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## The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry

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# The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry

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## I. INTRODUCTION

Corporations, in the form of small, doctor-owned, proprietary hospitals<sup>1</sup> and community or charity nonprofit hospitals,<sup>2</sup> have pervaded the provision of health care services for many years. Recently, however, private, for-profit corporations increasingly have entered the health care field.<sup>3</sup> One industry expert predicts that by the mid-1990s, ten national firms will provide fifty percent of the nation's medical care.<sup>4</sup> Nationwide hospital chains, nonexistent twenty years ago, now own or manage twelve percent of the nation's hospitals.<sup>5</sup> The proliferation of health maintenance organizations, freestanding emergency centers,<sup>6</sup> and other proprietary health care delivery systems<sup>7</sup> exemplify the increased commercialization of medicine. Indeed, many young physicians now shun private practice to work as employees for corporate health care entities.<sup>8</sup>

Despite the increased level of corporate involvement in health

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1. Before 1900 physicians owned most hospitals as an extension of their practices. These proprietary hospitals decreased in number through the first half of this century as they were displaced by larger and more comprehensive nonprofit institutions. Accordingly, in 1928, 2435 proprietary hospitals constituted approximately 36% of the total. Relman, *The New Medical-Industrial Complex*, 303 *NEW ENG. J. MED.* 963, 963 (1980).

2. See Willcox, *Hospitals and the Corporate Practice of Medicine*, 45 *CORNELL L.Q.* 432, 432 (1960).

3. Dr. Arnold Relman, editor of the *New England Journal of Medicine*, describes the proliferation of for-profit corporations in health care as a "medical-industrial complex". He views this complex as equal to the "military-industrial complex" in its potential to influence public policy. Relman, *supra* note 1, at 963.

4. Hull, *Four Hospital Chains, Facing Lower Profits, Adopt New Strategies*, *Wall St. J.*, Oct. 10, 1985, at 1, col. 6 (quoting Paul Ellwood, Jr., founder of the modern health maintenance organization movement).

5. *Id.* According to Hull:

If [these chains] have their way, health care in the future will be provided by just a handful of huge corporations, offering services through regional networks of hospitals, clinics and doctors. These will all be tied together by cut-rate insurance plans that encourage patients to use the network facilities. Both insurer and hospital will be controlled by the same company and advertised by a brand name. Patients will gain access to services with a plastic membership card, much like Visa or MasterCard.

*Id.*

6. See *infra* notes 272-74 and accompanying text.

7. Dr. Relman lists proprietary nursing homes, home health care businesses, and kidney dialysis centers as some of the for-profit entities delivering medical care. Relman, *supra* note 1, at 964-65.

8. Wessell, *More Young Doctors Shun Private Practice, Work as Employees*, *Wall St. J.*, Jan. 13, 1986, at 1, col. 1. A 1983 study conducted by the American Medical Association (AMA) found that 39% of patient-care doctors younger than 36 were employees of corporate entities or large group practices. The percentage of doctors who are employed decreases in older age groups as follows: 23% of those between 36 and 45, 20% of those between 46 and 55, and 19% of those over 56.

care, many states officially subscribe to a legal doctrine that prohibits a corporate entity from providing medical services.<sup>9</sup> This doctrine, generally known as the corporate practice of medicine prohibition, originated within the medical profession at the turn of the century as an ethical restriction on physicians' economic relations.<sup>10</sup> The leaders of the profession feared that if physicians were permitted to work for corporations, corporations ultimately would control physicians' level of income, their methods of treatment and diagnosis, and their relationships with patients.<sup>11</sup>

Courts accepted the corporate practice prohibition as an extension of the purposes promoted by state medical practice acts and on public policy grounds.<sup>12</sup> Generally, courts held that the doctrine prohibited corporations from practicing medicine through licensed employees or from realizing profits through the distribution of a physician's professional services. Because the doctrine has been applied quite differently in different jurisdictions, no clear rule defining the scope of the corporate practice of medicine prohibition has emerged.

The rule against corporate practice stands as a formidable threat to lay entities attempting to establish health care provider services. Physicians angered by a loss of autonomy and states attempting to regulate competition in the health care field are probable parties in future corporate practice litigation. If this kind of litigation ensues, courts should reevaluate the rationale for disallowing corporations to employ or contract with physicians. Today's health care industry is very different from the one in which the corporate practice prohibition originated. Many of the reasons that once existed for limiting corporate involvement in medicine no longer apply. Accordingly, both courts and state legislatures should clarify the doctrine's scope and modify the doctrine to reflect current practices in the health care market.

This Note examines the development of the corporate practice prohibition and addresses its efficacy in the modern health care industry. Part II describes the American medical profession's struggle to establish itself and the threat that corporate involvement in medicine posed to the early profession. Part III traces the history of the profession's ethical restraints on corporate practice and explains the ways in which courts have applied the doctrine.

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9. See *infra* notes 135-84 and accompanying text.

10. See *infra* notes 85-134 and accompanying text.

11. See *infra* notes 66-84 and accompanying text.

12. See *infra* notes 135-84 and accompanying text.

Part IV presents recent applications of the corporate practice prohibition. Finally, Part V demonstrates that the doctrine has become obsolete in light of the court-ordered abolition of ethical restraints on physicians and the impact of modern health care delivery alternatives.

## II. HISTORICAL BACKGROUND

### A. *The Medical Profession's Struggle for Autonomy*

Understanding the genesis of the corporate practice of medicine prohibition requires an appreciation of the struggle of nineteenth century physicians to establish themselves as professionals. Physicians of the period practiced in a highly competitive environment, competing for patients not only among themselves,<sup>13</sup> but also with "irregulars"—quacks and healing sectarians who did not obtain a traditional medical education.<sup>14</sup> Many considered medicine an inferior occupation.<sup>15</sup> Medical practice offered little financial security<sup>16</sup> and, unless the physician came from a privileged

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13. See G. ROSEN, *THE STRUCTURE OF AMERICAN MEDICAL PRACTICE 1875-1941* at 19 (1983); W. ROTHSTEIN, *AMERICAN PHYSICIANS IN THE NINETEENTH CENTURY* 108 (1972); P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 77, 80 (1982).

