Spring 1999

Medicaid Fraud: Medical Students' and Physicians' Attitudes and Perceptions

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MEDICAID FRAUD: MEDICAL STUDENTS' AND PHYSICIANS' ATTITUDES AND PERCEPTIONS

by

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B.A. May 1997, Virginia Wesleyan College

A Thesis Submitted to the Faculties of
Old Dominion University and Norfolk State University
in Partial Fulfillment of the
Requirement for the Degree of

MASTER OF ARTS

APPLIED SOCIOLOGY

OLD DOMINION UNIVERSITY AND NORFOLK STATE UNIVERSITY
May 1999

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ABSTRACT

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The purpose of this study is to determine the attitudes and perceptions of medical students and physicians concerning Medicaid fraud. The primary tool was an anonymous survey distributed to both medical students and physicians in the Hampton Roads area. Previous research suggests that physicians would be more likely to view Medicaid fraud as less serious and less justifiable than medical students would. Since little research looks specifically at the attitudes and perceptions of medical students and physicians two theories, Differential Association and the Theory of Organizational Misconduct, were used because they best fit the research already out there. The analyses were found to be statistically significant, revealing that physicians, not medical students actually perceive Medicaid fraud as more serious than medical students do. These findings, although significant, are in the opposite direction than originally hypothesized. Hirschi's Control Theory was used to explain these differences and has been found to fit better in this study than the first two theories originally reviewed.

This thesis is dedicated to my husband, Donnie, and my parents, Joyce and Pat Howe. This project could have not been accomplished without all of their love, support, and encouragement.

ACKNOWLEDGEMENTS

I would like to thank those people whose contributions made completing this thesis possible. First, a special thanks to my committee chair, Dr. Brian Payne, for his guidance and laid back nature throughout the thesis process. I am especially grateful for his help assisting me in developing a clear understanding of the analysis needed for this study, always having time to discuss any questions I have, and always being aware of the graduation time line I have tried to accomplish. I would also like to thank him for the opportunity to work on a summer research project and was very exited about publishing our findings.

I would also like to thank Dr. Carole Seyfrit for all the support she has given me over the last two years. The opportunity for allowing me to work on her research grants and for all the opportunities that have come to me with this work. She has also been very helpful as a committee member by providing me with guidance, encouragement and her knack to find formatting mistakes that the "normal" eye would never see. It is truly amazing! I would also like to thank Dr. Otto Sampson for sitting on my thesis committee and providing me with feedback.

I would also like to give a special thank you to my parents for supporting my husband and I throughout our education. They have made it possible for my husband and I to focus on our education by allowing us to live with them. My mother is truly my role model and my father is one of my best friends.

Finally, I would like to thank my husband, Donnie, who has always been there for me and has always encouraged me to pursue my dreams, for reading EVERY paper that I have ever turned in during my college years and for truly being one of my best friends.

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CHAPTER I

INTRODUCTION

Health care fraud has become a top national priority for the FBI and even organized crime is switching to health care fraud because they know that the punishments they will face will be less serious (Ford 1992). Lyndon Johnson signed the Medicare and Medicaid laws in 1965 with the objective of providing health care access to the poor and elderly. The objective was to "mainstream" medicine by allowing the poor and elderly to receive health services purchased by the government from sources including hospitals, nursing homes, doctors, and pharmacists, which are commonly known as "providers" (Fiske 1980; Mitchell and Cromwell 1982; Pontell, Jesilow and Geis 1984; Jesilow, Pontell, and Geis 1985). This mainstreaming of health services has cost the government an enormous amount of money, and subsequently caused problems for the providers. To illustrate how much money is spent and to show how this amount continues to increase over time, the U.S. Chamber of Commerce in 1992 estimated that by 1994 the spending of

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health care would reach $1 trillion. They also estimated that this amount would probably double again by the turn of the century (Ford 1992).

Due to this tremendous increase of assets required to fund these government programs, physicians have begun to feel the effects. Over the last fifteen years there has been a serious dissatisfaction in the way physicians feel about their profession. Surprisingly this dissatisfaction was not correlated with cuts in physicians' income or with the level of debt that younger physicians have incurred but stems from our nation's inability to come to grips with using expenditures for health care (Schroeder 1992). One aspect of these disbursements for health care shows that medical students and physicians are dissatisfied with focuses on the cut in the money allocated for government funded programs.

Bart Stupak (1995), a Republican from Michigan, argues against any more cuts in Medicare and Medicaid programs because he believes that cuts could be a reason for such a high rate of fraud within these programs. The idea of cuts in these programs has become a very serious problem. However, even though physicians are members of one of the most highly regarded professional groups in society it does

not mean that all practitioners meet high ethical standards (Pontell et al. 1984).

THE EXTENT OF FRAUD WITHIN THE HEALTH CARE INDUSTY

The Bureau of Justice Statistics reports that in the period between 1980 and 1985 the number of federal convictions for white-collar crime rose 18 percent. This report also showed that in 1985 only 40 percent of those found guilty of white-collar crime went to prison and were sentenced to an average of only 29 months (Dillingham 1987). These low prison terms are allowing for this type of behavior to continue and it seems to be increasing, especially within the medical profession. The staff of the Senate Special Committee on Aging has been investigating the explosion of fraud and abuse throughout the U.S. health care system. Nearly a trillion dollars is spent on health care each year, and roughly 10 percent is lost through abusive practices and fraudulent activities (Cohen 1995; Kennedy 1995). Jesilow et al. (1985) note that officials have estimated that fraud associated with benefit programs may range from 10 percent to 40 percent. There exists not only the concern of fraud and abuse, but also the concern of common error. According to Dr. Marc J. Roberts, professor of Political Economy and Health Policy at

Harvard, 90 percent of all hospital bills are incorrect, not necessarily fraudulent, but wrong nonetheless (Davis 1995).

It is estimated that Medicare spending will more than double by the year 2003 to more than $389 billion. However, this may be a moot point because the Medicare Trustees project that the Medicare Hospital Insurance Trust Fund (in the U.S.) will run out of money by the year 2002 (Kennedy 1995). The Health Care Finance Administration is aware that health care scams and abuse practices plague Medicare, but the exploitation continues (Glenn 1995).

Reiman (1998) suggests that the commercialization of the U.S. health care system and the growing threat of corporatized managed care will affect the autonomy of doctors. Therefore, it is essential that they preserve their traditional ethical commitments to their patients. Otherwise, they will become engulfed by the health care corporations and be driven by profit incentives instead of patient care. There is no place for greed when it comes to serving the sick and the ethical standard of the physician must remain intact. However, there are still physicians who do not uphold this ethical standard and they do cause a threat to the profession (Crawshaw 1994). These physicians

make it hard for the rest of the physicians who put their patients first.

There are many types of fraudulent behavior that take place within the medical profession. In 1984, a California ophthalmologist was convicted of performing unnecessary eye operations that left fourteen patients with impaired vision in a scheme to defraud the state (Pontell, Jesilow, Geis and O'Brien 1985). This, of course, is an extreme example of fraud where the physician had no concern for his or her patients. Another example of this type of fraudulent behavior took place in Dade County, Florida. This scam has been labeled as one of the largest home health care fraud operations and consisted of two healthcare administrators and five physicians who allegedly defrauded the Medicare program for $15 million. A total of 102 indictment charges were placed which included fraud, conspiracy and money laundering (Kreier 1997). This fraudulent behavior did not directly put any patients' lives on the line; however, this activity is clearly breaking the ethical standards that are set for physicians.

Another scam involved generic drugs. A company marketed a drug that was supposed to be the generic counterpart to a brand name drug. However, the company was using the non-generic drug and passing it off as the

generic drug because the company who marketed the generic drug first was most likely to make more money (Coleman 1989). These acts are referred to as generic drug substitutions by fraud investigators and scholars (Payne and Dabney 1997).

THE ROLE OF THE GOVERNMENT IN FIGHTING AGAINST FRAUD

Because fraud in the United States has grown, the government has gotten involved trying to remedy the situation. In 1977, as a response to the increase in fraud and abuse that accompanied expansion of the programs, Congress passed the Medicare-Medicaid Anti-Fraud and Abuse Amendments. These amendments tightened loopholes in the existing statutes and imposed stiffer penalties for violations. Despite the existence of the Amendments and other overlapping statutes under which Medicare-Medicaid fraud and abuse may be prosecuted, only a slim percentage of offenses are detected or punished. The sponsor of the bill, Senator Herman Talmadge, intended it to halt the widespread fraud plaguing the program. He states, "[This is] an opportunity to send a clear, loud signal to the thieves and the crooks, and the abusers that we mean to call a halt to their exploitation of the public and the public purse" (Fiske 1980:287).

The savings and loan scandal in the 1980s opened the eyes of Public Officials. In 1985, state and federal authorities decided to increase their efforts to police the Medicare and Medicaid programs. An office was created in the federal department of Health and Human Services to fight fraud and abuse in government programs. Around the same time 30 states established Medical Fraud Control units to monitor Medicare and Medicaid. Tougher civil recovery statutes were also enacted to aid in the recoupment of monies lost through fraud (Pontell et al. 1985). Congress passed the Financial Institutions Reform Recovery and Enforcement Act of 1989. The law authorized $75 million annually for three years to fund the Justice Department's efforts to prosecute financial fraud. The FBI budget for these cases went from less than $60 million for fiscal year 1990 to over $125 million in 1991, and FBI personnel dedicated to financial fraud almost doubled. Also, President Bush announced a plan to bail out the crippled industry and investigate and prosecute thrift crime (Calavita and Pontell 1994).

Health care fraud is also a top investigative priority within the FBI's white-collar crimes program and as a combative measure the FBI has developed a national strategy to investigate incidents of health care fraud (Ford 1992).

Federal, state, and local law enforcement agencies have all played a role in combating health care fraud (Ford 1992). President Clinton used the occasion of the White House Conference on Aging to announce "Operation Restore Trust" a federal, state and industry initiative to crackdown on Medicare and Medicaid fraud, waste and abuse (American Hospital Publication 1995). Since then, President Clinton has asked for almost $600 million to fund Medicare and Medicaid antifraud initiatives across the United States (Korcok 1997).

Though political reaction has occurred, very little research has examined how medical students and physicians perceive Medicaid fraud. Four broad questions concerning Medicaid fraud are addressed in this thesis. First, do medical students and physicians view the seriousness and justifiability of Medicaid fraud differently? Second, do medical students' and physicians' attitudes differ by type of Medicaid fraud (e.g. billing for services not performed or the over-utilization of services)? Third, is there an association between physicians' attitudes toward Medicaid and how many individuals they supervise? And fourth how do medical students' and physicians' attitudes toward Medicaid fraud compared to their attitudes toward fraud in other occupations?

These issues of Medicaid fraud are very important because attitudes toward this growing problem need to be determined. If medical students and physicians perceive professional fraud within their own profession as not being serious and justifiable then it needs to be determined why they are not concerned with this growing problem. Before policy implications can be put into place concerning this issue it is important to determine first the attitudes medical students and physicians have concerning this issue and what variables determine their attitudes.

The following chapter will discuss the theoretical framework as well as the literature on medical students' and physicians' attitudes and perceptions toward Medicaid fraud.

CHAPTER II

REVIEW OF THE LITERATURE

Edwin Sutherland coined the term "white-collar criminality" in 1939 and he defined the term as crimes committed by elite classes (Sutherland 1940; Jesilow et al. 1985). Sutherland is also well known for his theory of differential association which states that criminal behavior is learned like any other behavior, and is usually learned through individuals who are very close and intimate with one another (Coleman 1992). Since Edwin Sutherland coined the phrase "white-collar crime" almost fifty years ago there has been controversy over exactly what the definition of white-collar crime is and whether the behavior is learned in various settings (Braithwaite 1992; Geis 1992; Schlegel and Weisburd 1992). Research done on criminality has focused on street criminals and how they can harm individuals in a more personal manner than the white-collar criminal (Weisburd and Schlegel 1992; Hochstetler and Shover 1997; Mannon 1997). Also, funding has been more readily available for research focusing on street crime (Friedrichs 1996). However, the government has begun to provide funding to fight the growing problem of white-collar crime and, therefore, there has been a

significant increase in research efforts directed toward white-collar crime (Baumgartner 1987; Benson, Cullen, and Maakestad 1990; Snider 1990; Parry and Hunt 1993; Weisburd and Schlegel 1992; Levi 1996).

The idea of white-collar crime has changed a great deal since Sutherland. He believed that individuals of the elite class "persons of the upper socioeconomic class" were the only ones to participate in white-collar crime (Sutherland 1940:1). During the time period this was understandable because the individuals of the so-called "elite class" were the only ones who had access to commit these types of crimes (Weisburd and Schlegel 1992). However, with time, this has changed. Given the development of computers and the advancement of technology, many individuals have been able to participate in white-collar crime. Small business owners not necessarily trying to make money, but to prevent their own livelihood from failing typically commit these types of crimes (Vaughan 1992; Weisburd and Schlegel 1992). There are also the employees of the savings and loan scandal of the 1980s and the impeachment of Richard Nixon. The focus of this study, however, will be on Medicaid fraud against the health care industry. Specifically, it will focus on medical students' and physicians' attitudes toward Medicaid fraud.

Interestingly Sutherland was also the first to incorporate medical offenses as part of white-collar crime. In his book, White Collar Crime he only mentioned doctors as examples because they were perceived as the most honest of the professionals reviewed. He believed that their violations were important to note because physicians were prime examples of explaining why individuals that are not impoverished still participate in illegal activities (Jesilow et al. 1985).

Some researchers have published literature warning physicians of the dangers concerning Medicare and Medicaid fraud. For example, some authors insist that physicians need to be aware of billing practices within their own practice (Tettlebaum 1986; Marcus 1995; Noon 1996). Another area of research focuses on the extent of the problem of health care fraud and if the problem stems from the way the government runs the Medicare and Medicaid programs (Mitchell and Cromwell 1982; Pontell et al. 1984; Jesilow et al. 1985). There has not been as much research on the attitudes and perceptions that medical students and physicians have about Medicaid fraud. This study will focus on how medical students and physicians view Medicaid fraud. First it will be determined if they feel that in

certain circumstances it is permissible to perform illegal acts against Medicaid.

