in anybody’s mind about that. In many cases several of our facilities in our region were admitting as much as 120 to 130 percent of their license capacity. Even though the people at the home office knew that this was taking place, it was still allowed to go on for several months. If you take a look at the salaries and the way we recruited psychiatrists in the health care profession, it's not unusual for people to go out and recruit physicians and to help them establish their practice. We were over generous. We would pay for such things as setting up their office. we would pay for their personnel staff for veral months after they were in business. In almost all cases, of the psychiatrists we recruited, we we paid them a monthly stipend, anywhere from $8,000 to $15,000 a month. In addition, the chief of the medical staff was permitted to earn 50 percent bonus. As we admitted patients then, they would be assigned to psychiatrists. They could then bill from $100 to $150 a day for seeing that patient. The contracts that we would write with the psychiatrist was usually for 25 percent of their time, which meant that we were asking for somewhere between two hours a day or ten hours a week of their time. For that then, of course, we paid them the additional. It was very easy for a psychiatrist in our facilities to generate $600,000 to $900,000 in private practice fees from us alone and he was still free then to go out and set up their own private practice in addition.
You'll hear that the psychiatric facilities are talking about free care. In the health care Industry, we talk charity care and we talk about contractual allowances and we talk about the patients that we don't receive payments on. In the psychiatric business that is not the case. In almost every case we'll agree up front that if a patient cannot pay for their deductibles and coinsurances, that we'll waive that portion and just collect the insurance benefits. So, if we have a $35,000 bill and the co-insurance and the deductible is $2,500, we'll collect $32,500 on that bill. Also, whenever anything was successful at one psychiatric facility, it was quickly picked up by the rest of us. We would have a regional meeting on a monthly basis and things that had successful for other psychiatric hospitals or for other regions within our group, those items were

also passed on. One of items was the fact that we created the policy that we would not discharge patients on Friday, Saturday or Sunday. Now, what that does is that gives you three additional days to have that patient in-house and also your greatest number of admits usually were on the weekend.

p121 ... the Joint Commission on the Accreditation of ealth Care Organizations that sets standards and approves programs for these hospitals, and even some patients who take advantage of what their insurance will pay. However, the most prominent common pathway of them all is the private profit oriented, programmatic psychiatric hospital. In my judgment, the primary factors that have caused or allowed the current state of affairs to develop are the following: One, the American Psychiatric Association's classification of illnesses or disorders, some of which in my opinion and in the opinion of many other psychiatrists, are not actually illnesses. This, in effect, often creates a need for treatment. Two, advertising and personal promotion by health care providers and facilities which, in the mental health context, successfully exploits the fears and insecurities of a vulnerable, trusting public. Three, the programmatic concept of treatment in a medical facility or hospital with the resultant abandonment of the traditional medical model of care and abandonment of the doctor-patient relationship. In the programmatic concept, a medical facility is used by persons with absolutely no medical training to perform activities under neither medical nor therapy, but the activities are labeled as therapy and are billed as such to patients and insurance companies. The programs provided are inappropriate for a medical setting, do not necessitate a hospital facility, and could be inexpensively provided in alternate settings. Four, third party coverage for many problems that are, in my judgment, not valid illnesses and payment for activities that are not true therapies. Today, as never before, Americans are at risk of being victimized by the mental health care industry. I believe federal legislation in certain areas could prove extremely helpful in reducing this risk. Realizing that the following suggestions may anger many special interest groups and organizations, I nonetheless feel that the life, health, safety and welfare of the individual patient should be our first concern. I have made a list of a number of suggestions for your consideration, but for time and interest will only highlight a few. For example, patients admitted to psychiatric hospitals against their will should have the right to a second psychiatric opinion within 24 hours of admission. The second opinion should be in writing and made part of the hospital record. The right of a hospitalized psychiatric patient to visit with family members on a daily basis should not be restricted. Activities such as group meetings, family meetings, recreational activities, exercises, music, drama and art provided by a hospital or its employees should not qualify as therapy, should not be billed on a separate individualized basis, should not be mandatory and should not be provided without the consent of the patient and the treating physician. The abuse of substances such as alcohol, drugs and tobacco should not by itself qualify for treatment in a psychiatric hospital. Patients with such problems should be admitted only for the management of physical complications or for the treatment of underlying major psychiatric diseases.