14. D. KONOLD, *A HISTORY OF AMERICAN MEDICAL ETHICS 1847-1912* at 14-16 (1962); G. ROSEN, *supra* note 13, at 19; see R. COE, *SOCIOLOGY OF MEDICINE* 193 (1970). The AMA's *Code of Ethics*, as adopted in 1847, distinguished the so-called regular physician from irregulars with the following language: "No one can be considered a regular practitioner, or a fit associate in consultation, where practice is based on an exclusive dogma to the rejection of the accumulated experience of the profession, and of the aids actually furnished by anatomy, physiology, pathology, and organic chemistry." C. CHAPMAN, *PHYSICIANS, LAW, AND ETHICS* 109 (1984) (quoting *Proceedings of the National Medical Conventions Held in New York, May 1846, and in Philadelphia, May 1847*, at 100 [hereinafter *Proceedings*]); see also J. HALLER, *AMERICAN MEDICINE IN TRANSITION 1840-1910* at 256 (1981).

The principal sectarian practitioners in the second half of the nineteenth century were eclectics, distinguished by their use of medicines made from plants, and homeopaths, who maintained that diseases could be cured by giving heavily diluted doses of drugs which produced symptoms similar to that of the disease. Both of these sects drew closer to regular medicine in the twentieth century. For histories of these sects, see W. ROTHSTEIN, *supra* note 13, at 217-46. Other large sects included the osteopaths and Christian Scientists. D. KONOLD, *supra* note 14, at 15.

15. P. STARR, *supra* note 13, at 82-83. An 1851 study conducted by the newly formed AMA tracked the careers of 12,400 men who had graduated from eight of the nation's leading colleges between 1800 and 1850. Twenty-six percent of the men entered the clergy and a similar percentage entered law. Less than eight percent became physicians. The colleges in the study were Amherst, Brown, Dartmouth, Hamilton, Harvard, Princeton, Union, and Yale. *Id.* at 82 (citing *Report of the Committee on Medical Education*, 4 *TRANSACTIONS OF THE AMERICAN MEDICAL ASSOCIATION* 420-23 (1851)). A study published in 1882, whose survey included 39,054 alumni graduating from 58 colleges, reported proportions similar to those published in 1851. *Id.* at 458 n.5.

16. Late nineteenth century evidence indicates that medicine was not a particularly

background, little guarantee of increased social standing.<sup>17</sup> Young physicians did not enjoy organized professional support or the prospect of a fixed career pattern.<sup>18</sup>

The public regarded nineteenth century physicians with some skepticism. Treatments popular at the time included bloodletting, purging, and administering heavy dosages of mercury or quinine.<sup>19</sup> Disenchanted with the often ineffective and sometimes fatal results of these treatments, patients turned to the irregulars and their promises of speedy cures.<sup>20</sup> Competition also forced some regular physicians to promote their cures and treatments aggressively, much like the irregulars.<sup>21</sup> The public, in turn, recognized no clear distinction among health practitioners.<sup>22</sup>

The call for a national medical convention in 1846 and the subsequent establishment of the American Medical Association (AMA or Association)<sup>23</sup> grew out of physicians' dissatisfaction with their mediocre standard of living and with the poor standing of their profession.<sup>24</sup> The young organization set out to establish the preeminence of the regular medical profession in the provision of health care by imposing higher standards on the profession and by distinguishing it from sectarianism and quackery.<sup>25</sup> To achieve

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lucrative occupation. An 1850 report on public health in Massachusetts showed that an average doctor in the state had annual billings of \$800 and income of \$600. Very few physicians earned income in the thousands. See P. STARR, *supra* note 13, at 84; see also J. HALLER, *supra* note 14, at 234-35. By way of comparison, one economist estimates that around 1860 a working-class family's income ranged from \$200 to \$800; a middle class family's from \$800 to \$5000, and a wealthy family's from \$5000 to \$10,000. See P. STARR, *supra* note 13, at 84. Estimates of doctors' incomes around 1900 range from \$750 to \$1500. As reported by the United States Bureau of the Census, in 1904 average incomes for all occupations except farm labor were \$540; federal employees made approximately \$1000, while ministers earned \$759. Although physicians at the turn of the century did well relative to most occupations, they likely did not stay on par with other professionals. *Id.* at 85; see also Markowitz & Rosner, *Doctors in Crisis: Medical Education and Medical Reform During the Progressive Era, 1895-1915*, in HEALTH CARE IN AMERICA: ESSAYS IN SOCIAL HISTORY 185, 188-89 (S. Reverhy & D. Rosner eds. 1979).

17. See P. STARR, *supra* note 13, at 81, 89.

18. See *id.* at 88-89; G. ROSEN, *supra* note 13, at 16.

19. See R. COE, *supra* note 14, at 181-82; D. KONOLD, *supra* note 14, at 5; P. STARR, *supra* note 13, at 94-95.

20. See R. COE, *supra* note 14, at 182; W. ROTHSTEIN, *supra* note 13, at 125; D. KONOLD, *supra* note 14, at 56; J. HALLER, *supra* note 14, at 192.

21. See D. KONOLD, *supra* note 14, at 19.

22. *Id.*

23. For a discussion of the events leading to the first convention, see D. KONOLD, *supra* note 14, at 8. See also J. HALLER, *supra* note 14, at 212.