THEORETICAL FRAMEWORK

Two theories seem to explain the existence of Medicaid fraud: Differential Association and the Theory of Organizational Misconduct. Indeed, to fully address the issues surrounding this type of fraud, attention must be given to what these two theories suggest and how they relate to Medicaid fraud.

Sutherland's theory of Differential Association focuses on the fact that individuals learn crime from other individuals and usually these individuals are people that they are close with. He also takes this approach when referring to white-collar crime and believes that individuals usually learn crime from the people with whom they work (Coleman 1992). Sutherland's theory of Differential Association was a landmark in the study of white-collar crime; however, the fact that crime is learned does not explain where the origins of the abnormal attitudes, values, and definitions of this learned behavior begin (Coleman 1998). Sutherland originally defined white-collar crime as "crime committed by a person of respectability and high social status in the course of his

occupation" (Calavita and Pontell 1994:298). However, according to some, today individuals of different socioeconomic statuses can commit white-collar crime (Stohl 1996). Many times low socio-economic individuals, such as hospital and insurance carrier employees, will commit these crimes and feel that it is justifiable because they are acting in the best interest of the organization for whom they are working (Stohl 1996).

That an organization's interests contribute to the existence of Medicaid fraud relates to another theory of white-collar crime, the Theory of Organizational Misconduct. This theory includes individuals acting in their own interests but focuses more on individuals who focus on their organizational interests (Vaughan 1992). There are three main elements to this theory: competitive environment, organizational characteristics, and regulatory environment.

The first element, "competitive environment", suggests that competition forces organizations to break the law so that the organization will be able to obtain certain goals (Vaughan 1992). Consider for example, a case where a hospital was approached for investigation by the state's Medicaid program. Troy Collins, the Finance Director of the hospital, told the investigator that in October they

went through the expense account and sent checks to individuals who were due a refund, leaving the balance that they owed Medicaid to be $24,431. However, the investigator was a little suspicious and told Mr. Collins that he would be back the following week to review canceled checks to make sure that these individuals had indeed been paid. Mr. Collins confessed that the checks had not been mailed out and that they were sitting in the hospital's safe. Mr. Collins' excuse was that the hospital's cash flow had been really tight and that they needed that money to keep the hospital in business (Stohl 1996). Mr. Collins' goal was to keep the organization that he worked for running and by doing so he had to break the law. Clearly this is a case where white-collar crimes were committed to meet the needs of the organization (Vaughan 1992).

The second element, "organizational characteristics", is concerned with the administration of the organization. Further, different structures, processes and transitions occurring within an organization provide numerous opportunities to violate the system (Vaughan 1992). Consider, for instance, cases where dentists often bill Medicare for dentures when in fact their patients are usually younger individuals who are getting braces. In

some instances the government run systems Medicare and Medicaid are easy to violate (Saeger 1989). In many cases, the fraudulent dentists justify their actions by stating that they acted in the best interests of their patients and since Medicare does not pay for braces they believe they have to do this to provide the best care for their patients. The other justification is the fact that braces usually cost more than dentures anyway so they still have to pay more (Saeger 1989).

The third element, "regulatory environment", is concerned with three aspects of regulatory behavior: a) the relationship between the regulators and those they regulate, b) difficulties regulating the actions, and c) problems controlling and detering violations (Vaughan 1992). Research by Payne and Berg (1997), for example, showed that only those cases that are clearly violations come into the criminal justice system. Payne (1995) cites a case where detection occurred only because a physician billed for numerous sonograms for young male children. Others also suggest that difficulties detecting, controlling, and prosecuting cases provide a setting wherein fraud is terribly pervasive (Jesilow et al. 1985). Further, researchers have determined that the investigators for the Medicare and Medicaid programs are poorly trained

and at times go after the wrong physicians. This in turn leads to the code of silence in which many physicians participate (Geis, Jesilow, Pontell and O'Brien 1985; Taylor 1992).

FRAUD PHYSICIANS PERPETRATE

There are many different types of fraud that doctors have been accused of committing. At the broadest legal level, fraud involves cases where doctors intentionally deprive the system (Geis et al. 1985). On a more specific level, the different types of fraud are viewed differently by physicians. Some types of fraud are not viewed as seriously as other types. For instance, billing for services not performed is regarded as less serious than over-utilization of services, but is believed to be more widespread (Keenan, Brown, Pontell and Geis 1985). The two most popular types of fraud, auditors believe, are over-billing and billing for services never provided (Stohl 1996). First, over-billing involves circumstances where physicians charge more than regulators permit. Second, billing for services not performed, often referred to as phantom billing, involves instances where physicians submit claims to the insurer for services never rendered to the patient (Taylor 1992). Other types of fraud include

kickbacks, unbundling, and providing false identification on reimbursement forms (Fiske 1980; Taylor 1992). Kickbacks are when medical suppliers, home health care agencies or other agencies give monetary benefits to physicians who recommend their business to their patients. Unbundling is when physicians bill Medicaid separately as if the procedures that were performed were done on different days (Taylor 1992).

Billing for unnecessary services involves cases where physicians bill for services not needed. Another type of fraud is double billing, in which administrative personnel will double bill by billing Medicaid and Medicare for the same service (Taylor 1992). Even though the administrative personnel such as billing clerks are the ones involved in the fraudulent act, the physician is the one held responsible. Richter (1994) notes that sometimes physicians will purposely submit a claim to one carrier and a claim for that same patient to another carrier and get paid twice. It is important to note that occasionally fraud takes place within physician's offices by employees without the physician's knowledge.

Other scams that take place within the health profession are rolling labs, which usually take place in lower income housing and elderly neighborhoods. These labs

call individuals and inform them that they are able to receive a free check up. The people running the labs will do all kinds of tests that are not needed and then turn around and charge the Medicare and Medicaid programs. Sometimes unneeded equipment will be ordered and sent to individuals because physicians are convinced to sign paper work billing the government for the equipment. In these cases the government is always charged more for the equipment than its original purchase price. Another type of fraud is when physicians will make their patients stay in the hospital even after treatment has been completed so they can bill the government for these services. There is reason to believe that extending hospital stays happens more in mental illness situations because it is hard to determine whether the patient is indeed better or not (Witkin, Friedman, and Guttman 1992).

Even though all these acts are crimes against the government, as mentioned earlier, this study wants to look at over-billing and billing for services never provided because these are two of the most popular types of fraud within the medical community (Stohl 1996). One purpose of this study is to determine if medical students and physicians view over-billing or billing for services never provided as being more serious and if committing one of

these frauds against Medicaid is more justifiable. As Vaughan (1992) notes in her Theory of Organizational Misconduct, individuals will focus more on their "organizational" interests and not on their "own" interests. In this thesis, whether medical students and physicians perceive fraud in their own profession differently than crime in other professions was examined. Also, comparing physicians' views and medical students' views allowed for an assessment of the role that the "organization" has in contributing to these attitudes.

MEDICAL STUDENTS' ATTITUDES TOWARD FRAUD

Keenan et al.'s (1985) study on medical students' attitudes towards Medicare and Medicaid programs and on the problem of fraud and abuse with in these programs focused on four issues. They focused on the quality of these programs, the seriousness of physician fraud, the punishment that should be given and the causes for these abuses. They discovered that attitudes which students have toward fraud and abuse are rather serious with a mean rating of 3.84 on a scale from 1 "not sure" to 5 "very serious". They found that fraud and abuse was slightly more serious than program abuse, which had a mean rating of 3.44 on a scale of 1 being "poor" and 5 being "excellent".

This study found that the students' mean scores were fairly consistent between the different years of school suggesting that the educational experience does not really effect the way that they view fraud. Even though there are ethics classes in medical school they still do not change the opinions of the students. However, this study had a low response rate.

Since medical students start working in the field during their third and fourth years of school they may actually start to see first hand how the government systems work and may have different attitudes than the first and second year students. In the same study, medical students suggested that if the government would increase reimbursement rates and simplify billing procedures it could potentially lessen the magnitude of fraud against the government programs. Only one out of the 144 students surveyed believed that education could be a means for preventing fraud and abuse (Keenan et al. 1985).

Medical school has been regarded as one of the most intensive phases of professional socialization (Keenan et al. 1985). However, many physicians believe that this socialization does not necessarily mean that students will make ethical decisions when it comes to their patients. Many physicians believe that a large number of medical

students are not interested in the field of medicine for the right reasons (Jesilow et al. 1985). Jesilow et al. (1985) also suggest that many times the seed of medical crime starts early in the medical training. In Keenan et al.'s (1985) study one pre-medical student felt justified in cheating because he argued that all medical students were good students and that they needed to help each other to get through school.

Pontell et al. (1984) suggest that some medical schools may be inefficient in their training of adequate ethical standards. Further Keenan et al. (1985) found that medical students viewed Medicare and Medicaid in the same unflattering light as practicing physicians. They gave Medicare and Medicaid low ratings, especially on administrative dimensions. When students were asked why they believed that physicians were against the programs they found that students believed that physicians felt justified in their actions because they perceived the programs as being unfair. Thirty-five percent of the students' causal explanations for fraud and abuse referred to some aspect of the Medicare or Medicaid programs. They believed that the way these programs are run strongly affects whether or not physicians participate in fraudulent acts.

Understanding medical students' attitudes, the sources of their attitudes, and how the attitudes differ from practicing physicians will shed some light on what is needed to reduce fraud in the Medicaid system. Unlike Keenan et al.'s (1985) study this thesis focuses on the transition from medical school to residency positions and practicing or attending positions. This is done to determine if there is an association between respondents' occupation and their attitudes and perceptions about Medicaid fraud. Assessing such variation fits well within the assumptions of Differential Association Theory and the Theory of Organizational Misconduct.

PHYSICIANS' ATTITUDES TOWARD FRAUD

Physicians in all specialties have complained about the low fee schedules and the bureaucratic red tape associated with Medicare and Medicaid (Mitchell and Cromwell 1982). The reimbursement rate in these government programs is one-half of what these physicians usually would charge for their services (Pontell et al. 1984). Saeger (1989) notes that these government programs can be especially difficult and the fee schedules are "pitifully low", especially for dentists. Research suggests that physicians prefer private health care where the market

place and their own interests operate more freely (Mitchell and Cromwell 1982; Jesilow, et al. 1985). A national survey in 1982 found that almost one-fourth of the primary-care physicians that were surveyed were not participating in the government run health programs due to the freedom that was lost by participating in the Medicare and Medicaid programs (Mitchell and Cromwell 1982).

Due to the low fee schedules and the red tape within these government programs certain physicians feel justified in participating in fraudulent acts against these programs (Geis et al. 1985). A common self-defense physicians use to justify their actions is to reassure themselves that they should be getting paid more money than the government offers, therefore, it is acceptable for them to add time to their bills (Geis et al. 1985). In some instances physicians will blame others for their misjudgments. Jesilow, Geis, and Pontell (1991) interviewed physicians who had been sanctioned for participating in Medicaid fraud. They found that a majority of the physicians interviewed would, "Place the blame for their violations of the program, their employees, patients or others. In particular they find program guidelines confusing and irrational and insist that they intrude on what ought to be independent medical judgements" (p.3318). Medicaid and

Medicare regulations have been known to be inefficient. These regulations make it very hard to perform a criminal or administrative investigation. It has also been known to be restrictive of medical practices making it more practical for physicians to violate the programs' rules (Pontell et al. 1984).

Another aspect of physicians' negative attitudes towards the government programs is directly concerned with the regulatory environment considered earlier (Vaughan 1992). In particular a lack of trust may contribute to the problems. Most health care providers welcome fraud and abuse investigators into their hospitals and private practices, however physicians are skittish about these investigators becoming too overzealous which may allow for these investigators to proceed with claims that are honest mistakes by these providers (Gonzales 1997). Also Reginald Ballantyne III, president of PMH Health Resources Inc. and Chairman of the American Hospital Association notes,

> I think it is fair to say that some of the so-called anti-fraud activity and investigations are being conducted as if every doctor, every nurse, every pharmacist, every hospital and every other health care giver in America is guilty of original sin. It has, to some extent, become an exercise in hysteria. (Gonzales 1997:2)

Another health care provider, John Rivers, president and chief executive officer of the Arizona Hospital and

Health Care Association hopes that federal investigators are able to distinguish between real fraud and honest mistakes. He indicated that honest mistakes are easily made in complex medical systems (Gonzales 1997). The government has been known to label honest mistakes as fraud and, because of this, physicians are concerned that even innocent, unintentional mistakes can cost them lots of money and it keeps them on edge. To guard against unfair prosecution some states make a distinction between fraud and abuse. Briefly, fraud involves acts where conduct is present and abuse involves cases lacking intent on the part of the health care provider (Geis et al. 1985).

Many physicians want to be "doctors" and not "businessmen" however, since there is the specter of investigation they feel that they have to be in charge of the business side of their practice (Muehls-Sussman 1997). When the government does make an honest mistake and goes after an innocent provider, the provider still feels the effect even after the government decides to drop the case. This is usually because the investigators are not discrete in their actions and often contact patients who are seeing the physicians in question. Many times these patients will switch physicians because they believe that there is some criminal activity occurring (Fine 1997).

These investigators have been known to be improperly trained, poorly supervised, and in some states out of control (Clement, Williams, and Sanders 1989). To many physicians this is quite alarming because seventy-five percent of these investigator's budgets come from the federal government. The Dental Surveys of America found that the training received by fraud investigative personnel consisted primarily of on the job training with no medical or dental background. Also, program manuals, policies, and procedures were found to be so technically flawed that no case of Medicaid fraud should have or could have been brought against any dental Medicaid providers in some states (Clement et al. 1989).

It should be noted that many of the investigators that review the fraud physicians participate in feel that fraudulent physicians are merely self-serving and greedy (Jesilow et al. 1991). This of course indicates that there is bias on both sides, but for the purpose of this study, the focus will be on the attitudes of medical students and physicians. Determining how they perceive fraud in their organization and whether the structure of the Medicaid system contributes to fraud will serve as a starting point from which a better understanding about fraud in the health care system will evolve.