123 PREPARED STATEMENT OF CHARLES S. ARNOLD, M.D., PSYCHIATRIST, SAN ANTONIO, TX
Ms. Schroeder and Members of the Committee, It is personally very difficult for me to make critical comments about my specialty, to which I have dedicated my professional life, and I assure you there are many honest and ethical mental health care providers and psychiatric hospitals throughout the United States. However, there have been significant changes in the nature of the mental health care field in the past decade, changes which have resulted in over-utilization of psychiatric facilities and the excessive provision of mental health services. Many psychiatric hospitalizations are unnecessary, or are too lengthy, and many services provided are not indicated. The introduction of the commercial enterprise mentality to psychiatric care, the abandonment of ethical, scientific principles by many mental health care providers, and the indulgence of greed have allowed these developments to occur. The provision of mental health care, especially as it relates to the psychiatric hospital industry, has largely changed from what was once a professional and caring environment and an

honorable part of the medical world, to one that is based on commercialism and profit. The changes that have developed over the past decade are very pervasive, deeply entrenched, and have occurred across the entire United States. Perhaps the best way to illustrate what has been happening over the past decade is to describe an event which took place in 1984. On June 12, 1984, the program director of a private, for-profit psychiatric hospital came to my office to solicit my cooperation in working with his program services. Because of what I had already learned about this hospital, I took the liberty of recording our conversation. I was given a detailed explanation of how other psychiatrists had been made rich, and was told that this would be done for me if I would go along with the program. I will quote a few of his statements: "Where are your loyalties? If we're going to give you a patient and make you $15,000.00 for not having to do a damn thing but write your name and admit him , or if I've got a patient for you to admit, if I put him in there and I give you that (patient), why not give us the (psychological) testing (in return)?"

124 The methods of obtaining people for admission to the hospital were also described: "We've got people we're paying out there... and we're going to hire another one in marketing that does nothing but beat the bushes and finds the patients and sends them to the hospital..." Referring to a prior situation in a Houston psychiatric hospital: "They called (person's name deleted) and said 'Look, you want to be rich? You, let us set up this program the way we want to set it up. All you do is be the admitting psychiatrist and we'll make you rich'. We made him rich." Another comment: "The trend is going in this direction and I think the quicker...that you look at this kind of a situation and consider getting involved in something like this, the better it'll be for you." Following this conversation, I contacted my attorney. It was agreed that federal authorities should be informed. The matter was eventually put in the hands of the U.S. Department of Health and Human Services, who began monitoring the hospital. Tragically, a large number of psychiatrists, psychologists, social workers, therapists, and psychiatric hospitals have chosen to go in the direction proposed by this program director, have betrayed the public trust, have misused this honored trust to benefit themselves financially, and have in effect sold their souls. I do not believe any participant in the psychiatric care picture is completely free of blame for the current problems. Among these are the psychiatrist or the psychologist who ignores historically established professional standards, the psychiatric hospital and its "therapists" who solicit business, the insurance companies that approve payments, the Joint Commission on the Accreditation of Healthcare Organizations that sets standards and approves programs for these hospitals, and even some patients who take advantage of what their insurance will pay. However, the most prominent common pathway of them all is the private, profit oriented, programmatic psychiatric hospital. In my judgement, the primary factors that have caused or allowed the current state of affairs to develop are the following: 1. The American Psychiatric Association's classification of "illnesses" or "disorders", some of which, in my opinion, are not actually illnesses. This, in effect, often creates a "need" for "treatment". Additionally, organized psychiatry presumes certain problems, such as alcohol or drug abuse, to be amenable to psychiatric knowledge and methods.

125 Though problems such as alcohol and drug abuse are very serious social problems in America, in the opinion of many mental health professionals they are not psychiatric illnesses and psychiatry does not have the solution to these problems. 2. Advertising and personal promotion by health care providers and facilities which, in the mental health context, successfully exploits the fears and insecurities of a vulnerable and trusting public. 3. The "programmatic" concept of treatment in a medical facility (hospital) with the resultant abandonment of the traditional medical model of care, and abandonment of the doctor-patient relationship. In the "programmatic" concept, a medical facility is used by persons with absolutely no medical training to perform activities that are neither medical nor therapy, but the activities are labelled as "therapy" and are billed as such to patients and insurance companies. The programs provided are inappropriate for a medical setting, do not necessitate a hospital facility, and could be inexpensively provided in alternate settings. 4.