24. See J. HALLER, *supra* note 14, at 212; P. STARR, *supra* note 13, at 90; see also R. COE, *supra* note 14, at 193.

25. See C. CHAPMAN, *supra* note 14, at 103; D. KONOLD, *supra* note 14, at 16-19.

these goals, the AMA proposed developing an ethical code under which regulars would practice, establishing licensing requirements, and raising the standards of medical education.

### 1. Ethical Code

The AMA adopted its *Code of Ethics* one year after the organizing convention.<sup>26</sup> The new *Code* served the AMA's need for a document that would demonstrate to the public the moral purposes of the profession, grant the AMA leadership control over its membership, and help establish a health care monopoly for regular practitioners.<sup>27</sup> The *Code's* introductory statement declaimed the superiority of regular physicians over irregulars<sup>28</sup> and implied that legal controls were necessary to prevent the "fraud and poisoning" carried out by irregulars.<sup>29</sup> The statement also urged physicians to limit their ranks to those with proper moral and intellectual training.<sup>30</sup>

The *Code* itself included provisions designed to distinguish regulars from their competitors. The *Code* prohibited regulars from promoting secret remedies or holding patents on medicines, instruments, or appliances. The *Code* proscribed physicians' advertising to enhance their reputation<sup>31</sup> and sought to restrict severely any consultation or professional relationships between regulars and irregulars.<sup>32</sup>

26. See C. CHAPMAN, *supra* note 14, at 106.

27. *Id.* at 107; see also J. HALLER, *supra* note 14, at 235.

28. See C. CHAPMAN, *supra* note 14, at 106.

29. *Id.* The author of the introductory statement wrote that the law is "silent and, of course, inoperative in the cases of both fraud and poisoning so extensively carried on by the host of quacks who infest the land." *Id.* (quoting *Proceedings*, *supra* note 14, at 86-87).

30. *Id.* at 107. The introductory statement's author writes that physicians are the "trustees of science and almoners of benevolence and charity." He urges physicians to use increasing vigilance to prevent the introduction into their body of those who have not been prepared by a suitably preparatory moral and intellectual training . . . We are under the strongest ethical obligations to preserve the character which has been awarded by the most learned men and best judges of human nature to the members of the medical profession, for general and extensive knowledge, great liberality and dignity of sentiment, and prompt effusions of beneficance.

*Id.* (footnote omitted) (quoting *Proceedings*, *supra* note 14, at 90).

31. See C. CHAPMAN, *supra* note 14, at 109; D. KONOLD, *supra* note 14, at 19.

32. See C. CHAPMAN, *supra* note 14, at 109; D. KONOLD, *supra* note 14, at 22; W. ROTHSTEIN, *supra* note 13, at 83. The *Code* prohibited any consultation with one whose practice was "based on exclusive dogma to the rejection of the accumulated experience of the profession." C. CHAPMAN, *supra* note 14, at 109. For the full text of the consultation restriction, see *supra* note 14. See also D. KONOLD, *supra* note 14, at 22. The AMA strictly enforced this prohibition. In 1858 the Association censured a member who had recommended for a particular position a doctor who previously had been expelled from the AMA for selling patent

## 2. Licensing Legislation

The *Code*, although effective in consolidating the members of the regular medical profession, was only partially successful in bettering the livelihood of physicians and in permitting the regulars to realize exclusive control over the practice of medicine.<sup>33</sup> In the 1870s some of the more liberal regular physicians, frustrated by the lack of progress, collaborated with the more respected healing sects<sup>34</sup> to win passage of some minimal licensing statutes.<sup>35</sup> These first licensing statutes typically required nothing more than a diploma to practice medicine.<sup>36</sup> At the time, students could obtain diplomas from medical colleges, none of which were subject to any standardized curricula requirements or oversight.<sup>37</sup> Later statutes created state licensing boards to review diplomas and reject candidates from schools the boards deemed inadequate.<sup>38</sup> By 1905 all but three states required candidates not only to hold an acceptable diploma, but also to pass an independent state examination.<sup>39</sup>

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medicines. The member's recommendation was deemed a violation of the consultation restriction. The AMA pardoned the member only after he formally apologized for his violation. The incident remained as a warning to those physicians who considered straying from the organization's doctrine. *Id.* at 23.

33. See G. ROSEN, *supra* note 13, at 24.

34. See *supra* note 14.

35. See D. KONOLD, *supra* note 14, at 28-29; P. STARR, *supra* note 13, at 102; see also J. BURROW, *ORGANIZED MEDICINE IN THE PROGRESSIVE ERA* 58 (1977).

According to Konold, members of the medical profession succeeded in passing medical licensing statutes early in the nineteenth century. D. KONOLD, *supra* note 14, at 3-4. As public respect for regular physicians declined, however, these limited controls on irregulars were abolished. See *supra* notes 19-22 and accompanying text; D. KONOLD, *supra* note 14, at 7.

36. See P. STARR, *supra* note 13, at 100. In the latter half of the nineteenth century, obtaining a medical diploma did not necessarily mean that one obtained an adequate level of medical training. In 1894, 21 "diploma mills" were selling degrees. One of these mills is said to have sold 60,000 diplomas over a 40-year period. See J. HALLER, *supra* note 14, at 224.

37. See *infra* notes 52-55 and accompanying text.

38. See P. STARR, *supra* note 13, at 104; W. ROTHSTEIN, *supra* note 13, at 286. In 1877 Illinois passed legislation empowering a state board of medical examiners to withhold licenses from graduates of disreputable medical schools until graduates passed a state examination. Graduates of approved schools were licensed automatically. The year the legislation passed, 3600 nongraduates were practicing in the state. Consequently, 1400 of them left within one year. In 10 years 3000 were driven from medical practice. See P. STARR, *supra* note 13, at 104.