SUPERVISING PHYSICIANS AWARENESS OF MEDICAID FRAUD

Research has focused on how to help physicians or to at least make them aware of the trouble that they could get themselves into if they or individuals they supervise decide to participate in fraudulent behavior (Tettlebaum 1986; Marcus 1995; Noon 1996). Marcus (1995) focuses on how physicians need to take responsibility for their actions and not rely on others within their practice. He believes that physicians need to be a part of the administrative side of their practice because if the practice is investigated and found guilty of fraudulent acts, the physicians, and no one else, will be responsible for the claim. Tettlebaum (1986) more or less discusses the same aspect as Marcus by discussing the importance of physicians being involved with the paperwork within their offices dealing with the Medicare and Medicaid programs. Noon (1996) notes that most physicians do not appreciate it when their integrity is challenged and she suggests three steps a physician can take to minimize the consequences of a state or federal investigation. First, the physician must be familiar with the rules. Second, physicians must monitor their billing systems. And thirdly, it is important that they seek professional advice if they are not sure what they should do. As a result of these three

steps it would be a good assumption that many physicians that supervise individuals are concerned about getting in trouble with the government program Medicaid even if they themselves are not participating in fraudulent acts against the Medicaid program.

WHAT SHOULD THE PENALTIES BE?

The view that the law should punish white-collar crime grew during the Watergate era and it was believed that due to the Watergate incident that the laws have become harsher for white-collar criminal offenders (Hagan and Palloni 1986). Calavita and Pontell (1994) found that a number of empirical studies indeed reported an increased willingness to prosecute and sanction white-collar offenders in general. However, other researchers suggest that this is not the case within the health care industry (Hagan and Palloni 1986; Moore and Mills 1990; Tillman and Pontell 1992). Hagan and Palloni's (1986) research found that white-collar offenders suffer less than others who are prosecuted. Their research analysis did suggest however that there was an increase in white-collar offenders being imprisoned after Watergate but for shorter periods. When a procedure was used that allowed one to combine information from decisions on whether to imprison with decisions as to

length of imprisonment the results indicated that a canceling of effects occurred.

Tillman and Pontell (1992) did a study to determine whether the criminal justice sanctions imposed on Medicaid offenders are less severe than those imposed on similarly charged street criminals. Their data support the commonly held view that white-collar criminals receive preferential treatment when convicted of crimes. Moore and Mills' (1990) research also came to the same conclusion. This may be because people do not believe that physicians should receive the same penalty that a street criminal should. In Tillman and Pontell's (1992) study one investigator being interviewed states,

> A physician who is defrauding the Medi-Cal program in my mind, is not the same as some sleaze that goes into a bank and pulls a gun and says, "give me your money". He is not the same kind of criminal as somebody who is working in a store and goes over and takes money from the cash register and sticks it in his pocket. They get caught up in a scheme, which allows them to perpetrate fraud. It's a system that's really flawed, which allowed them to do this, and to me, even though I work in this industry to me they're not the same. (p.565)

Tillman and Pontell (1992) concluded that health care offenders have historically benefited from the attitudes of members of the criminal justice system. Many judges and prosecutors view white-collar crime by health care providers differently than white-collar offenders who are

involved in commercial activities. This may be due to the fact that physicians are viewed as upstanding citizens within a community and are respected as individuals who take care of the sick and save lives (Jesilow et al. 1985). Judges and prosecutors sometimes have a hard decision to make to weigh the difference between what the physician has done wrong and what they have given to the community (Tillman and Pontell 1992). Tillman and Pontell (1992) concluded that high educational and occupational prestige, which many white-collar offenders have, cause what they term a "status shield", meaning that these white-collar offenders are protected against harsher penalties that are often applied to street criminals. They also concluded that due to high income these white-collar offenders are able to hire established legal counsel which is not usually accessible for the underprivileged defendant.

Even when states do decide to prosecute physicians to the fullest extent of the law, it does not prevent them from moving to states that have less punitive penalties allowing these physicians to open practices that have few if any restrictions (Ford 1992; Public Citizen Health Research Group 1996). Keenan et al. (1985) note that medical students believed that physicians were unlikely to be penalized for program violations and most of the

students surveyed believed that a moderate penalty (which would include fines, suspension from the program, community service, or simple warning) was a sufficient punitive response. Although this study is focusing on attitudes and perceptions of Medicaid fraud, it is important to note that penalties are less severe in the medical community and this could play a part in how medical students or physicians view Medicaid fraud.

CODE OF SILENCE

The medical community has rarely expressed suspicions about its own members and are known to keep quiet about "wrong doings" that other members within the field are participating in (Geis et al. 1985; Taylor 1992). Stohl (1996) interviewed several perpetrators who felt justified in their actions because they claimed, "this is common practice in the industry" referring to fraudulent acts that they participated in. Because this is such a common practice, physicians often feel that they may be ostracized if they step forward and give up colleagues (Stohl 1996). Other physicians believe that what is going on is justified and needs to take place for the health care industry to thrive. Some physicians believe that "outsiders" do not really understand what goes on within the health care

industry and that the "outsiders" impose rules that almost make it impossible for physicians to do their job which is to treat patients (Jesilow et al. 1985). If a fellow co-worker testifies against a physician for participating in fraud it is often not due to the ethical standards that they believe in but because they are upset with the physicians due to other circumstances (Geis et al. 1985).

There are also instances where communities are aware of the fraud occurring within a physician's office. However, the community is reluctant to report the physicians because most of the time these are in rural areas where it is hard to recruit a physician in the first place (Jesilow et al. 1985). These communities could lose access to a physician for several years if their physician is convicted (Taylor 1992).

SERIOUSNESS OF THE PROBLEM

Columbia, the world's largest health care corporation with a 1996 revenue of over twenty billion dollars, was under a large investigation for fraud and in the process several Chief Executive Officers resigned. During this investigation investigators wanted to send a message to other health care industries that fraud was a serious problem and that it would not be tolerated (Beaver 1997).

However, physicians and other health care employees do not find it to be such a serious problem. As one respondent put it "There's certain things you do. You'll bend the rules a bit. In your mind you're not violating the law, you're bending a rule" (Simpson 1992:294). Some physicians believe that they can over-bill Medicare because there were times when they did not bill the program as much as they could have and "it will all come out it the wash" (Noon 1996). In this case the counsel can turn the physician's actions away from being criminal and toward reckless conduct (Noon 1996). Needless to say, this frustrates the investigators who spend so much time devoted to convicting fraudulent physicians.

SUMMARY

The first purpose of this study is to determine if medical students' and physicians' attitudes about Medicaid fraud differ. Medical students' first two years of training mainly take place in a classroom setting. There are classes taught on ethics, however, these classes do not go into a lot of detail about criminal or deviant acts against the medical system (Office of Public Affairs from the medical school used in this thesis 1997). It is likely that physicians who have been practicing for a period of

time become more aware of the problems associated with Medicaid fraud by colleagues and also understand the overwhelming problems that physicians have with this program. Finding out if differences exist between the two groups will help determine if professional socialization impacts attitudes about the system.

A second purpose of this study is to determine if there is an association between medical students' and physicians' attitudes toward Medicaid fraud and how they perceive the Medicaid program. Their opinions will be elicited to determine if the Medicaid program is believed to provide quality care, reaches all those in need of service, is cost-effective, has a good reimbursement scale and has a program that is efficient. This is an important issue to research because medical students and physicians who do not perceive Medicaid as doing well may be more likely to believe that the fraudulent acts performed against this program are less serious and more justifiable. In turn, perceptions might equate to increased likelihood of deviance.

A third purpose of this study is to determine the attitudes of medical students and physicians about the difference in billing for unnecessary services and over-billing to determine which one of these crimes is seen as more serious and less justifiable.

A fourth purpose of this study is to determine if there is an association between individuals' attitudes toward Medicaid and how many individuals they supervise.

HYPOTHESES

Based on the literature and theoretical framework that has been reviewed a survey has been designed to test the following hypotheses:

1. Physicians will be more likely to view Medicaid fraud less seriously than medical students will.
2. Individuals who supervise four or more employees will be more likely to have a less serious response to Medicaid fraud than those who supervise only a few individuals.
3. Medical students will view instances where physicians over-bill as more serious than physicians will.
4. Physicians will be more likely to view instances where lawyers, auto mechanics, and financial consultants over-bill services as more serious than medical students will.
5. Medical Students will be more likely to view instances where physicians bill for unnecessary services as more serious than physicians will.

6. Physicians will be more likely to view instances where lawyers, auto mechanics, and financial consultants bill for unnecessary services as more serious than medical students will.
7. When asked to rank the seriousness of various types of occupational fraud, medical students will rank Medicaid fraud as more serious than physicians will.
8. Medical students will rate the effectiveness of Medicaid higher than physicians will.

CHAPTER III

METHODOLOGY

The primary purpose of this study was to survey medical students and physicians and to seek their attitudes toward Medicaid fraud. This research project focused on four specific areas in the larger topic of Medicaid fraud. First, do medical students and physicians view the seriousness and justifiability of Medicaid fraud differently? Second, do medical students' and physicians' attitudes differ by type of Medicaid fraud (e.g. billing for services not performed or the over-utilization of services)? Third, is there an association between physicians' attitudes toward Medicaid and how many individuals they supervise? And fourth how do medical students' and physicians' attitudes toward Medicaid fraud compare to their attitudes toward fraud in other occupations?

This chapter reviews the methods employed in collecting and measuring the concepts and testing the hypotheses outlined in Chapter II. A discussion of the sample, the questionnaire, the dependent and independent variables, and the statistical procedures used in the analysis are presented.

RESEARCH SETTING

The questionnaire was distributed in two different settings. These settings were a medical school in southeast Virginia and a hospital also located in southeast Virginia. The medical school was established in 1973 and accepted their first students the same year. The school provides a broad range of services, including such specialized areas as endocrinology, genetics, geriatrics, gynecologic oncology, and maternal-fetal medicine just to name a few. Today, the medical school provides medical education for approximately 400 medical students each year. The school provides residency and fellowship training for approximately 300 physicians each year and it also offers educational seminars and symposia for more than 2,000 physicians and allied health professionals each year. In addition to its M.D., residency, and continuing medical education programs, the medical school also sponsors a Ph.D. program in biomedical sciences, a doctorate in clinical psychology and a Master of Science degree in art therapy.

The hospital is a 644-bed tertiary care facility situated within a large medical complex that includes the medical school described above and a children's hospital. It is the primary teaching hospital for the medical school.

The hospital's medical staff consists of about 2,500 physicians, and employs more than 3,300 people (The preceding information was obtained from a brochure from the medical school's Office of Public Affairs and the hospital's home page. The full references were omitted to protect the confidentiality of the research setting).

DATA COLLECTION

Administration of the Survey

The surveys, which were approved by the Institutional Review Board of Old Dominion University, were distributed at the medical school to four hundred medical students, two hundred to the first and second year students and two hundred to the third and fourth year students. First and second year students, who were in a classroom setting, completed the questionnaire on the medical school campus. The questionnaire was distributed during students' class time and the professors teaching these classes gave permission. A sealed "drop box" was provided for these students to drop off their questionnaire at the end of class. It should be noted that this procedure was followed, however, it was discovered that there is usually only a fifty-percent attendance rate, at any given time, for these students to attend class. Therefore,

approximately fifty-percent of the first and second year students were not surveyed.

Third and fourth year students, who are involved in clinical training at several area hospitals, received the questionnaire in their mailboxes, located at the medical school, and they were asked to return completed surveys to a sealed "drop box" located in the mailroom. Since there was a chance for a lower response rate from the third and fourth year students a second survey was distributed in their mailboxes with a different cover letter thanking the individuals who had already participated in the survey and encouraging those who had not yet participated. A similar distribution was used by Keenan et al. (1985) which yielded a reliable sample.

The surveys distributed at the hospital were distributed to physicians. Each physician in charge of the different rotations through the medical school were asked to distribute the questionnaire during rounds. These rotations were going to include Internal Medicine, Surgery, Family Medicine and Pediatrics. However, only the departments of Internal Medicine and Pediatrics allowed distribution of the survey during rounds.

Survey Contents

The survey instrument (see Appendix) consists of 20 questions designed to collect data on attitudes associated with professional misrepresentation. The data reflects not only misrepresentation within the medical field but also among professions outside the medical field. This is used as a comparison measure to determine if medical students and physicians do indeed view fraud outside their profession differently. A portion of the misrepresentation seen in the medical field deals with the government administered program Medicaid. There has been a recent increase in health care professionals' dissatisfaction with this program and, therefore, it is important to determine if medical students and physicians perceive misrepresentations within their own field differently depending on their perceptions of Medicaid.

Six of the questions ask for basic demographic information: gender, age, race, occupation, how long in current position and how many individuals supervised while eight of the questions measured medical students' and physicians' attitudes toward professional misrepresentation.

These eight questions were in the form of scenarios and were categorized into four different occupations (Auto-

Mechanic, Physician, Lawyer, and Financial Consultant). These scenarios are also broken into two different types of misrepresentations (over-billing time and over-billing unnecessary services). Looking at other professions gave a comparison to determine if in fact medical students and physicians perceive fraud within their own profession as less serious and more justifiable. The over-billing for time scenarios were stated as follows:

> "An auto-mechanic bills insurance companies for at least an hour of labor even if the labor actually took less time."
>
> "A physician bills Medicaid for at least an hour consultation even if the consultation actually took less time."
>
> "A lawyer bills corporations for at least an hour consultation even if the consultation actually took less time."
>
> "A financial consultant bills companies for at least an hour consultation even if the consultation took less time."

After reading each scenario, the respondents determined whether they believed the scenario was Very Serious, Somewhat Serious or Not at all Serious. They also had to determine whether they believed the scenario was

Very justifiable, Somewhat Justifiable or Not at all Justifiable.

The over-billing of unnecessary service scenarios were stated as follows:

"A physician bills Medicaid for a full set of laboratory, x-ray and EKG studies, some of which were not necessary."

"An auto mechanic bills insurance companies for parts and diagnostic testing, some of which were not necessary."

"A lawyer bills corporations for legal research and expert consultations, some of which were not necessary."