Third party coverage for many problems that are, in my judgement, not valid illnesses, and payment for activities that are not true therapies. Today, as never before, Americans are at risk of being victimized by the mental health care industry. I believe federal legislation in certain areas could prove extremely helpful in reducing this risk. Realizing that the following suggestions may anger many special interest groups and organizations, I nonetheless feel that the life, health, safety, and welfare of the individual patient should be our first concern. Therefore, I offer the following suggestions for your consideration: 1. No person should be admitted to a legitimate psychiatric hospital except by a duly licensed psychiatrist who is board eligible or board certified by the American Board of Psychiatry and Neurology (ABPN). 2. All psychiatrists utilizing hospitals should be required to remain current in continuing medical education (CME) activities. 3. The admitting psychiatrist may allocate treatment duties to other mental health professionals in a hospital, but should remain responsible and liable for the results and consequences of treatment. 4. Patients admitted to psychiatric hospitals against their will should have the right to a second psychiatric opinion within 24 hours of admission. The second opinion should be in writing and made part of the hospital record. 5. The right of a hospitalized psychiatric patient to visit with family members on a daily basis should not be restricted.

127 Chairwoman SCHROEDER. I again want to thank the panel. I think you've made some very helpful comments in putting this into context. Congressman Rowland. Mr. ROWLAND. Thank you, Madam Chair. I was interested in what you were saying, Doctor Arnold, about the Federal Government becoming involved in, to some extent, regulation. One realizes that licensure is essentially a function of state, has been for physicians as well as for health care facilities. What specifically were you speaking about that the Federal Government should be involved in?
Dr. ARNOLD. In my list of suggestions, I made a number of other recommendations. These problems that I have run across, I have had the opportunity to do peer review for a couple of years and I've reviewed up to maybe 600 cases across the country. It occurs to me that a number of these standards are going to be difficult to do in 50 separate places. Certainly basic fundamental rights, responsibilities for patients, standards and so forth seems to me would be coming from central government since it's a national problem.
Mr. ROWLAND. Do you think we ought to supercede state government in some of these areas that you're talking about?
Dr. ARNOLD. I think that's reasonable in the realization that these problems are prevalent throughout the nation. It would be good for individual states, but it seems to me some of these fundamental principles would be applicable
Mr. ROWLAND. Do you have any concern that we might go so far as to require federal licensure, for example, of physicians? Do you have some concern that once the Federal Government gets involved that it just might snowball?
Dr. ARNOLD. That could happen. That could be a problem, that's correct. I would think that licensure and things of that nature could be handled, I would think, at the state level. Mr. ROWLAND. Let me ask either of you. In looking at the cause of why this happened, why these hospitals became involved, I guess you would say, in the greed factor, how did that evolve? How did that come about? You think your colleagues would have been so opposed to that that they would have risen up in opposition to it. What took place to allow that to come about?
Dr. ARNOLD. That is hard to explain. I do think that a number of entities that the APA classifies as illnesses really aren't. I think they can be used to justify activities that aren't therapy and utilizing a facility called a hospital in which these things aren't necessary. Almost without fail in cases I review, things that are performed many, many times could be done in a summer camp, of taking someone for a walk and charging them $40.00 for that, for example. We don't have any clear cut definitions, having people who are not doctors providing therapy and facilities that don't seem to me to qualify as hospitals being called hospitals, activities that aren't therapies. Mr. ROWLAND. That, in fact, is a violation of state law, isn't it?
Dr. ARNOLD. Sir?
Mr. ROWLAND. That's a violation of state law, isn't it, people providing care that are not licensed to do that?