39. See D. KONOLD, *supra* note 14, at 29. In 1901, 25 states and the District of Columbia required candidates to earn a diploma and pass an independent state examination. Eleven states required only an examination and required either passage of a state exam or presentation of a diploma from an acceptable school. See P. STARR, *supra* note 13, at 104, 461 n.67. For a chart of all state licensing laws in effect in 1901, see *Laws Regulating the Practice of Medicine in the Various States and Territories of the United States*, 37



These increased licensing requirements eliminated many potential doctors from medical practice.<sup>40</sup>

In addition to raising licensing standards, regulars sought to establish themselves as the gatekeepers to medical practice by advocating legislation requiring physicians to obtain a license from state licensing boards composed exclusively of regular physicians.<sup>41</sup> Unable to muster political strength against the larger sects,<sup>42</sup> the regulars compromised with the sects to create either boards on which the sects were represented or board systems in which each group would examine their own candidates.<sup>43</sup> While the regulars had to compromise with the sects, they did realize some progress in upgrading the standards of medical practice and in controlling the number of practitioners.<sup>44</sup> Their success prompted the AMA, in the early twentieth century, to lobby for legal controls<sup>45</sup> rather than rely on ethical restrictions to gain superiority over irregular practitioners.<sup>46</sup>

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J.A.M.A. 1318 (1901). In 1888 the United States Supreme Court passed on the legitimacy of medical licensing requirements in *Dent v. West Virginia*, 129 U.S. 114 (1888). Dr. Dent was an eclectic physician, *see supra* note 14, who had been in practice for six years. The State Board of Health ruled Dr. Dent's diploma from the American Medical Eclectic College of Cincinnati, Ohio to be unacceptable. *Id.* at 118. The state convicted and fined Dr. Dent under an 1882 statute requiring a physician to hold a degree from a reputable medical school, pass the state examination, or prove that the physician had been practicing for the past 10 years. *Id.* at 115-16, 118. In a unanimous decision the Court upheld the law, noting that states have the power to regulate entry into a vocation when the regulation is not applied arbitrarily and when the regulation's purpose is the protection of the public welfare. *Id.* at 122-24.

The Court's decision in *Dent* legitimized the efforts of the early medical establishment to control entrance into its ranks. The decision also is noteworthy because it indicates how the medical profession, by 1888, had gained status and public respect. "Few professions," stated the Court, "require more careful preparation . . . than that of medicine." *Id.* at 122. According to the Court, the medical profession deals "with all those subtle and mysterious influences upon which health and life depend, and requires not only a knowledge of the properties of vegetable and mineral substances, but of the human body in all its complicated parts, and their relation to each other, as well as their influence upon the mind." *Id.* Furthermore, the Court stated that "comparatively few can judge . . . the qualifications of learning and skill which [the doctor] possesses." *Id.*

40. *See* P. STARR, *supra* note 13, at 118; *supra* note 38.

41. *See* J. BURROW, *supra* note 35, at 58.

42. *See supra* note 35 and accompanying text.

43. *See* J. BURROW, *supra* note 35, at 58-59 & 162 app. (listing the structures of medical boards by state as of 1917); D. KONOLD, *supra* note 14, at 29.

44. *See* D. KONOLD, *supra* note 14, at 29-30; W. ROTHSTEIN, *supra* note 13, at 287 (showing table of the number of medical schools, students, and graduates, by sect, from 1850-1920).

45. D. KONOLD, *supra* note 14, at 31.

46. *Id.* at 30-31; *see* C. CHAPMAN, *supra* note 14, at 113; W. ROTHSTEIN, *supra* note 13, at 298.

### 3. Medical Education Reform

Although improvement of medical education was a principal reason for the AMA's formation,<sup>47</sup> the organization met with little initial success in gaining acceptance of its proposed reforms.<sup>48</sup> Medical schools and physicians who took on apprentices offered the most resistance to specified preliminary education requirements and stronger medical curricula.<sup>49</sup> Educational reform stood contrary to the interests of schools, which competed for students' tuition, and physicians, which competed for apprenticeship fees and office assistance.<sup>50</sup> Resistance to higher standards continued as medical schools, and competition among them, proliferated after the Civil War.<sup>51</sup>

Licensing requirements, which brought minimal standards to medical education, were not stifling the operation of low-grade medical colleges.<sup>52</sup> Without higher educational standards, entry into the medical profession was available to virtually everyone through the weaker university programs and privately owned schools.<sup>53</sup> Professional leaders did not believe that graduates of these programs possessed the qualifications attendant upon true professionals.<sup>54</sup> These leaders also felt that producing low-quality

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47. The impetus for the original AMA convention came in part from the New York State Medical Society's discussions about educational reform in that state. The society's leaders realized that stricter standards in one state simply would drive students to neighboring states for a medical education. Thus, some type of national effort was necessary. See D. KONOLD, *supra* note 14, at 8; W. ROTHSTEIN, *supra* note 13, at 114; P. STARR, *supra* note 13, at 90-91. Three of the six resolutions adopted during the first convention were related to educational reform. See C. CHAPMAN, *supra* note 14, at 105.

48. See D. KONOLD, *supra* note 14, at 16-17; W. ROTHSTEIN, *supra* note 13, at 115-16. The AMA's first educational proposal called for three years of study with a preceptor, including two courses at a medical college. In addition, the proposal recommended that colleges have a seven member staff, extend lecture courses from four to six months, require three months of dissection training, and offer one session of hospital training. See D. KONOLD, *supra* note 14, at 16. For an account of the AMA's efforts in educational reform through the second half of the 1900s, see *id.* at 17-19.

49. See D. KONOLD, *supra* note 14, at 16-17; W. ROTHSTEIN, *supra* note 13, at 116.

50. See W. ROTHSTEIN, *supra* note 13, at 116-17.

51. See D. KONOLD, *supra* note 14, at 19; W. ROTHSTEIN, *supra* note 13, at 286, 291.

52. Some of the requirements simply were ignored unless the licensing agency enforced them. Furthermore, the licensing examination, when required, was not so difficult that the inept could not pass. See W. ROTHSTEIN, *supra* note 13, at 291.