"A financial consultant bills companies for investment services and tax planning, some of which were not necessary."

After reading the scenario, the respondents determined whether they believed the scenario was Very Serious, Somewhat Serious or Not at All Serious. They also were asked whether they believed the scenario was Very Justifiable, Somewhat Justifiable or Not at All Justifiable.

Three other survey questions dealt with issues about Medicaid and issues of fraud. Respondents rated five

aspects of Medicaid on a 5 point scale with 1 being "poor" and 5 being "excellent". These questions were modeled after those asked by Keenan et al. in 1985. The respondents also ranked the seriousness of the following types of fraud: Automotive fraud, Financial Consultant fraud, Legal fraud and Medicaid fraud. "One" represents the most serious and "four" is the least serious. Respondents were also asked had to rate the prevalence of fraud among these four occupations on a 4 point interval scale ranging from 1 (20 percent or less) to 4 (61 percent or more).

VARIABLES

Dependent Variable

The dependent variable is medical students' and physicians' attitudes toward professional fraud. This variable was measured through eight different scenarios, which are mentioned above. These scenarios view different types of fraud, over-billing or over-utilization of services, and review different professions participating in these types of fraud such as auto-mechanics, physicians, lawyers, or financial consultants.

Independent Variables

The independent variables in this study are occupation, number of individuals an individual supervises, and medical students' and physicians' perceptions of the Medicaid program. The variable occupation was broken into six different categories. MI represents the first year of medical school, which is designed to assist students in making the transition from college to medical school. Anatomy, biochemistry, and physiology provide students with a firm foundation in the normal structure and function of the human body and they also have classes in medical ethics, medical interviewing and problem solving.

MII represents the second year of medical school, which introduces students to the structural and functional abnormalities of the human body and the various therapeutic interventions used in the treatment of these disorders.

MIII represents the third year of medical school, which allows students to begin their clinical rotations that introduce them to the practice of clinical medicine. Students complete rotations that include twelve weeks of internal medicine, eight weeks of gynecology, psychiatry, and surgery, and six weeks each of family medicine and pediatrics.

MIV represents the fourth year of medical school, which allows medical students to continue to gain clinical experience through rotations in surgical subspecialties and advanced pediatrics. The remainder of the year is devoted to elective experiences in both clinical and basic sciences.

Resident represents an individual who receives additional training in a specific field after graduating from medical school and has been board certified to practice medicine. Resident programs can be competitive and even though residents are physicians they are still gaining knowledge and are paid around one-quarter of what they will be paid once they finish their residency. Residencies vary in length ranging from four to ten years depending on the type of medicine the individual wants to practice. Some of the residency programs offered through this medical school are Emergency Medicine, Family Medicine, General Surgery, Internal Medicine and Pediatrics just to name a few. Attending/Practicing represents a physician who has completed his or her training.

The second independent variable is the number of individuals an individual supervises and is included to determine if there is an association between the number of individuals an individual supervises and how these

individuals view Medicaid fraud. This question within the survey was not broken into categories but was an open-ended question. The number of employees an individual supervises was categorized after the surveys had been completed.

The third independent variable is medical students' and physicians' attitudes towards Medicaid. This variable was measured by scaling five questions from Keenan et al. (1985) to determine whether physicians and medical students believe that the program Medicaid is effective. The scaling technique is discussed in more detail in the analysis section.

STATISTICAL ANALYSIS

The data was analyzed using the statistical package SPSS for Windows. Descriptive statistics such as means, standard deviations, and correlation coefficients were used to report the frequency of specific variables and to describe the sample data. The analysis of association tested the relationship and associations between the independent variables and the dependent variables. These relationships and associations tested the hypotheses within this study.

Scaling Techniques

A Likert type scale was developed to assess overall satisfaction with Medicaid. This scale was formed under the assumption that the overall score of these items would be a good measure for the variables in question. The scale deals with Medicaid and how effective medical students and physicians believe this program to be. Following Keenan et al.'s (1985) research, five aspects of the programs were questioned: Quality of care delivered, ability to reach all those in need of service, cost-effectiveness, reimbursement scale and program efficiency. The respondents were able to choose from Poor, Fair, Good and Excellent. This allowed for all these questions to be collapsed into one scale to judge how medical students and physicians perceive the effectiveness of this program.

CHAPTER IV

RESULTS

As stated previously, the general aim of this study is to examine how medical students and physicians perceive the seriousness and extent of Medicaid fraud. More specifically there are four distinct areas within the larger topic of Medicaid fraud that were addressed. These four areas were addressed through responding to the following questions: First, do medical students and physicians view the seriousness and justifiability of Medicaid fraud differently? Second, do medical students' and physicians' attitudes differ by type of Medicaid fraud (e.g. billing for services not performed or the over-utilization of services)? Third, is there an association between physicians' attitudes toward Medicaid and how many individuals they supervise? And fourth how do medical students' and physicians' attitudes toward Medicaid fraud compared to their attitudes toward fraud in other occupations?

Addressing these specific questions will shed some light on the role of training in the fostering of attitudes about the seriousness and justifiability of Medicaid fraud.

The population of this study included medical students and physicians from a medical school and hospital located in southeast Virginia; therefore, the results contained herein can not necessarily be generalized to all medical schools and hospitals. However, because research focusing on the way that academic socialization contributes to attitudes about medical deviance is so rare, any attention in this area is important for advances in criminological theory, white-collar crime research, and medical education.

A survey was conducted in order to test the hypotheses in this study. An overview of the sample is included in Table 1. As shown in the table, the average age of the respondents is 29.00 (s=7.14) years with respondents ranging from the youngest who is 20 years to the oldest who is 54 years. Nearly three-fourths (n=150) of the respondents are white and the rest are minorities (n=47). Additionally, slightly over half are male (n=106) with a little under half being female (n=91).

Seventy-six percent(n=150) of the respondents are medical students and twenty-four percent (n=47) are physicians. Out of these respondents 85 percent (n=167) supervise zero to three individuals and 15 percent (n=30) reported supervising more than three individuals. The average number of employees respondents reported

Table 1. Sample Characteristics

Variables	N = 197	Percentage
Gender		
Male	106	53.8
Female	91	46.2
Age		
20-30	135	68.5
31-40	48	24.1
41&up	13	6.5
Mean = 29.00		
Range = 20-54		
Standard Deviation = 7.14		
Occupation		
1st year medical student	53	26.9
2nd year medical student	44	22.3
3rd year medical student	21	10.7
4th year medical student	32	16.2
Resident	19	9.6
Attending/Practicing	28	14.2
How long in current position		
1-3 years	130	66.0
4-6 years	52	26.5
7-9 years	5	2.5
10 years and up	10	5.0
Mean = 3.19		
Range = 1-20		
Standard Deviation = 2.98		
Individuals Supervised		
0-3 Supervised	167	84.8
4 or more supervised	30	15.2
Mean = 1.23		
Range = 0-15		
Standard Deviation = 2.64		
Race		
White/Caucasian	150	76.1
Asian	25	12.7
Black/African American	18	9.1
Other	4	2.0

supervising was 1.15 (SD=.36). Note this number is low because a majority of the sample reported supervising no individuals (n=149). The average amount of time the respondents have been in their current positions is 3.19 years(SD=2.98).

Tables 2 and 3 display the eight scenarios that were used in this study and they show the respondents' perceptions of the seriousness and justifiability of each scenario. The scenarios were recoded because many of the cells displayed had a frequency of less than 5. In particular, when asked about the seriousness of the crime scenarios, most of the respondents were unwilling to respond that the offense was "not at all" serious. As well, when asked to indicate the justifiability of the fraudulent actions, very few of the respondents indicated that the acts were "very" justifiable.

To deal with this dilemma, the variables dealing with the seriousness of fraud were recoded into two categories. Specifically, "Not at All Serious" responses were combined with the "Somewhat Serious" responses. Doing this resulted in two categories: "Very Serious" and "Somewhat to Not at All Serious". In addition to collapsing the categories for means of statistical analysis, conceptual arguments support the recoding. In particular, "Very Serious" implies a

Table 2. Respondents' Perceptions of Seriousness of Each Scenario

Scenarios	Seriousness		
	Very	Somewhat	Not at all
Scenario 1 "An auto-mechanic bills insurance companies for at least an hour of labor even if the labor actually took less time."	32(16.2)	131(66.5)	34(17.3)
Scenario 2 "A physician bills Medicaid for at least an hour consultation even if the consultation actually took less time."	63(32.0)	118(59.9)	16(8.1)
Scenario 3 "A lawyer bills corporations for at least an hour consultation even if the consultation actually took less time."	44(22.3)	134(68.0)	19(9.6)
Scenario 4 "A financial consultant bills companies for at least an hour consultation even if the consultation took less time."	39(19.8)	134(68.0)	24(12.2)

Table 2. Continued

Scenarios	Seriousness: Very	Somewhat	Not at all
Scenario 5 "A physician bills Medicaid for a full set of laboratory, x-ray and EKG studies, some of which were not necessary."	105(53.3)	82(41.6)	10(5.1)
Scenario 6 "An auto mechanic bills insurance companies for parts and diagnostic testing, some of which were not necessary."	69(35.0)	117(59.4)	11(5.6)
Scenario 7 "A lawyer bills corporations for legal research and expert consultations, some of which were not necessary."	71(36.0)	115(58.4)	11(5.6)
Scenario 8 "A financial consultant bills companies for investment services and tax planning, some of which were not necessary."	71(36.0)	115(58.4)	11(5.6)

Table 3. Respondents' Perceptions of Justifiability of Each Scenario

	Justifiability		
Scenarios	Very	Somewhat	Not at all
Scenario 1 "An auto-mechanic bills insurance companies for at least an hour of labor even if the labor actually took less time."	5(2.5)	108(54.8)	84(42.6)
Scenario 2 "A physician bills Medicaid for at least an hour consultation even if the consultation actually took less time."	0(0.0)	106(53.8)	91(46.2)
Scenario 3 "A lawyer bills corporations for at least an hour consultation even if the consultation actually took less time."	1(0.5)	106(53.8)	90(45.7)
Scenario 4 "A financial consultant bills companies for at least an hour consultation even if the consultation took less time."	6(3.0)	101(51.3)	90(45.7)

Table 3. Continued

Scenarios	Justifiability: Very	Somewhat	Not at all
Scenario 5 "A physician bills Medicaid for a full set of laboratory, x-ray and EKG studies, some of which were not necessary."	4(2.0)	68(34.5)	125(63.5)
Scenario 6 "An auto mechanic bills insurance companies for parts and diagnostic testing, some of which were not necessary."	5(2.5)	60(30.5)	132(67.0)
Scenario 7 "A lawyer bills corporations for legal research and expert consultations, some of which were not necessary."	4(2.0)	69(35.0)	124(62.9)
Scenario 8 "A financial consultant bills companies for investment services and tax planning, some of which were not necessary."	4(2.0)	69(35.0)	124(62.9)

sense of outrage about the acts. Conversely, "Somewhat to Not at all Serious" suggests that the acts are not that problematic. If certain groups are more likely to fall into one category as opposed to the other, very clear implications about the differences between the groups would arise.

The variables dealing with the justifiability of fraud were also recoded into two categories. Specifically, "Very Justifiable" was combined with "Somewhat Justifiable" leading the justifiability variable to include the following categories: "Very to Somewhat Justifiable" and "Not at All Justifiable". This distinction makes a lot of sense substantively in that those who said the respective act was "Not at All Justifiable" were responding with an absolute belief about the justifiability of the act. Alternatively, those who said the act was either "Very" or "Somewhat" justifiable, at least to a degree, saw circumstances that would justify the criminal acts.

Respondents were also asked to indicate how extensive they viewed the following types of fraud: automotive, financial, legal and Medicaid. Responses to this question are outlined in Table 4. As shown in the table, both students and physicians perceived Medicaid fraud as being the least extensive of the four types of fraud discussed in

Table 4. Respondents Perceptions' of Extent of Fraud in the Four Occupations

	Perceived Extent			
Fraud Type	20%orless	21%to40%	41%to60%	61%ormore
Automotive Fraud	41(20.8)	50(25.4)	69(35.0)	36(18.3)
Financial Fraud	72(36.5)	67(34.0)	48(24.4)	9(4.6)
Legal Fraud	52(26.4)	60(30.5)	55(27.9)	29(14.7)
Medicaid Fraud	89(45.2)	58(29.4)	39(19.8)	10(5.1)

this study. Conversely, both groups viewed automotive fraud as being the most extensive type of fraud.

CROSSTABULAR ANALYSIS

Cross tabulation procedures for occupation, number of individuals supervised and different types of fraud were conducted to see if significant differences exist between the groups. Many significant results were found. What follows is a description of the findings with regard to each hypothesis. For ease of presentation, the findings are discussed in terms of frequencies and percentages and the results of each hypothesis test separately described separately.

Occupation by Physician Fraud

The first hypothesis in this study states that *physicians will be more likely to view Medicaid fraud less seriously than medical students will.* To test this hypothesis, respondents were asked to determine how serious and justifiable Medicaid fraud was to them by reading two scenarios dealing with Medicaid fraud. One scenario dealt with over billing for services and the other dealt with performing unnecessary tests and services (see Scenario's 2 and 5 in the Appendix). These two scenarios were collapsed

together to determine how serious and justifiable the respondents perceive Medicaid fraud. To collapse these scenarios the two variables were added together and then re-scaled to reflect the new variable that does not distinguish between over billing for services and performing unnecessary tests against Medicaid. Table 5 outlines incidents of Medicaid fraud, comparing occupation, medical students and physicians, by seriousness and justifiability of physician fraud.

Seriousness. Cross tabulation procedures were conducted to see if medical students and physicians perceived the seriousness of Medicaid fraud differently. Results indicate statistical significance with a somewhat moderate relationship appearing (Chi-square = 22.81, phi = .34; p = .001). In particular, only 18 percent of the medical students indicated that Medicaid fraud was very serious while 53 percent of the physicians responded that Medicaid fraud was very serious. Note, however, although there is a significant relationship, it is in the opposite direction than hypothesized.