128 Dr. ARNOLD. I'm not capable of answering that. I do not know. It should be, I would think, but it's certainly done everywhere. In fact, I reviewed a case recently in another state, I think it was Kansas, I cannot remember. A patient who was clearly psychiatrically impaired in my judgment, probably on a major depression, was receiving outpatient psychotherapy twice a week. As I questioned the provider, it became apparent to me that he didn't seem very well qualified and as tactfully as I could I said, "What is your training? I m just curious about it." He was a social worker. This patient had a condition that, simply in my limited knowledge of the case, it was possible this man had an endocrine disorder, metabolic problem, brain tumor, epilepsy, a number of things and this was a social worker doing therapy and being paid apparently by an insurance company.
Mr. ROWLAND. Not prescribing medication but doing therapy?
Dr. ARNOLD. That's correct.
Mr. ROWLAND. Yes. Okay. Any other comments from any members of the witness panel relative to the question that I just asked Doctor Arnold?
Dr. BOK. If I may respond, Congressman Rowland. One of the ways that psychiatrists and doctors may act is see no evil, hear no evil, do no evil. Unless it involves them directly, they may be very, very reluctant to speak up about any abuses. The person that may do that is usually not looked on very well. I think there are certain laws in many states mandating that it be imperative that the person, especially a professional, who is a witness or who has knowledge of child abuse, even in a hospital situation, is obligated to report it. That hasn't happened.
Mr. DURRETT. The other thing that happens here, I think, too in the for profit environment we made it very profitable for the psychiatrist. So, when you first went out to talk to the psychiatrist it was very easy to convince them that what we were doing were some of the things that they wanted to do. Then, once they got involved, it was very we have to reeducate the physician as to how we want our practice provided. So, it was that reeducation process that got a lot of the psychiatrists trapped in the middle of the situation.
Dr. ARNOLD. If I may address that, when I was approached by this individual, it was pointed out to me that it was rephrased over and over again, "If you will simply go along with the program and change your way of thinking, we will do the work for you. All you have to do is drop by and say hello and you can bill the insurance company for $100.00, $125.00 a day." I have specific knowledge of at least one case where the psychiatrist had 35 patients in the hospital and nobody in the world can take care of that many people, charging $100.00 a day. That's in the neighborhood of $90,000 to $100,000 a month. What's happening herethis is what I was asked to do, to sell my M.D. degree which gives me admitting power to a hospital. Once that's done, the sky is the limit. If you, as you said, look the other way, you'll become enormously wealthy and the treatment is taken over by the non-medical people, absolutely non-medical with no medical training at all. Mr. ROWLAND. Thank you.

129 Thank you, Madam Chair.
Chairwoman SCHROEDER. Thank you. Congressman Peterson?
Mr. PETERSON. Yes. Thank you, Madam Chair. To continue on Doctor Rowland's comments, it sounds to me like the ethical standards among the medical profession vary by the individual as opposed to the profession. Getting hack to some of the questions we had earlier about the internal policing mechanism, I m appalled that, Doctor Bok, did you go to your professional association and say, "Look, this is happening in my hospital and it's being done by my colleagues. I need some help here. They're ready to ring me up and bounce me out because I'm the good guy here,' yet that's not available to you, or is it available to you?
Dr. BOK. In this case what I did do, after I'd been reported to the Austin, Texas committee, which is the central committee of the Texas Medical Association Impaired Physicians Committee, I appeared before the county committee, Impaired Physicians Committee that is, and they assessed me and evaluated me and they decided, as a result of that assessment, that no further action needed to be taken. They did, in fact, help me in that instance.
Mr. PETERSON. Again, I'd like your comments. Is everybody an independent agent? Is it unfair for us to describe the medical profession or the legal profession or any other profession, is everybody on their own or is there an ethical

standard that is adhered to? Clearly if the standards were kept, then you wouldn't be testifying about coercion and the incredible pieces of fraud that's taking place because ultimately it's the physician or somebody who signs the ticket that gets the billing done. So, there are those people out there and no one is policing it. What do we do? You can write all the legislation you want. It's a matter of how you're going to enforce it.
Dr. ARNOLD. Well, as someone has said, you cannot legislate morals or ethics. I do think that the general medical community, medicine, surgery and the general medical community has extremely high ethics, from what I know. They do seem to be much higher, and I hate to say this, in their ethical standards than the psychiatric specialty of medicine. I can't explain why that's true. I do not know the answer to that, but I would say that I don't think the mechanism actually exists. If I would want to go to a higher group in my specialty of psychiatry, I don't think such athat would be a waste of time.
Mr. PETERSON. But doesn't the associationisn't it kind of you get what you tolerate? If that was to suggest that the medical side of the professional scale in the medical area, they're obviously not tolerating.
Dr. ARNOLD. That's correct.
Mr. PETERSON. And therefore they're getting more precise enforcement.
Dr. ARNOLD. I can't explain why psychiatry tolerates it. I do not know why. I question this too. I don't know the reason it's happening.
Mr. BRYANT. If it's okay to jump in there, you talked about a psychiatrist who had 35 patients and said that no one could handle that level of patients and he's billing $100.00 a patient a day.