53. See W. ROTHSTEIN, *supra* note 13, at 291-92; P. STARR, *supra* note 13, at 116-17.

54. See J. BURROW, *supra* note 35, at 31. Burrow recounts some observations made in the first decade of the twentieth century:

At the Tulane University School of Medicine, George Dock testified to the virtual illiteracy of his third-year students whose assaults on orthography included "inflamed," "bowalls," "simptom," "tetnas," "puss," and "irruption." Lincoln Cothran, as a mem-

graduates not only resulted in too much competition, but also hampered efforts to raise the societal status of physicians.<sup>55</sup>

Soon after the AMA's reorganization at the beginning of the twentieth century and the AMA's establishment as the profession's central source of power and policy-making,<sup>56</sup> the AMA declared medical education reform a top priority.<sup>57</sup> By dictating medical school entrance requirements, strengthening curricula, and lengthening the required time of study, the AMA sought to control both the quality and the level of competition within the profession.<sup>58</sup> The AMA achieved its goals in relatively few years.<sup>59</sup> The new requirements increased students' tuition and required greater time commitments, which consequently increased lost earnings to a point at which many students no longer could afford to attend medical schools.<sup>60</sup> In addition, the new requirements rendered pri-

ber of the California State Board of Medical Examiners, found graduates in their "untutored earnestness" offering such approximations as "tung," "bludvescles," "dy-aftram," "uren," and "recktum." Henry Beates, Jr., President of the Medical Council of Pennsylvania, declared that of the papers he graded on licensing examinations some 30 or 40 percent represented appalling examples of illiteracy. George M. Gould, a prominent medical editor, complained that three-fourths of the four-thousand annual graduates of medical institutions could not practice medicine intelligently. Laying much of the blame for degraded standards on commercial medical colleges, Charles H. Wallace, while president of the Missouri Medical Association observed, "These student hunters entice the barber from his chair, the mechanic from his hench and the huckster from his wagon, all with imperfect education, and push them by roseate pictures into the field of medicine. What can such conditions bring forth [he asked] but imperfectly-feathered fiedglings who flutter along the marshes and never rise to the dignified heights of the real physician.

*Id.* at 31.

55. See Markowitz & Rosner, *supra* note 16, at 189-90; G. ROSEN, *supra* note 13, at 64; P. STARR, *supra* note 13, at 117.

56. For a description of the AMA's reorganization and consolidation of power, see J. BURROW, *AMA: VOICE OF AMERICAN MEDICINE* 27-53 (1963). See also W. ROTHSTEIN, *supra* note 13, at 316-20.

57. See G. ROSEN, *supra* note 13, at 62; P. STARR, *supra* note 13, at 117; see also J. BURROW, *supra* note 35, at 33; J. BURROW, *supra* note 56, at 33.

58. See J. BURROW, *supra* note 35, at 32; G. ROSEN, *supra* note 13, at 36, 61-66. For an account of the AMA's early objectives in educational reform, see J. BURROW, *supra* note 35, at 33-37.

59. The AMA's Council on Medical Education began inspecting schools in 1906. Out of 161 schools inspected, 82 were deemed acceptable; 47 were thought imperfect, but redeemable; and 32 were unsatisfactory. These inspections were responsible in part for the closing of 29 schools by 1910. J. HALLER, *supra* note 14, at 225. For a detailed discussion of the Council's first inspection of medical schools, see J. BURROW, *supra* note 35, at 35-37.

60. See G. ROSEN, *supra* note 13, at 67; see also P. STARR, *supra* note 13, at 118. Starr explains as follows:

The academic year, time almost wholly lost for earnings, went from four to eight or nine months, and the total period of training from two years, possibly without high school, to four, then five, and eventually more than eight years beyond high school.

vate, for-profit schools unprofitable.<sup>61</sup> The early 1900s witnessed a steady decrease in the number of physicians<sup>62</sup> and a steady increase in the quality of those who became physicians.<sup>63</sup>

Through the development and enforcement of an ethical code, the AMA was able to organize regular physicians and distinguish them from less reputable practitioners. By procuring passage of licensing legislation, the regular medical profession began to limit competition and raise the quality of practitioners. With successes in educational reform, the AMA further controlled competition and advanced physicians' expertise. By the early twentieth century, the AMA brought public respect and greater financial reward to physicians<sup>64</sup> and established the regular medical profession's virtual control over medical care.<sup>65</sup>

### B. *The Corporate Threat To Autonomy*

The AMA had been very successful in attaining autonomy for the profession. A new threat to that autonomy, however, arose out of corporate entities' growing involvement in medicine.<sup>66</sup> A substantial segment of the medical profession harbored hostility toward forms of organizing medical practices and methods of paying for medical services that increased competition among independent physicians.<sup>67</sup>

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Under the emerging system, young doctors could scarcely hope to be making a living on their own before age thirty.

*Id.*

61. State licensing boards were requiring that medical schools have modern laboratories, libraries, and clinical facilities. No medical school could cover the increased expenses with tuition alone. Thus, the privately owned schools that had no endowments or state support were forced to close. See W. ROTHSTEIN, *supra* note 13, at 193-94; P. STARR, *supra* note 13, at 118.

62. See G. ROSEN, *supra* note 13, at 15; P. STARR, *supra* note 13, at 126. Starr notes that census data indicate that in 1900 there were 173 physicians for every 100,000 people. In 1920 the ratio of doctors to population had decreased to 137 per 100,000, and to 125 per 100,000 in 1930, where the ratio remained for the next two decades.