Justifiability. A cross-tabulation analysis was carried out to see if medical students and physicians perceived the justifiability of Medicaid fraud differently. Results indicate that doctors were less likely to see the

Table 5. Occupation by Seriousness and Justifiability of Physician Fraud

Occupation	Seriousness: Very		Seriousness: Somewhat to Not at all	
	N	Percent	N	Percent
Medical Students	27	18.0	123	82.0
Physicians	25	53.2	22	46.8
Total	52	26.4	145	73.6
Chi-square (d.f. = 1)		22.812***		
Phi		.340		

Occupation	Justifiability: Very To somewhat		Justifiability: Not at all	
	N	Percent	N	Percent
Medical Students	115	76.7	35	23.3
Physicians	21	44.7	26	55.3
Total	136	69.0	61	31.0
Chi-square (d.f. = 1)		17.128***		
Phi		.295		

*** p<.001

acts as justifiable than students were (Chi-square = 17.13, phi = .30, p = .001). This is a weak to moderate relationship. More specifically, only (23 percent) of the medical students felt that Medicaid fraud was never justifiable while over half (55 percent) of the physicians felt these acts were never justifiable. Again, the direction on the relationship is in the opposite direction of the original hypothesis.

Individuals by How Many Individuals Supervised

The second hypothesis in this study states that *individuals who supervise four or more employees will be more likely to have a less serious response to Medicaid fraud than those who supervise only a few individuals.* To test this hypothesis, the same scale as in the previous hypothesis is used. It is important to note that the number of individuals supervised was collapsed to a dichotomous variable for statistical and conceptual reasons. First, statistically, a large percentage of the sample reported supervising very few individuals and tests based on the mean would be misleading and flawed. Second, conceptually, those who supervise four or more employees are in a group more likely to be viewed as an organization as opposed to a single individual. The Theory of

Organizational Misconduct suggests this is the case. This theory includes individuals acting in their own interests but focuses more on individuals who focus on their organizational interests (Vaughan 1992). Table 6 reveals how those who supervised four or more individuals viewed the seriousness and justifiability of Medicaid fraud as opposed to those who supervised three or less employees

Seriousness. Using cross tabulation procedures, those who supervised three or fewer individuals perceived Medicaid fraud differently than those who supervised four or more individuals (Chi-square = 7.49, phi = .20, p = .006). Specifically, only 23 percent of the respondents who supervise three or fewer employees felt that Medicaid fraud was very serious while 47 percent of the respondents who supervised four or more felt that Medicaid fraud was very serious.

Justifiability. Results of cross tabulation procedures also reveal that those who supervise fewer individuals were more likely to view fraud as justifiable as opposed to those who supervised four or more individuals (Chi-square = 6.00, phi = .18, p = .01). In particular, only just over one fourth (26 percent) of the respondents who supervised three or fewer individuals felt that physician fraud was never justifiable while one half of

Table 6. Individuals Supervised by Seriousness and Justifiability of Physician Fraud

Individuals Supervised	Seriousness: Very N	Seriousness: Very Percent	Seriousness: Somewhat to Not at all N	Seriousness: Somewhat to Not at all Percent
Supervises 0-3	38	22.8	129	77.2
Supervises 4-up	14	46.7	16	53.3
Total	52	26.4	145	73.6
Chi-square (d.f. = 1)		7.485**		
Phi		.195		

Individuals Supervised	Justifiability: Very To somewhat N	Justifiability: Very To somewhat Percent	Justifiability: Not at all N	Justifiability: Not at all Percent
Supervises 0-3	121	72.5	46	27.5
Supervises 4-up	15	50.0	15	50.0
Total	136	69.0	61	31.0
Chi-square (d.f. = 1)		5.999*		
Phi		.175		

*p<.05 **p<.01

those who supervised four or more felt it was never justifiable.

Occupation by Physicians who Over-Bill Services

The third hypothesis in this study states that *medical students will view instances where physicians over-bill services more serious than physicians will.* To test this hypothesis, respondents were asked to determine how serious and justifiable Medicaid fraud was by reading one scenario dealing with Medicaid fraud (see Scenario 2 in Appendix). This scenario dealt with a fraudulent act where a physician billed for services but did not provide the full amount of services for which the physician is reimbursed. Table 7 outlines the relationship between occupation and respondents' perceptions about the seriousness and justifiability of over billing.

Seriousness. Results of the cross tabulations procedure show that medical students and physicians do indeed perceive the seriousness of physician over-billing differently (Chi-square = 15.46, phi = .28, p = .001). Although only a weak to moderate relationship, just 25 percent of the medical students felt that over-billing of services by physicians was very serious while 55 percent of

Table 7. Occupation by Seriousness and Justifiability of Physicians Who Over-Bill Services

Occupation	Seriousness: Very		Seriousness: Somewhat to Not at all	
	N	Percent	N	Percent
Medical Students	37	24.7	113	75.3
Physicians	26	55.3	21	44.7
Total	63	32.0	134	68.0
Chi-square (d.f. = 1)		15.458***		
Phi		.280		

Occupation	Justifiability: Very To somewhat		Justifiability: Not at all	
	N	Percent	N	Percent
Medical Students	85	56.7	65	43.3
Physicians	21	44.7	26	55.3
Total	106	53.8	91	46.2
Chi-square (d.f. = 1)		2.068		

*** p<.001

the physicians felt that over-billing of services by physicians as being serious.

Justifiability. As expected, similar trends were found when justifiability was considered. Specifically, physicians were more likely than medical students to say that the acts were not at all justifiable (Chi-square = 2.07, phi = .10, p = .15). Note, however, that the relationship was not statistically significant with 43 percent of the medical students indicating that over-billing of services by physicians was not at all justifiable and 55 percent of the physicians indicating that the act was never justifiable.

Occupation by Over-Billing of Services by Auto-Mechanics, Lawyers and Financial Consultants

The fourth hypothesis in this study states that *physicians will be more likely to view instances where lawyers, auto-mechanics, and financial consultants over-bill services as more serious than medical students will.* To test this hypothesis, respondents were asked to determine how serious and justifiable fraud within these three different groups were by reading three scenarios dealing with over-billing of service by, auto mechanics, lawyers and financial consultants (see Scenarios, 1, 3, and

4, on the questionnaire in Appendix). Tables 8a, 8b, and 8c outline the way that physicians and medical students perceive the seriousness and justifiability of fraudulent acts in these other professions. While discussing the results of Hypothesis 4, each occupational category is reviewed separately. These categories are auto-mechanics, lawyers, and financial consultants.

Auto-Mechanic Fraud

Seriousness. As with the other scenarios, respondents were asked to indicate how serious they believe an instance where an auto-mechanic over-bills for services. In this case, there were no significant differences between students' perceptions of seriousness and physicians' perceptions of seriousness (see Table 8a). Indeed, only 14 percent of the medical students felt that automotive fraud was very serious while 23 percent of the physicians felt that automotive fraud was very serious.

Justifiability. In a similar vein, there were no statistically significant differences concerning how justifiable the two groups viewed auto mechanic over-billing. In fact, roughly the same percentage of students (43 percent) and physicians (40 percent) indicated that the

Table 8a. Occupation by Seriousness and Justifiability for Over-Billing of Services by Auto-Mechanics, Lawyers and Financial Consultants

Over-Billing of Services by Auto-Mechanics

Seriousness

Occupation	Very		Somewhat to Not at all	
	N	Percent	N	Percent
Medical Students	21	14.0	129	86.0
Physicians	11	23.4	36	76.6
Total	32	16.2	165	83.8
Chi-square (d.f. = 1)		2.326		

Justifiability

Occupation	Very To somewhat		Not at all	
	N	Percent	N	Percent
Medical Students	85	56.7	65	43.3
Physicians	28	59.6	19	40.4
Total	113	57.4	84	42.6
Chi-square (d.f. = 1)		.124		

Table 8b. Occupation by Seriousness and Justifiability for Over-Billing of Services by Auto-Mechanics, Lawyers and Financial Consultants

Over-Billing of Services by Lawyers

Seriousness

Occupation	Very		Somewhat to Not at all	
	N	Percent	N	Percent
Medical Students	28	18.7	122	81.3
Physicians	16	34.0	31	66.0
Total	44	22.3	153	77.7
Chi-square (d.f. = 1)		4.877*		
Phi		.157		

Justifiability

Occupation	Very To somewhat		Not at all	
	N	Percent	N	Percent
Medical Students	83	42.1	67	34.0
Physicians	24	12.2	23	11.7
Total	107	54.3	90	45.7
Chi-square (d.f. = 1)		.263		

* $p<.05$

Table 8c. Occupation by Seriousness and Justifiability for Over-Billing of Services by Auto-Mechanics, Lawyers and Financial Consultants

Over-Billing of Services by Financial Consultants

Seriousness

Occupation	Very		Somewhat to Not at all	
	N	Percent	N	Percent
Medical Students	24	16.0	126	84.0
Physicians	15	31.9	32	68.1
Total	39	19.8	158	80.2
Chi-square (d.f. = 1)		5.709*		
Phi		.170		

Justifiability

Occupation	Very To somewhat		Not at all	
	N	Percent	N	Percent
Medical Students	85	56.7	65	43.3
Physicians	22	46.8	25	53.2
Total	107	54.3	90	45.7
Chi-square (d.f. = 1)		1.402		

* $p<.05$

incident described in the scenario was not at all justifiable.

Lawyers

Seriousness. The same procedure was used to see if medical students and physicians perceived the seriousness of instances where lawyers overcharge differently. As shown in Table 8b, significant differences were found with medical students being less likely to define the cases as very serious than physicians were (Chi-square = 4.88, phi = .15, p = .027). Specifically, only 19 percent of the medical students responded that this type of lawyer fraud was very serious while 34 percent of the physicians suggested that it was very serious.

Justifiability. Using the same procedures showed that no differences exist when the justifiability of these acts are considered. In particular 34 percent of the medical students indicated that cases where lawyers overcharge was not at all justifiable while 12 percent of the physicians responded it was not justifiable.

Financial Consultants

Seriousness. As shown in Table 8c, cross tabulation analysis revealed that differences between medical students

and physicians exist when instances of financial consultant fraud are considered (Chi-square = 5.71, phi = .17; p = .02). However, this is a weak relationship. Only 16 percent of the medical students suggested that financial consultant fraud was very serious. On the other hand, 32 percent of the physicians indicated that financial planner fraud was very serious.

Justifiability. Using the same procedures, however, showed that medical students' and physicians' perceptions about the justifiability of financial consultant fraud did not vary significantly. In fact, 43 percent of the medical students indicated that financial consultant fraud was not at all justifiable while 53 percent of the physicians felt it was not justifiable.

To sum up hypothesis four, there is moderate support for the prediction that physicians would view instances where lawyers and financial consultants over bill as more serious than medical students do. In particular, physicians were more likely to view legal fraud and financial consultant fraud as more serious than medical students. However, significant differences between the two groups' perceptions about the justifiability of each act were not found.

Occupation By Physicians Billing for Services Not Necessary

The fifth hypothesis in this study states that *medical students will be more likely to view instances where physicians bill for unnecessary services as more serious than physicians will.* To test this hypothesis, respondents were asked to determine how serious and justifiable it is for physicians to bill for unnecessary services by reading one scenario dealing with physicians who bill for unnecessary services (see Scenario 5 in Appendix). This scenario dealt with a fraudulent act where a physician bills for services that where not necessary. Table 9 outlines the way that medical students and physicians perceive the seriousness and justifiability of billing for unnecessary services.

Seriousness. As with the other hypotheses, cross tabulation procedures were conducted to determine whether a relationship exists between occupation and perceptions about the seriousness of billing for unnecessary services. Results shown in Table 9 indicate that a rather moderate to strong relationship exists with physicians being extremely more likely to view billing for unnecessary services as more serious than medical students do (Chi-square = 36.19, phi = .43, p = .001). More specifically, less than half of the medical students (41 percent) felt that billing for

Table 9. Occupation by Seriousness and Justifiability by Physicians Billing for Services not Necessary

Occupation	Seriousness: Very		Seriousness: Somewhat to Not at all	
	N	Percent	N	Percent
Medical Students	62	41.3	88	58.7
Physicians	43	91.5	4	8.5
Total	105	53.3	92	46.7
Chi-square (d.f. = 1)		36.168***		
Phi		.428		

Occupation	Justifiability: Very To somewhat		Not at all	
	N	Percent	N	Percent
Medical Students	67	44.7	83	55.3
Physicians	5	10.6	42	89.4
Total	72	36.5	125	63.5
Chi-square (d.f. = 1)		17.869***		
Phi		.301		

*** p<.001

services not necessary by physicians was very serious. Alternatively, nearly all of the physicians (92 percent) responded that billing for services not necessary by physicians was a very serious offense.

Justifiability. Similar results were found when the perceived justifiability of billing for unnecessary services was examined in that students were more likely to view the act as justifiable than physicians were (Chi-square = 17.87, phi = .30, p = .001). When asked to indicate whether the act was justifiable, slightly over half of the medical students (55 percent) suggested that billing for services not necessary by physicians was not justifiable under any circumstances. Conversely, nearly all of the doctors (89 percent) said the act was never justifiable.

Clearly, billing for services not needed is an act that physicians do not take lightly. As with the other hypotheses, the direction of the relationship was not in the direction originally predicted. The important question that arises, and will be addressed in the discussion section, is why students seem to view these sorts of actions as less serious than doctors do.

Occupation by Billing for Unnecessary Services by Auto-Mechanics, Lawyers and Financial Consultants

The sixth hypothesis in this study states that *physicians will be more likely to view instances where lawyers, auto-mechanics, and financial planners bill for unnecessary services as more serious than medical students will.* To test this hypothesis, respondents were asked to determine how serious and justifiable fraud within these three different groups were by reading three scenarios dealing with billing for unnecessary services by lawyers, auto mechanics, and financial consultants (see Scenarios 6, 7, and 8 in Appendix). Tables 10a, 10b, and 10c outline the relationship between occupation and perceptions about the seriousness and justifiability of billing for unnecessary services in these other occupations. To make the results easier to follow, each occupation category is discussed separately. They are auto-mechanics, lawyers, and financial consultants.