133 long to get paid, so we didn't want them and we had enough census without them.
Chairwoman SCHROEDER. And the ones that you were taking as the primary payer never came to look at these wonderful arrangements where you have doctors
Mr. DURRETT. I never had an insurance auditor look at any bill that we created.
Chairwoman SCHROEDER. Never?
Mr. DURRETT. Never once. Chairwoman SCHROEDER. And did anybody look at the practices you talked about of hiring physicians in this strange way where you set them up and they would suddenly be making $600,000 and $900,000 a year?
Mr. DURRETT. Well, that's not really illegal. That's done even in the med/surg environment. The small community that's losing its last family practitioner will go out and recruit a physician and guarantee him a salary and provide him office space and guarantee him a certain level of service. That's not the part that is the questionable business practice. It's the amount of money that they were allowed to make and the patient load that we gave them. It was not uncommon for our physicians in our program, various programs, to have 25 to 30 patients assigned to them on a daily basis and they spent less than two hours a day in the hospital.
Chairwoman SCHROEDER. Boy, they must have seen them real fast. That's real microwave therapy almost, huh? You also mentioned that they targeted adolescents a bit.
Mr. DURRETT. Adolescents for us was our big money winner. So, we did target adolescents. We actively had a group in our referral network that they would go out and meet with all the junior highs and the high schools. Then when we added the children's program, we put a new group in there that went out and hit the elementary schools. We would do such things as we would pay for counselors in the school. We'd pay the school district for the counselor and put him out in the school and then our marketing people would be in constant contact with those people. We also got a lot of our adolescent referrals through the juvenile authorities. So, we were big in marketing to juvenile authorities.
Chairwoman SCHROEDER. And all those were paid for, right? Did you do a lot of charity work, Mr. Durrett?
Mr. DURRETT. Charity work? No, we did no charity work.
Chairwoman SCHROEDER. You did no charity work?
Mr. DURRETT. We were a for profit company looking for the bottom line.
Chairwoman SCHROEDER. And so you had a wide net spread looking for anybody who could pay?
Mr. DURRETT. I personally, even as the controller of the hospital, I had to make five cold calls a week out in the community and out in the surrounding area to

try to drum up additional referral networks that we could use. Everybody in the hospital had a certain number of cold calls that they had to make.
Chairwoman SCHROEDER. You're all like salesmen?
Mr. DURRETT. We were super salesmen.
Chairwoman SCHROEDER. Incredible.

134 Then we get back to the psychiatric practices that my colleagues were talking about. Is this tendency to always admit, is that because of malpractice? Is that what people are afraid of? Is there a lot of malpractice in psychiatry if you don't admit?
Dr. BOK. I don't think that that was the controlling dynamic. I think the controlling issue and variable was the influence which the hospital corporation exerted over some of the psychiatrists.
Chairwoman SCHROEDER. What happened if you said, "This person, we'll let him be treated on an outpatient basis? I didn't put him in."
Dr. BOK. You became the pariah of the hospital's medical staff in the estimation of the hospital corporation that controlled some of the doctors. You were at risk sometimes of losing your privileges.
Chairwoman SCHROEDER. Does anybody ever look at how many are ever turned away? I guess there's no such thing as a second opinion. That was your point,
Mr. Durrett, that a second opinion might police some of this if they were outside of that realm.
Mr. DURRETT. That's correct. We did turn many patients away, but it was not because they needed help, it was because they had limited insurance benefits or they had no insurance benefits. So, we gave them a list of the places that they could go to seek their free help.
Chairwoman SCHROEDER. Could they sue you if you turned them away because they didn't have insurance benefits?
Mr. DURRETT. No one ever sued. I suppose they could have. Chairwoman SCHROEDER. So, you had a great deal. If they had insurance benefits
Mr. DURRETT. We took them.
Chairwoman SCHROEDER. You took them. But even if they needed help, out they went when they ran out?
Mr. DURRETT. A lot of times on weekends, for example, one of the top three, the administrator, the associate administrator and myself, were on call. So, we made the decision whether or not that patient was to be admitted or not and we would make it from the insurance benefits that were out there. Then, on Monday or Tuesday, if we found out that the patient did not have insurance benefits, they would then be discharged. So, we did eat a few of those type situations. That was part of the free care we gave.
Chairwoman SCHROEDER. What a heart. Anybody else have any further questions? Well, let me thank you very, very much. We may come up with some more and open the record to put it in, but the hour is late and I don't want to keep you any longer. Thank you again for your patience and your bravery in standing up for what we think is ethical even if others don't. Thank you.
Dr. BOK. Thank you.