63. See G. ROSEN, *supra* note 13, at 66; P. STARR, *supra* note 13, at 123-24.

64. See *supra* note 16; G. ROSEN, *supra* note 13, at 70.

65. See P. STARR, *supra* note 13, at 127.

66. See P. STARR, *supra* note 13, at 198-206; see also J. BURROW, *supra* note 35, at 119 (stating "contract practice stood out in the Progressive Era as the most dangerous threat to whatever degree of unity the regular medical profession had achieved"); cf. G. ROSEN, *supra* note 13, at 36. Contract practice did exist in the nineteenth century. See J. BURROW, *supra* note 35, at 119; D. KONOLD, *supra* note 14, at 57. The AMA, in fact, classified contract work as a form of irregular practice as early as 1869. Physicians, however, were rarely disciplined for participating in the schemes. See D. KONOLD, *supra* note 14, at 57; J. HALLER, *supra* note 14, at 245-47.

67. See G. ROSEN, *supra* note 13, at 36. In addition to contract and corporate practice,

The early involvement of business corporations in medicine took two forms. In the first form, popularly known as contract practice,<sup>68</sup> corporations employed physicians to serve the medical needs of employees.<sup>69</sup> In the isolated industries of railroad, mining, and lumbering, doctors contracted to treat employees for a predetermined salary.<sup>70</sup> Corporations in smaller and more urban industries contracted with independent physicians to provide medical care to the corporations' employees for a set rate per worker per month.<sup>71</sup> Under both schemes the corporation dictated the choice of physicians.<sup>72</sup>

In the second form, known as corporate practice, for-profit medical service companies marketed physicians' services to the public.<sup>73</sup> Corporate practice developed in its largest scale in Oregon and Washington in the early 1900s. Corporations in these states contracted with mining and lumber companies to provide medical services to company employees for a fixed rate per worker.<sup>74</sup> The corporations first employed their own doctors to perform these ser-

many physicians resented the development of health department clinics, pay clinics, group practice, and health insurance. *Id.*

68. See J. BURROW, *supra* note 35, at 119-20; J. HALLER, *supra* note 14, at 245-47.

69. See J. BURROW, *supra* note 35, at 119-20; D. KONOLD, *supra* note 14, at 57-58; P. STARR, *supra* note 13, at 200-06. In another form of contract practice, fraternal and benevolent societies contracted with doctors to provide health care to their members. Much like the corporations in smaller industries, the societies paid doctors a fixed fee for each lodge member in return for an indefinite volume of work. See J. BURROW, *supra* note 35, at 121-22; see also P. STARR, *supra* note 13, at 206-09. The issues raised by lodge practice are much the same as those that arise when corporations pay a fixed rate for medical services. This Note does not discuss this type of contract practice.

70. See P. STARR, *supra* note 13, at 201-02; see also J. BURROW, *supra* note 35, at 119-20.

In the years following the Civil War the railroad, mining, and lumber industries employed doctors to treat victims of industrial accidents. By 1900 railroads employed more than 6000 surgeons to treat workers, pedestrians, and passengers. As the railroads moved West, lines would organize their own services by relocating salaried doctors to unsettled areas. Similarly, the mining and lumbering industries were forced to provide medical services to employees simply because of the location of their businesses. Estimates indicate that by 1930, 530,000 railway employees, as well as an unknown number of dependents, were covered by these industrial health programs. Passage of workers' compensation laws around 1910 also promoted this form of corporate involvement in medicine. Corporations concerned with liability and insurance costs employed doctors to conduct regular examinations and to attend to the health maintenance of workers. See P. STARR, *supra* note 13, at 200-02.

71. See P. STARR, *supra* note 13, at 202. The contracting doctor would be paid out of deductions from the workers' paychecks. The doctor typically would receive 50 cents a month for an unmarried man and 75 cents for a married man and his family. See J. HALLER, *supra* note 14, at 146; see also J. BURROW, *supra* note 35, at 119.

72. See P. STARR, *supra* note 13, at 202; J. HALLER, *supra* note 14, at 246.

73. See P. STARR, *supra* note 13, at 204-06.

74. *Id.* at 204-05.

vices, but later subcontracted the work to independent doctors. Although physicians founded these corporations, eventually they were managed by lay people. Corporate management maintained limited control over the doctors with whom they contracted. Management required second opinions before surgery, reviewed the length of hospital stays, and refused to pay fees deemed excessive.<sup>75</sup>

Contract and corporate practice raised myriad concerns among the medical establishment. Contract or corporate practice, critics argued, would force doctors to maintain a high patient load and, thus, the quality of services delivered would deteriorate.<sup>76</sup> Furthermore, fixed salaries and fees repudiated the traditional fee-for-service mechanism<sup>77</sup> that allowed physicians to value their own services<sup>78</sup> and, as a result, control their own income levels.<sup>79</sup> Fixed salaries and fees paid for indefinite volumes of work, however, would result in low earnings and potential out-of-pocket expenses for physicians.<sup>80</sup>

Opponents of contract and corporate practice also complained that these schemes forced doctors to bid against each other for contracts, thus driving their reimbursements down to unconscionable levels.<sup>81</sup> The schemes also threatened the profession's monopo-

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75. *Id.* at 205.

76. See Berlant, *Medical Ethics and Monopolization*, in *ETHICS IN MEDICINE: HISTORICAL PERSPECTIVES AND CONTEMPORARY CONCERNS* 61 (J. Reiser, A. Dyck & W. Curran eds. 1977).

77. See J. BURROW, *supra* note 35, at 119; see also G. ROSEN, *supra* note 13, at 4, 25.

78. See J. HALLER, *supra* note 14, at 242; Berlant, *supra* note 76.

79. Cf. D. KONOLD, *supra* note 14, at 58 (stating that after 1892 the AMA, while permitting contracts that paid doctors at or above fee-for-service rates, would not allow contracts that paid less because these contracts would weaken efforts to raise physicians' incomes).