Auto-Mechanic Fraud

Seriousness. To determine whether medical students and doctors perceived the seriousness of instances where auto mechanics bill for unnecessary services differently. Cross tabulation procedures were conducted. Results

Table 10a. Occupation by Seriousness and Justifiability by Billing for Services not Necessary by Auto-Mechanics, Lawyers and Financial Consultants

Billing for Services not Necessary by Auto-Mechanics

Seriousness

Occupation	Very		Somewhat to Not at all	
	N	Percent	N	Percent
Medical Students	56	37.3	94	62.7
Physicians	13	27.7	34	72.3
Total	69	35.0	128	65.0
Chi-square (d.f. = 1)		1.472		

Justifiability

Occupation	Very To somewhat		Not at all	
	N	Percent	N	Percent
Medical Students	46	30.7	104	69.3
Physicians	19	40.4	28	59.6
Total	65	33.0	132	67.0
Chi-square (d.f. = 1)		1.542		

Table 10b. Occupation by Seriousness and Justifiability by Billing for Services not Necessary by Auto-Mechanics, Lawyers and Financial Consultants

Billing for Services not Necessary by Lawyers

Occupation	Seriousness: Very		Somewhat to Not at all	
	N	Percent	N	Percent
Medical Students	56	37.3	94	62.7
Physicians	15	31.9	32	68.1
Total	71	36.0	126	64.0
Chi-square (d.f. = 1)		.456		

Occupation	Justifiability: Very To somewhat		Not at all	
	N	Percent	N	Percent
Medical Students	55	36.7	95	63.3
Physicians	18	38.3	29	61.7
Total	73	37.1	124	62.9
Chi-square (d.f. = 1)		.041		

Table 10c. Occupation by Seriousness and Justifiability by Billing for Services not Necessary by Auto-Mechanics, Lawyers and Financial Consultants

Billing for Services not Necessary by Financial Consultants

Seriousness

Occupation	Very		Somewhat to Not at all	
	N	Percent	N	Percent
Medical Students	56	37.3	94	62.7
Physicians	15	31.9	32	68.1
Total	71	36.0	126	64.0
Chi-square (d.f. = 1)		.456		

Justifiability

Occupation	Very To somewhat		Not at all	
	N	Percent	N	Percent
Medical Students	53	35.3	97	64.7
Physicians	20	42.6	27	57.4
Total	73	37.1	124	62.9
Chi-square (d.f. = 1)		.800		

outlined in Table 10a show that the two groups did not hold different attitudes about the seriousness of this offense. In fact, just over a third of the medical students (37 per cent) of the medical students felt that this type of automotive fraud was very serious while just under a third of the doctors (28 percent) felt that it was very serious.

Justifiability. The same statistical procedures were used to see if medical students' and physicians' perceptions about the justifiability of mechanics billing for unnecessary services varied. Again, results indicated that no differences exist. In all, 69 percent of the medical students felt that this type of automotive fraud was not at all justifiable while 60 percent of the physicians felt it was not justified.

Lawyers

Seriousness. Cross tabulation procedures were also used to see if medical students and doctors varied in their perceptions about the seriousness of instances where lawyers bill for unnecessary services. Again, results suggest that no differences exist (see Table 10b). Nearly the same proportion of medical students (37 percent) as physicians (32 percent) contended that lawyer fraud was very serious.

Justifiability. Similar results were found regarding the justifiability of lawyers billing for unnecessary services. In particular, medical students and physicians seemed to see these sorts of acts as rarely justifiable. Again, nearly the same percentage of medical students (63 percent) and physicians (62 percent) argued that the cases where lawyer's bill for unnecessary services was not at all justifiable while.

Financial Consultants

Seriousness. As with the previous hypotheses, cross tabulation procedures were used to see if physicians and medical students perceived the seriousness of cases where financial consultants bill for unnecessary services differently (see Table 10c). Once again, no significant differences were found. Within this data, only 37 percent of the medical students felt that financial consultants was very serious while 32 percent of the physicians felt that financial consultant fraud was very serious.

Justifiability. Analyses were also conducted to determine if medical students and physicians perceptions about the justifiability of instances where financial planners bill for unnecessary service differed significantly. Results were not significant. In all, 65

percent of the medical students and 58 percent of the physicians responded that financial consultant fraud was not at all justifiable.

To sum up hypothesis six, there were no differences in how medical students and physicians perceived the seriousness or the justifiability of instances where auto-mechanics, lawyers or financial consultants bill for unnecessary services. The interesting irony that once again surfaces is that there were differences in how the two groups perceived the seriousness of cases where physicians bill for unnecessary services. Also, there were differences in how the two groups perceived the seriousness of auto-mechanics, lawyers and financial consultants overcharging customers (see hypothesis 4). As will be shown in the discussion section, these paradoxes have important implications for theory and medical education.

Occupation by Ranking the Seriousness of Occupational Fraud

Hypothesis seven was the following: *When asked to rank the seriousness of various types of occupational fraud, medical students will rank Medicaid fraud as more serious than physicians will.* To test this hypothesis, respondents were asked to rank the following types of fraud in order of seriousness: automotive fraud, financial consultant fraud,

legal fraud and Medicaid fraud. The original ranking scale used 1 as the most serious type of fraud and four as the least serious type of fraud. These variables were recoded into the following scale: (1=3, 2=2, 3=1, and 4=0). This allowed the scale to be treated as an interval level scale with a true zero point. Also, conceptually it is easier to understand that higher values equate to more seriousness.

To see if medical students and physicians ranked the four types of fraud differently t-tests were conducted. Results are outlined in Table 11. As shown in the table, there were no differences in the way the two groups ranked automotive fraud, legal fraud, and financial consultant fraud. However, significant differences were found regarding the way that the respondents ranked the seriousness of Medicaid fraud. Specifically, on average, physicians ($x=2.90$, $s = .30$) rated Medicaid fraud as more serious than students ($x=2.41$, $s = .83$) did. Note, however, that the direction of the relationship is in an opposite direction than originally hypothesized. This certainly does not diminish the significance of the findings.

Table 11. Mean Ranking and Standard Deviations of Fraud Seriousness by Occupation Type, t-values, and Significance

Fraud Type	Medical Students (n=136) x	s	Physicians (n=42) x	s	Total (n=178) x	s	t
Automotive Fraud	.36	.76	.29	.45	.34	.55	.59
Financial Fraud	1.22	.80	1.05	.73	1.18	.79	1.24
Legal Fraud	2.01	.79	1.76	.62	1.96	.76	1.90
Medicaid Fraud	2.41	.83	2.90	.30	2.53	.77	-5.83***

*** p<.001

Occupation by the Effectiveness of Medicaid

Hypothesis eight postulated that *medical students will rate the effectiveness of Medicaid higher than physicians will*. To test this hypothesis, respondents were asked to rate the effectiveness of Medicaid according to a scale developed by Kennan et al. (1985). As used in this thesis, respondents were asked to judge Medicaid based on the following five criteria: a) the quality of care delivered; b) the ability of Medicaid to reach all those in need of service; c) the program's cost effectiveness; d) Medicaid's reimbursement scale; and e) Medicaid's efficiency. Respondents were asked to indicate whether they believe Medicaid's impact in these areas is poor, fair, good, or excellent. Individual item scores range from 1 to 4 respectively. To arrive at an overall Medicaid effectiveness score, the scores of the five specific criteria were summed. Thus, theoretically, scores could range from 5 (which would mean the respondent believes Medicaid is poor in every single area) to 20 (which would mean that the respondent thinks Medicaid is excellent in every single area).

The average rating respondents gave Medicaid was 8.79 ($s = 2.96$). This suggests that, in general, respondents are less than satisfied with the Medicaid program. The

least amount of satisfaction was found with the reimbursement process with respondents indicating that, in general, their perceptions about Medicaid's reimbursement scale was somewhere between poor and fair ($x = 1.41$, $s = .67$). Medicaid's program efficiency, the ability of the program to reach others who would not receive health care, and its cost-effectiveness were rated slightly higher than the reimbursement process; however, scores still averaged between poor and fair. In fact, Medicaid's quality of care delivered was the only item that averaged between fair and good ($x = 2.42$, $s = .93$).

To see if medical students rated Medicaid differently than physicians did t-tests were conducted. The results of the t-tests are outlined in Table 12. As shown in the table, the overall effectiveness attributed to Medicaid did not vary significantly between students and physicians. In fact, the average overall score of students ($x = 8.79$, $s = 2.96$) was almost identical to the average overall score of physicians ($x = 8.74$, $s = 2.66$).

On the surface, this implies that students and physicians hold similar perceptions about Medicaid. However, when comparing specific criteria used to evaluate Medicaid's effectiveness, three significant differences arose. First, physicians ($x = 1.17$, $s = .38$) rated

Table 12. Respondents' Mean Rating and Standard Deviation of Medicaid Using Keenan et al.'s Scale, t-values, and Significance

Fraud Type	Medical Students (n=150)		Physicians (n=47)		Total (n=197)		t
	x	s	x	s	x	s	
Quality of Care delivered	2.25	.84	2.96	1.00	2.42	.93	-4.80***
Ability to Reach all	1.66	1.62	1.62	.68	1.65	.74	.34
Cost effectiveness	1.74	.84	1.49	.51	1.68	.78	2.49*
Reimbursement	1.48	.72	1.17	.38	1.41	.67	3.83***
Program Efficiency	1.65	.73	1.51	.38	1.62	.72	1.19
Overall score	8.79	2.96	8.78	2.66	8.78	2.88	.08

* $p<.05$ ***$p<.001$

Medicaid's reimbursement process lower than students (x=1.48, s = .72) did. Second, students (1.74, s = .84) rated Medicaid's cost effectiveness higher than physicians (x=1.49, s = .51) did. Third, physicians (x=2.96, s = 1.00) rated the quality of care delivered higher than students (x = 2.25, s = .84). Therefore, the hypothesis that students will rate the effectiveness of Medicaid higher than physicians will is only partially supported with students seeing Medicaid as more cost effective and rating the reimbursement process a little more positively than physicians who, in turn, rated quality of care higher than students did.

CHAPTER V

DISCUSSION AND CONCLUSION

This chapter discusses the results previously presented, including the testing of the hypotheses and whether the findings are supported by the literature. It also addresses the limitations of the study and recommendations for future research.

DISCUSSION OF RESULTS

Although this research had a number of objectives with respect to fraud, the primary purpose of this study was to survey medical students and physicians and to seek their attitudes toward Medicaid fraud. In accomplishing these objectives, four broad research questions were asked and eight hypotheses were tested. The discussion will revolve around the four broad questions addressed in this thesis concerning Medicaid fraud. These questions are 1) do medical students and physicians view the seriousness and justifiability of Medicaid fraud differently? 2) do medical students' and physicians' attitudes differ by type of Medicaid fraud (e.g. billing for services not performed or the over-utilization of services)?, 3) is there an association between physicians' attitudes toward Medicaid

and how many individuals they supervise?, and 4) how do medical students' and physicians' attitudes toward Medicaid fraud compared to their attitudes toward fraud in other occupations?

The first question in this study asks if medical students and physicians view Medicaid fraud differently. Past research would suggest that physicians would view Medicaid fraud more serious (see e.g. Mitchell and Cromwell 1982; Geis et al. 1985), however that was not supported; indeed results were in the opposite direction than hypothesized. Past research suggests, physicians in all specialties have complained about the low fee schedules and the bureaucratic red tape associated with Medicare and Medicaid (Mitchell and Cromwell 1982). Due to these low fee schedules and the red tape within these government programs certain physicians feel justified in participating in fraudulent acts against these programs (Geis et al. 1985).

A common self-defense physicians use to justify their actions is to reassure themselves that they should be getting paid more money than the government offers, therefore, it is acceptable for them to add time to their bills (Geis et al. 1985). These findings would suggest that physicians are more likely to view Medicaid fraud less

seriously than medical students are, however, this was not the case in this study. The physicians responding to this survey clearly believe, more so than medical students, that physicians who participate in Medicaid fraud are committing a very serious act and physicians find these acts are not justifiable. Originally it was postulated that desensitization would allow physicians to view Medicaid fraud as less serious. However, it seems to be the opposite. Maybe physicians realize how serious Medicaid fraud is and their perceptions are best understood using the social control approach as a framework.

Such a suggestion is supported by the belief that perhaps physicians have invested a great deal of time, money, and effort into their careers and that these investments increase their perceptions about the importance of their medical education and their careers. Putting it in simple control theory terms, physicians have more to lose through violations of their occupational norms than medical students do (Hirschi 1969). Therefore, any perceptions about the seriousness of Medicaid fraud likely reflect the fact that physicians would lose more than students would if they committed the crime described in the scenario. Thus, their perceptions about seriousness, though in the opposite direction than predicted, are still

understandable, at least in the context of control theory (Macionis 1991).

The second question in this thesis addresses whether there is a difference in attitude between different fraudulent acts committed. The two most popular types of fraud, auditors believe, are over-billing and billing for services never provided (Stohl 1996). First, over-billing involves circumstances where physicians charge more than regulators permit. Second, billing for services not performed, often referred to as phantom billing, involves instances where physicians submit claims to the provider for services never rendered to the patient (Taylor 1992). The next four hypotheses reflect instances were over-utilization of services is performed, or there is billing for unnecessary services by physicians, auto mechanics, lawyers, and financial consultants.

The results in this thesis for occupation by physicians who over-bill services, is not supported. Again physicians, not medical students, believed that fraudulent acts committed by over-billing of services were more serious. Research suggests there are many different types of fraud that physicians have been accused of committing. Some types of fraud are not viewed as seriously as other types. For instance, billing for services not performed is

regarded as less serious than over-billing of services, but is believed to be more widespread (Keenan et al. 1985). The results of this thesis are similar.

There has not been, however, any research that suggests medical students would view over-billing of services as more or less serious than physicians would. But again due the fact that physicians were expected to view Medicaid fraud as a whole less serious than medical students it was also hypothesized here that physicians would view over-billing of services less serious. However, this study finds the exact opposite. The physicians responding to this survey clearly feel, more so than medical students, that physicians' over-billing of services is a very serious act and find these acts not to be justifiable.

Physicians were, however, predicted to view over-billing of services by other occupations as more serious than medical students were. In this study that was the case. But, there were no differences in the way the two groups justified over-billing by physicians, lawyers, and auto mechanics.

Regarding billing for unnecessary services medical students were predicted to view physicians participating in this type of fraud as more serious than physicians.

However, more physicians found this type of fraud to be more serious.

The third question this thesis addresses if the number of individuals supervised plays a part in how individuals view Medicaid fraud. The findings of this thesis show that the number of individuals an individual supervises affects perceptions about fraud seriousness in an opposite direction than previous literature implies it should. For instance, research has focused on how to help physicians or to at least make them aware of the trouble that they could get themselves into if they or individuals they supervise decide to participate in fraudulent behavior (Tettlebaum 1986; Marcus 1995; Noon 1996). Noon (1996) notes that most physicians do not appreciate it when their integrity is challenged and she suggests three steps a physician can take to minimize the consequences of a state or federal investigation. First, the physician must be familiar with the rules. Second, physicians must monitor their billing systems. And thirdly, it is important that they seek professional advice if they are not sure what they should do.

As a result of these three steps it would be a good assumption that many physicians that supervise individuals are concerned about getting in trouble with the government

program Medicaid even if they themselves are not participating in fraudulent acts against the Medicaid program. Therefore, it would seem that the more employees supervised the more serious that Medicaid fraud would appear because these physicians will have to answer for the misrepresentation that happens under them. However, this thesis suggests the opposite. It should first be noted that this might be because there was a problem with the measurement of this variable. This will be discussed in more detail under the limitations of this study. The reason that it was first stated that individuals who supervise more employees will be more likely to have a less serious response towards Medicaid fraud was because physicians who supervise more employees also probably will come in contact with more fraudulent acts. If a number of these employees invade the Medicaid system the physician will become immune to the fraudulent acts committed around them. The individuals responding to this survey, who supervise three or less compared to supervising four or more, clearly feel that physicians who participate in Medicaid fraud are committing a very serious act and find these acts not very justifiable.

Two caveats likely address this finding which is inconsistent with previous literature. First, there is a

possibility that those who supervised four or more employees were more likely to be physicians and based on the previous argument it is the state of "being a physician" that creates the differences. Second, and along a related line, control theory may again help explain why those who supervise more individuals perceive fraud as more serious than those who supervise fewer employees. Briefly, control theory asks the following: Why don't individuals commit crime? (Hirschi 1969). The answer to the question lies in the belief that people don't commit crime because they have strong bonds to society and they have too much to lose through deviance. Indeed, it is entirely likely that those who supervise more employees have more to lose (e.g. a business rather than a career). Occupational sociology research suggests that those who are heading businesses have invested a great deal of time and effort to become the supervisors (Vaughan 1992; Weisburd and Schlegel 1992). Based on this, the fact that those with more employees see Medicaid fraud as more serious is potentially explained by the fact that they perceived the actions as threatening not just their careers, but their businesses as well.

The fourth question in this thesis addresses whether medical students' and physicians' attitudes toward Medicaid

fraud is different than their attitudes toward fraud in other occupations. There was no past research found that addressed this issue, however, the findings in this thesis were interesting and attitudes toward fraud in all occupations should be addressed in future research.

When viewing how medical students and physicians rank the seriousness of medical fraud it was interesting to find that physicians rated Medicaid fraud is more serious than medical students did. However, when reviewing the overall effectiveness attributed to Medicaid it did not vary significantly between medical students and physicians. This coincides with Keenan et al. (1985) who also found that medical students viewed Medicare and Medicaid in the same unflattering light as practicing physicians. They gave Medicare and Medicaid low ratings, especially on administrative dimensions. When students were asked why they believed that physicians were against the programs they found that students believed that physicians felt justified in their actions because they perceived the programs to be unfair.

Based on these findings, there appears to be very little support for the Organizational Misconduct Theory (Vaughn 1992). As noted earlier, control theory best explains why physicians would see fraud as more serious

than students would. It was originally believed that the Organizational Misconduct Theory would be the best theoretical guide to understanding the hypotheses because physicians' experiences within the health care organization were believed to taint their image of Medicaid and subsequently increase the belief about the justifiability of fraud. Although this was not the case, this is not to suggest that the Organizational Misconduct Theory is flawed. Rather, the Organizational Misconduct Theory probably would be more useful to address structural changes in health care rather than process oriented beliefs, which were measured in this thesis.

Along a related line, the way that Sutherland's Differential Association theory relates to the findings of this study warrants brief attention. As the hypotheses were originally envisioned, it was believed that physicians would learn definitions favorable to rule violations while on the job and that students, due to a lack of medical experience, would not learn these definitions. Therefore, it was hypothesized that physicians would see Medicaid fraud as less serious than students would. The fact that the opposite pattern was found does not refute Differential Association Theory. Instead, it can still be used to address these findings in that it is possible that

physicians learn definitions unfavorable to law violations. Consequently, these definitions likely influence their perceptions about the seriousness of fraud in a way that causes physicians to define Medicaid fraud as very serious rather than not at all serious.

LIMITATIONS

At least six limitations need to be stated so that the importance of these findings is not overstated. First, this study is exploratory in nature because there has not been a large amount of research done examining how medical students and physicians perceive Medicaid fraud. This has made it difficult to rely on past research to predict the direction of any relationship about which I hypothesized.

Second, this study is limited in that the data were hard to obtain, therefore, producing a small sample size. Due to time and budgetary restraints, it was impossible to obtain more respondents. This small sample size produced low numbers within many categories of the variables. Even though a larger distribution within all three categories would have been desired it was necessary to collapse two of the categories together producing only two categories instead of the three that were in the original survey.

Third, the fact that medical students and physicians

from just one medical school were included in the study limits the findings to a degree. It is not possible to generalize the findings to other settings. However, because there has been so little research in this area, this research is a necessary step in developing a better understanding about Medicaid fraud.

Fourth, although significant differences were found between physicians and students, there was no way of determining with any degree of certainty why these differences exist. This is something that must be addressed in future research.

Fifth, using a sample of physicians who are affiliated with a teaching hospital limits the generalizability of the findings as well. It is entirely likely that physicians who are "teaching about how to be a physician" hold different perceptions about fraud than other physicians. Due to the small sample size, this study I could not determine whether medical educators were different from the other physicians.

Finally, it should be noted that this thesis was trying to determine if there was an association in how many individuals supervised and how serious individuals' view Medicaid fraud. However, the variable was coded in a manner that may not allow for an accurate representation of

the results. It should also be noted that a large part of the sample (n=149) supervised no individuals. Therefore, caution should be used in interpreting the results.

RECOMMENDATIONS FOR FUTURE RESEARCH

In closing, relevant literature done on criminality has focused on street criminals and how they can harm individuals in a more personal manner than the white-collar criminal (Weisburd and Schlegel 1992; Hochstetler and Shover 1997; Mannon 1997). Also, funding has been more readily available for research focusing on street crime (Friedrichs 1996). However, the government has begun to provide funding to fight the growing problem of white-collar crime and, therefore, there has been a significant increase in research efforts directed towards white-collar crime (Baumgartner 1987; Benson et al. 1990; Snider 1990; Parry and Hunt 1993; Weisburd, Waring and Chayet 1995; Levi 1996). The idea of added research towards white-collar crime and more specifically Medicaid fraud is exciting because there is definitely a need to discover the perceptions, of individuals who work within the medical profession, concerning Medicaid fraud. Although there has been research done on Medicaid fraud (Mitchell and Cromwell 1982; Pontell et al. 1984; Jesilow et al. 1985; Tettlebaum

1986; Marcus 1995; Noon 1996) very little research has focused on attitudes toward Medicaid fraud. A comprehensive review of literature reveals that no studies pertaining to medical students and physicians attitudes toward Medicaid fraud have been conducted. This study has been very fascinating and there have been some very interesting patterns and some significant findings.

Therefore, additional research should be considered pertaining to medical students' and physicians' attitudes toward Medicaid fraud. First, in order to evaluate the differences between medical students and physicians toward Medicaid, consideration should be given to administering a modified version of this survey to a larger representative sample of medical students and physicians. The sample should include both medical students and physicians from other medical schools and other hospitals to give a better representation of the sample and to provide a larger sample.

Ultimately, we can understand medical students' and physicians' attitudes toward Medicaid fraud. Once we have a better understanding of this social problem, organizational efforts will be made to eliminate the negative feelings that a large number of physicians have toward Medicaid. But until then, continued research is

warranted in an effort to fully understand Medicaid fraud by physicians.

On an even broader theoretical plane, the role of academic socialization in fostering definitions favorable or unfavorable to law violations is an important, yet overlooked, area. Most explanations of white-collar crime focus on the present status of the offender (Benson 1985) with very little attention given to the way that academic training and education influenced status development. The results of this thesis suggest that something changes between the time one is a student and one becomes a physician.

These results have implications for medical student education. The data reflect the fact that physicians view Medicaid fraud more seriously than medical students do. This chasm of ethics may be due to the fact that physicians have seen first hand the inadequacies of the Medicaid system and realize what a strong negative impact fraud has on both the amount and quality of services rendered. After all, Medicaid has limited resources and wasteful or malicious use of these funds for ends other than patient care aggravate the system wide shortages (Pontell et al. 1984). Since most physicians at some point in their practice, if not daily, have been at odds with the Medicaid

bureaucracy. Although this may produce negative feelings for the system as a whole, they realize that fraudulent use of Medicaid funds directly and negatively impacts patient care.

On the other hand, most medical students have yet to have that first person experience with the frustrations of the medical welfare system and its adverse effects of the health of their patients. Therefore, they do not view Medicaid fraud as being significantly serious. There are policy implications for medical student education here that are noteworthy. Although most medical schools have an ethics course or section, most focus on moral and ethical concerns such as end-of-life care, abortion, and religious values which oppose modern medicine. By and large, most ethics courses do not focus on such operational, real world issues as healthcare fraud, at least in any detail. One potential change in medical student education would be to incorporate a section on public health and the utilization of medical resources. This would give students an overall vision of the system and how Medicaid acts as a player in the healthcare system overall. They would then be allowed to draw more informed conclusions about the seriousness of Medicaid fraud. Whether these changes occur in other occupations needs to be addressed in future endeavors.

CONCLUSION

Although additional research in this area is essential, there appears to be a relationship between occupation and how serious and justifiable Medicaid fraud is perceived. Surprisingly, even though most of the research would suggest that physicians would view Medicaid fraud as less serious than medical students this study has shown the exact opposite. The code of silence is just one example as to why it would be suggested that physicians would view Medicaid fraud less serious. The medical community has rarely expressed suspicions about its own members and are known to keep quiet about "wrong doings" that other members within the field are participating in (Geis et al. 1985; Taylor 1992). Also, Marcus (1995) focuses on how physicians need to take responsibility for their actions and not to rely on others within their practice. He believes that physicians need to be a part of the administrative side of their practice because if the practice is investigated and found guilty of fraudulent acts, the physicians, and no one else, will be responsible for the claim. And finally, physicians in all specialties have complained about the low fee schedules and the bureaucratic red tape associated with Medicare and Medicaid (Mitchell and Cromwell 1982). The reimbursement rate in

these government programs is one-half of what these physicians usually would charge for their services (Pontell et al. 1984). Again past research would suggest that physicians would view Medicaid as less serious for different reasons, but this study suggests the opposite. More research needs to focus on this issue and more specifically review medical students' perceptions about Medicaid fraud.

REFERENCES

American Hospital Publication. 1995. "FBI: Health Care Fraud the Crime of Choice." *Hospitals and Health Networks* 69(May5):13.

Beaver, Stephen. 1997. "Columbia Probe Sends Message to Industry; Former Local Hospital Exec Isn't Only Target." *Indianpolis Business Journal* 18(32):11.

Baumgartner, M. P. 1987. "Utopian Justice: The Covert Facilitation of White-Collar Crime." *Journal of Social Issues* 43(3):61-9.

Benson, Michael. 1985. "Denying the Guilty Mind: Accounting for Involvement in a White Collar Crime." *Criminology* 23(4):589-99.

Benson, Michael, Francis T. Cullen, and William J. Maakestad. 1990. "Local Prosecutors and Corporate Crime." *Crime and Delinquency* 36(3):356-72.

Braithwaite, John. 1992. "Poverty, Power, and White Collar Crime: Sutherland and the Paradoxes of Criminological Theory." Pp. 78-107 in *White-Collar Crime Reconsidered,* edited by K. Schlegel and D. Weisburd. Boston, MA: Northeastern University Press.

Calavita, Kitty and Henry Pontell. 1994. "The State and White-Collar Crime: Saving the Savings and Loans." *Law and Society Review* 28(2):297-324.

Clement, Norman J., Daryl E. Williams, and Dalton Sanders. 1989. "Are Medicaid Fraud Control Units the Real Fraud?" *The Journal of Pedodontics* 14(1):3-11.

Cohen, William S. 1995. "Unanimous Consent Agreement." *Congressional Record* S7079-1117.

Coleman, James W. 1992. "The Theory of White-Collar Crime From Sutherland to the 1990s." Pp. 53-77 in *White Collar Crime Reconsidered,* edited by K. Schlegel and D. Weisburd. Boston, MA: Northeastern University Press.

_____. 1998. *The Criminal Elite: Understanding White-Collar Crime.* New York, NY: St. Martin's Press Inc.

Coleman, Barbara. 1989. "Feds Launch Generic Drug Probe." *AARP Bulletin: A Publication of the American Association of Retired Persons* 30(9):15-17.

Crawshaw, Ralph. 1994. "Are Dermatologists Greedy?" *Archives of Dermatology* 130(2):170-72.

Davis, L. J. 1995. "Medscam." *Mother Jones* 20:26-9.

Dillingham, Susan. 1987. "Uncle Sam's Record on White-Collar Crime." *Insight* 3(43):25.

Fine, Howard. 1997. "U.S. Investigation Hits L.A.'s Home Health Providers." *Los Angeles Business Journal* 19(45):1.

Fiske, Robert B. 1980. "White-Collar Crime: A Survey of Law." *American Criminal Law Review* 18(2):165-386.