80. See J. HALLER, *supra* note 14, at 246; Berlant, *supra* note 76. Burrow explains the type of exploitation in which some companies engaged:

In Michigan, the Michigan Alkali Company provided contract coverage to employees for monthly payments of fifty cents, while at Menominee, the Electrical and Mechanical Company offered medical and surgical care for only fifteen cents. Mining corporations generally provided individual medical coverage for monthly payments of from fifty cents to one dollar, while the United States Health and Accident Company gave contract coverage in several firms for annual payments ranging from \$1.50 to \$3.00. Aetna Life and Accident Company provided contract coverage to a number of firms for employee payments of one dollar per month, but of this sum allowed physicians only 10 percent . . . Careful estimates in 1907 of the cost of contract practice in Chicago, as opposed to the cost of similar service under the minimum fee bill, set the annual loss to the profession at a minimum of \$750.00.

J. BURROW, *supra* note 35, at 123.

81. See J. BURROW, *supra* note 35, at 123; see also D. KONOLD, *supra* note 14, at 58.

listic designs by creating stiff competition with individual physicians and by permitting lay persons to make policy decisions concerning which patients a doctor could see and the amount of services a doctor could provide.<sup>82</sup>

Despite the obvious threat of contract and corporate practice to the medical profession's recently established autonomy, the profession was not unified in opposition.<sup>83</sup> Some physicians, particularly those struggling to make a living, appreciated the stable income obtained through a contract or corporate arrangement.<sup>84</sup> Nevertheless, contract and corporate practice schemes caused great consternation among AMA members, prompting the body to enact a series of ethical pronouncements against the schemes' use.

### III. ESTABLISHMENT OF THE CORPORATE PRACTICE PROHIBITION

#### A. Ethical Restraints

##### 1. Development of the Ethical Provisions

In one of the AMA's earliest actions concerning contract and corporate practice, the AMA adopted a statement in 1890 declaring that the schemes had "gone too far" and that "[t]oo much of the spirit of trade has found its way into the profession, and [that] its further encroachment should be resisted—not encouraged."<sup>85</sup> In 1911 the editors of the *Journal of the American Medical Association* qualified the AMA's position on contract and corporate practice.<sup>86</sup> The editors explained that the term "contract practice"—used by the AMA to cover both contract and corporate arrangements<sup>87</sup>—was a misnomer<sup>88</sup> because the term implied that objections to the practice were grounded in the existence of a con-

82. See Berlant, *supra* note 76, at 61.

83. See J. BURROW, *supra* note 35, at 124-25.

84. *Id.*; see also J. HALLER, *supra* note 14, at 247; *infra* note 116.

85. *In re American Medical Ass'n*, 94 F.T.C. 701, 898 (1979) (quoting unnamed 1890 report to AMA House of Delegates).

86. See *Contract Practice*, 57 J.A.M.A. 145, 145 (1911); see also J. BURROW, *supra* note 35, at 128.

87. Editors of the *Journal of the American Medical Association* noted that "contract practice" had come to include a broad range of contractual arrangements:

In order to discuss intelligently what is generally known as contract practice, it is necessary first to define what one means by the term, since it is used to designate everything from the employment of a surgeon by a railroad to lodge practice and employment of physicians by burial and aid societies.

*Contract Practice*, *supra* note 86, at 145; see *supra* note 68.

88. See *Contract Practice*, *supra* note 86, at 145.

tract.<sup>89</sup> The editors observed that all medical care arises from a contract, either express or implied, between a doctor and patient.<sup>90</sup> The objection to contract practice, the editors stated, was only to the use of unfair contracts.<sup>91</sup>

The editors highlighted four parties requiring consideration in the context of medical care provision: the physician, the patient, the medical profession, and the public.<sup>92</sup> The editors argued that a physician could, without objection, enter into a contractual arrangement if none of the four parties suffered injury as a result.<sup>93</sup> The editors offered rough criteria by which local societies might test contract schemes. The societies were to examine the economic justification for the contract, the possibility of harm, and the opportunity for middlemen to exploit physicians.<sup>94</sup>

In 1912 the AMA confronted the contract and corporate practice issue for the first time in the Association's listing of ethical canons,<sup>95</sup> known at this time as the *Principles of Medical Ethics*.<sup>96</sup> The *Principles* did not offer any clear guidelines by which to judge contract schemes. Rather, the 1912 provision simply condemned as "unprofessional" any contractual arrangement that required physicians to perform under conditions that made "it impossible to render adequate service" or that "interfere[d] with reasonable competition among the physicians of a community."<sup>97</sup>

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89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.*

93. *Id.*

94. The AMA recommended that local societies ask the following three questions when judging a contract scheme:

1. Is there an economic justification for such an agreement?
2. Is the contract such a one that no one will be harmed thereby?
3. Is it a direct agreement between the physician and the patient or is the physician being exploited for the benefit of a middleman?

*Id.*; see also J. BURROW, *supra* note 35, at 128.

95. See Laufer, *Ethical and Legal Restrictions on Contract and Corporate Practice of Medicine*, 6 L. & CONTEMP. PROBS. 516, 518 (1939); see also *In re American Medical Ass'n*, 94 F.T.C. at 1011 n.59.

96. The AMA's original *Code of Ethics* was revised and retitled *Principles of Medical Ethics* in 1903. The profession complained that the *Code* was too rigid and unbecoming of professionals. The *Principles* were thought more becoming of the honorable persons in the profession. See D. KONOLD, *supra* note 14, at 68-70.