Ford, Joseph L. 1992. "Focus on Health Care Fraud." *FBI Law Enforcement Bulletin* 61(10):2-12.

Friedrichs. D. O. 1996. *Trusted Criminals: White Collar Crime in Contemporary Society.* Belmont, CA: Wadsworth.

Geis, Gilbert. 1992. "White-Collar Crime What Is It?" Pp. 31-52 in *White-Collar Crime Reconsidered,* edited by K. Schlegel and D. Weisburd. Boston, MA: Northeastern University Press.

Geis, Gilbert, Paul Jesilow, Henry Pontell, and Mary O'Brien. 1985. "Fraud and Abuse of Government Medical Benefit Programs by Psychiatrists." *American Journal of Psychiatry* 142(2):231-234.

Glenn, John. 1995. "Release of GAO High Risk List Report." *Congressional Record* S3066-68.

Gonzales, Angela. 1997. "State Hunted by Feds." *The Business Journal* 17(48):1-2.

Hagan, John and Alberto Palloni. 1986. "'Club Fed' and the Sentencing of White-Collar Offenders Before and After Watergate." *Criminology* 24(4):603-21.

Hirschi, Travis. 1969. *Cause of Delinquency*. Berkley: CA. University California Press.

Hochstetler, Andrew and Neal Shover. 1997. "Street Crime, Labor Surplus, and Criminal Punishment." *Social Problems* 44(3):358-68.

Jesilow, Paul, Gilbert Geis, and Henry Pontell. 1991. "Fraud by Physicians Against Medicaid." *Journal of the American Medical Association* 266(23):3318-22.

Jesilow, Paul D., Henry N. Pontell, and Gilbert Geis. 1985. "Medical Criminals: Physicians and White-Collar Offenses." *Justice Quarterly* 2:149-66.

Keenan, Constance E., Gregory C. Brown, Henry N. Pontell, and Gilbert Geis. 1985. "Medical Students' Attitudes on Physician Fraud and Abuse in the Medicare and Medicaid Programs." *Journal of Medical Education* 21: 167-73.

Kennedy, Edward. 1995. "Republican Budget Plans and Medicare Cuts." *Congressional Record* S7071-7078.

Korcok, Milan. 1997. "Medicare, Medicaid Fraud a Billion-Dollar Art Form in the US." *Canadian Medical Association Journal* 156(8):1195-7.

Kreier. 1997. "Five Doctors Indicted in Medicare Home Care Scams." *American Medical News* 40(33):3.

Levi, Michael. 1996. "Equal Before the Law? Politics, Powers, and Justice in Serious Fraud Prosecutions." *Crime, Law and Social Change* 24:319-40.

Macionis, John. 1991. *Sociology.* Englewood Cliffs, New Jersey: Prentice Hall

Mannon, James. 1997. "Domestic and Intimate Violence: An Application of Routine Activities Theory." *Aggression and Violent Behavior* 2(1):9-24.

Marcus, Gary. 1995. "Doctors Aren't Immune To Theft and Fraud." *Canadian Medical Association Journal* 152(6): 939-41.

Mitchell, Janet B. and Jerry Cromwell. 1982. "Medicaid Participation by Psychiatrists in Private Practice." *American Journal of Psychiatry* 139(6):810-13.

Moore, Elizabeth, and Michael Mills. 1990. "The Neglected Victims and Unexamined Costs of White-Collar Crime." *Crime and Delinquency* 36(3):408-18.

Muehls-Sussman, Wendi. 1997. "Feds Step Up Medicare Fraud Investigation." *The Business Journal-Milwaukee* 14(47):19-21.

Noon, Jody Ann. 1996. "Overbilling Medicare or Medicaid Is No Laughing Matter." *Business Journal Portland* 13(29):8.

Parry, Helen and Susan Scott Hunt. 1993. "Undercover Operations and White Collar Crime." *Journal of Asset Protection and Financial Crime* 2(2):150-59.

Payne, Brian K. 1995. "An Empirical Examination of the Characteristics, Consequences, and Causes of Elder Abuse in Nursing Homes." *Journal of Elder Abuse and Neglect.* 7(4):61-74.

Payne, Brian K. and Bruce L. Berg. 1997. "Looking For Fraud in all the Wrong Places." *The Police Journal* 70(3):220-230.

Payne, Brian and Dean Dabney. 1997. "Prescription Fraud." *Journal of Drug Issues* 27(4):807-20.

Pontell, Henry N., Paul D. Jesilow, and Gilbert Geis. 1984. "Practioner Fraud and Abuse in Medical Benefit Programs: Government Regulations and Professional White-Collar Crime." *Law & Policy* 6(4):405-24.

Pontell, Henry N., Paul Jesilow, Gilbert Geis, and Mary Jane O'Brien. 1985. "A Demographic Portrait of Physicians Sanctioned by the Federal Government for Fraud and Abuse Against Medicare and Medicaid." *Medical Care* 23(8):1028-1031.

Public Citizen Health Research Group. 1996. "13,012 Questionable Doctors." *Health Letter* 12(4):1-3.

Reiman, Arnold S. 1998. "Business and Professionalism in Medicine at the American Medical Association." *The Journal of the American Medical Association* 279(2): 169-170.

Richter. 1994. "Smart Machines and the Fight Against Medical Fraud." *Governing* 7:84.

Saeger, Michael. 1989. "Medicaid Fraud Investigations of Dentists." *Journal of Dental Practice Administration* 6(1):7-11.

Schlegel, Kip and David Weisburd. 1992. "White-Collar Crime: The Parallax View." Pp. 3-27 in *White-Collar Crime Reconsidered*, edited by K. Schlegel and D. Weisburd. Boston, MA: Northeastern University Press.

Schroeder, Steven A. 1992. "The Troubled Profession: Is Medicine's Glass Half Full or Half Empty?" *Annals of Internal Medicine* 116(7):583-92.

Simpson, Sally S. 1992. "Corporate-Crime Deterrence and Corporate-Control Policies: Views From the Inside." Pp. 289-305 in *White-Collar Crime Reconsidered*, edited by K. Schlegel and D. Weisburd. Boston, MA: Northeastern University Press.

Snider, Laureen. 1990. "Cooperative Models and Corporate Crime: Panacea or Cop-Out?" *Crime and Delinquency* 36(3): 373-90.

Stohl, Richard. 1996. "Fraud In The Health Care Industry." *Internal Auditor* 6:70-3.

Stupak, Bart. 1995. "Commonsense Medicare Reform." *Congressional Record* H10301-10302.

Sutherland, Edward H. 1940. "White-Collar Criminality." *American Sociological Review* 5(1):1-12.

Taylor, Jim. 1992. "Medicaid Fraud Control." *FBI Law Enforcement Bulletin* 17-20.

Tettlebaum, Harvey. 1986. "Beware of Medicaid Fraud." *Missouri Dental Journal* 66(6):14-15.

Tillman, Robert and Henry N. Pontell. 1992. "Is Justice "Collar-Blind"? Punishing Medicaid Provider Fraud." *Criminology* 30(4):547-74.

Vaughan, Diane. 1992. "The Macro-Mirco Connection in White-Collar Crime Theory." Pp. 124-145 in *White-Collar Crime Reconsidered*, edited by K. Schlegel and D. Weisburd. Boston, MA: Northeastern University Press.

Weisburd, David and Kip Schlegel. 1992. "Returning to the Mainstream: Reflections on Past and Future White-Collar Crime Study." Pp. 352-365 in *White-Collar Crime Reconsidered*, edited by K. Schlegel and D. Weisburd. Boston, MA: Northeastern University Press.

Weisburd, David, Elin Waring, and Ellen Chayet. 1995. "Specific Deterrence in a Sample of Offenders Convicted of White-Collar Crimes." *Criminology* 33(4): 587-601.

Witkin, Gordon, Dorian Friedman, and Monika Guttman. 1992. "Health Care Fraud." *U.S. News and World Report* 34-43.

APPENDIX

Cover Letter and Survey

January 1999

Dear Physicians and Medical Students,

It is important to know how professionals perceive misrepresentation within their own fields as well as other fields. A portion of the misrepresentation seen in the medical field deals with the government run program Medicaid.

The data and findings will be used for research purposes only. Any information you provide will be treated with the strictest confidentiality. This study is also anonymous so please do not put your name on the survey. All reports based on this survey will include only statistical information so no individual can be identified. Your participation in the project is voluntary, but without your cooperation this project will not be a complete success.

This research project has been reviewed and approved by Old Dominion University's Institutional Review Board.

When you are finished with this survey please put it in the box provided or give it to the person who distributed the survey.

Thank you for you assistance. Your responses are very important to this project.

Department of Sociology & Criminal Justice
Old Dominion University

Section 1. A few questions about yourself (Please check or fill in the blank)

1. **Gender:**
   ❒ Male ❒ Female

2. **Age:** _____

3. **Occupation:**
   ❒ MI ❒ MIV
   ❒ MII ❒ Resident
   ❒ MIII ❒ Attending/Practicing

4. **How long have you been in your current position?** _____

5. **How many individuals do you supervise?** _____

6. **Race:**
   ❒ White/Caucasian ❒ Black/African American
   ❒ Asian ❒ Other (Specify, _____)
   ❒ Hispanic

Section 2. Please read the eight scenarios below and determine the seriousness and justifiability for each scenario.

Scenario One

An auto-mechanic bills insurance companies for at least an hour of labor even if the labor actually took less time.

1. Do you perceive this to be: **(Select one answer in each column)**

	(Mark One)		**(Mark One)**
a.	❒ Very Serious	a.	❒ Very Justifiable
b.	❒ Somewhat Serious	b.	❒ Somewhat Justifiable
c.	❒ Not at all Serious	c.	❒ Not at all Justifiable

Scenario Two

A physician bills Medicaid for at least an hour consultation even if the consultation actually took less time.

2. Do you perceive this to be: **(Select one answer in each column)**

	(Mark One)		**(Mark One)**
a.	❒ Very Serious	a.	❒ Very Justifiable
b.	❒ Somewhat Serious	b.	❒ Somewhat Justifiable
c.	❒ Not at all Serious	c.	❒ Not at all Justifiable

****

Scenario Three

A lawyer bills corporations for at least an hour consultation even if the consultation actually took less time.

3. Do you perceive this to be: **(Select one answer in each column)**

	(Mark One)		**(Mark One)**
a.	❒ Very Serious	a.	❒ Very Justifiable
b.	❒ Somewhat Serious	b.	❒ Somewhat Justifiable
c.	❒ Not at all Serious	c.	❒ Not at all Justifiable

****

Scenario Four

A financial consultant bills companies for at least an hour consultation even if the consultation took less time.

4. Do you perceive this to be: **(Select one answer in each column)**

	(Mark One)		**(Mark One)**
a.	❒ Very Serious	a.	❒ Very Justifiable
b.	❒ Somewhat Serious	b.	❒ Somewhat Justifiable
c.	❒ Not at all Serious	c.	❒ Not at all Justifiable

Scenario Five

A physician bills Medicaid for a full set of laboratory, x-ray and EKG studies, some of which were not necessary.

5. Do you perceive this to be: **(Select one answer in each column)**

	(Mark One)		**(Mark One)**
a.	❒ Very Serious	a.	❒ Very Justifiable
b.	❒ Somewhat Serious	b.	❒ Somewhat Justifiable
c.	❒ Not at all Serious	c.	❒ Not at all Justifiable

****

Scenario Six

An auto mechanic bills insurance companies for parts and diagnostic testing, some of which were not necessary.

6. Do you perceive this to be: **(Select one answer in each column)**

	(Mark One)		**(Mark One)**
a.	❒ Very Serious	a.	❒ Very Justifiable
b.	❒ Somewhat Serious	b.	❒ Somewhat Justifiable
c.	❒ Not at all Serious	c.	❒ Not at all Justifiable

****

Scenario Seven

A lawyer bills corporations for legal research and expert consultations, some of which were not necessary.

7. Do you perceive this to be: **(Select one answer in each column)**

	(Mark One)		**(Mark One)**
a.	❒ Very Serious	a.	❒ Very Justifiable
b.	❒ Somewhat Serious	b.	❒ Somewhat Justifiable
c.	❒ Not at all Serious	c.	❒ Not at all Justifiable

Scenario Eight

A financial consultant bills companies for investment services and tax planning, some of which were not necessary.

8. Do you perceive this to be: **(Select one answer in each column)**

	(Mark One)		**(Mark One)**
a.	❒ Very Serious	a.	❒ Very Justifiable
b.	❒ Somewhat Serious	b.	❒ Somewhat Justifiable
c.	❒ Not at all Serious	c.	❒ Not at all Justifiable

Section 3. This section deals with issues about Medicaid and issues of fraud.

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1. Listed below are five aspects of Medicaid. Please indicate how effective you believe each aspect is.

	Poor	Fair	Good	Excellent
a. Quality of care delivered	❒	❒	❒	❒
b. Ability to reach all those in need of service	❒	❒	❒	❒
c. Cost-effectiveness	❒	❒	❒	❒
d. Reimbursement scale	❒	❒	❒	❒
e. Program efficiency	❒	❒	❒	❒

2. Rank the following types of fraud in order of seriousness. (1 is the most serious and 4 is the least serious)

a. ____ Automotive Fraud

b. ____ Financial Fraud

c. ____ Legal Fraud

d. ____ Medicaid Fraud

3. In your opinion indicate what percentage of professionals engage in each type of fraud. (Please only choose one percentage for each type of fraud.)

		20% or less	21% to 40%	41% to 60%	61% or more
a.	Automotive Fraud	❒	❒	❒	❒
b.	Financial Fraud	❒	❒	❒	❒
c.	Legal Fraud	❒	❒	❒	❒
d.	Medicaid Fraud	❒	❒	❒	❒

Section 4. Open-ended question

1. Please explain how the Medicaid program affects you in your current position?

2. In what ways do you believe the program <u>works well</u>?

3. In what ways do you believe the program <u>does not work well</u>?

(IF YOU NEED MORE SPACE PLEASE USE THE BACK OF THIS PAGE)

Thank you for participating in this study.

Please deposit in survey drop box or hand to distributor.

VITA

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