97. *In re American Medical Ass'n*, 94 F.T.C. at 1011 n.59. The provision stated: It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the



The 1912 provision did not eliminate or even reduce significantly suspect contract arrangements.<sup>98</sup> In 1927 the AMA's House of Delegates<sup>99</sup> approved, but did not formally introduce into the *Principles*, criteria suggested by the Judicial Council<sup>100</sup> to determine whether a contract for medical services was ethical.<sup>101</sup> The Judicial Council noted that contract-style arrangements were "entering into so many phases of the practice of medicine as to be a distinct menace to the stability of [the AMA]."<sup>102</sup>

In 1927 the Committee on the Costs of Medical Care, a national commission funded through private philanthropies, convened to study the country's health care system.<sup>103</sup> In 1932 the Committee recommended the expanded use of contract-style practice through group prepaid medical practice.<sup>104</sup> Many of the Committee's physician members, including some AMA officials, drafted a Minority Report opposing the Committee's recommendations.<sup>105</sup> Relying on the contract practice criteria developed by the Judicial Council in 1927, the minority criticized group prepaid practice. The minority claimed that group practice contracts lead to the solicitation of patients, created competition among physicians, and demoralized the profession.<sup>106</sup>

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profession.

*Id.* (quoting 1912 version of *Principles of Medical Ethics of the AMA*).

98. See Laufer, *supra* note 95, at 518.

99. The House of Delegates is the AMA's official legislative and policy-making body. For details concerning the House's composition and powers, see *In re American Medical Ass'n*, 94 F.T.C. at 710-11.

100. The Judicial Council is responsible for interpreting the AMA Constitution and Bylaws and the *Principles of Medical Ethics*. *Id.* at 711. The Council is composed of five physicians who are nominated by the AMA president and elected by the House of Delegates. *Id.* at 801-02.

101. The Judicial Council's report followed a 1926 request by the House of Delegates to investigate the contract and corporate practice issue. *Id.* The criteria developed by the Council eventually were incorporated in the *Principles of Medical Ethics*. For a listing of the criteria as finally adopted, see *infra* note 111.

102. *In re American Medical Ass'n*, 94 F.T.C. at 898.

103. *Id.*

104. *Id.*

105. *Id.*

106. *Id.* The Minority Report voiced the following concerns:

One of the strongest objections to industrial medical services, mutual benefit associations, so-called health and hospital associations, and other forms of contract practice is that there has been found no means of preventing destructive competition between individuals or groups concerned with these movements. This injects a type of commercialism into medical practice which is harmful to the public and the medical profession and results in inferior quality of medical service.

One of the pernicious effects of contract practice schemes is that each of them stimulates the launching of other similar schemes until there are many in the field

The AMA's House of Delegates endorsed the Minority Report in 1933, noting that the Report expressed the collective opinion of the medical profession.<sup>107</sup> That same year, the House replaced the 1912 provision on contract practice.<sup>108</sup> The new provision defined contract practice as an agreement between a physician or a group of physicians and an entity, such as a corporation, organization, political subdivision, or individual, to provide medical services to a group of individuals on the basis of a fee schedule, for a salary, or for a fixed rate per capita.<sup>109</sup> The provision stated that not all contract practice was per se unethical, but adopted the criteria formulated by the Judicial Council in 1927<sup>110</sup> for determining which contracts were unacceptable.<sup>111</sup>

In 1934 the House of Delegates added another ethical provision bearing on contract practice.<sup>112</sup> Entitled "Direct Profits to Lay Groups," the provision condemned arrangements in which a lay entity directly profited from compensation received by a physician for providing medical services.<sup>113</sup> Both the general provision on

competing with each other. The first may have safeguards against many of the abuses of contract practices, but as new ones are formed the barriers are gradually broken down in order to secure business.

*Id.* at 1013 (quoting Committee on the Costs of Medical Care, *Medical Care for the American People, Minority Report* (1932)).

107. *In re American Medical Ass'n*, 94 F.T.C. at 899.

108. *Id.*

109. See Laufer, *supra* note 95, at 519 (quoting *Principles of Medical Ethics of the AMA*, ch. III, art. VI, § 2, published in *AMERICAN MEDICAL DIRECTORY* 15 (15th ed. 1938)); see also *In re American Medical Ass'n*, 94 F.T.C. at 896.

110. See *supra* notes 100-01 and accompanying text.

111. The 1933 provision listing the conditions which made contracts unethical reads as follows:

Contract practice *per se* is not unethical. However, certain features or conditions if present make a contract unethical, among which are: 1. When there is solicitation of patients, directly or indirectly. 2. When there is underbidding to secure the contract. 3. When the compensation is inadequate to assure good medical service. 4. When there is interference with reasonable competition in a community. 5. When free choice of a physician is prevented. 6. When the conditions of employment make it impossible to render adequate service to the patients. 7. When the contract because of any of its provisions or practical results is contrary to sound public policy.

Each contract should be considered on its own merits and in the light of surrounding conditions. Judgment should not be obscured by immediate, temporary or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole.

Laufer, *supra* note 95, at 519 (quoting *Principles of Medical Ethics of the AMA*, ch. III, art. VI, § 2, published in *AMERICAN MEDICAL DIRECTORY* 15 (15th ed. 1938)).

112. See Laufer, *supra* note 95, at 519; see also *In re American Medical Ass'n*, 94 F.T.C. at 899.

113. See Laufer, *supra* note 95, at 519; see also *In re American Medical Ass'n*, 94 F.T.C. at 899. The provision reads as follows:

contract practice criteria, adopted in 1933,<sup>114</sup> and the prohibition on lay entity profit-taking, added in 1934, survived as part of the AMA's ethical doctrine through the 1970s.<sup>115</sup>

## 2. Analysis of the Ethical Provisions

The language of the 1933 and 1934 provisions indicates the struggle that the AMA faced on the contract and corporate practice issue. The AMA did not totally prohibit contract and corporate practice; the Association recognized that contract-style schemes were justifiable in certain cases.<sup>116</sup> The AMA also recognized that many physicians needed the contract and corporate work to survive in the profession.<sup>117</sup> Conversely, the AMA desired to prevent what it considered to be the unacceptable consequences of contract and corporate practice.

One of the unacceptable consequences of contract schemes was the commercialism of the medical profession. The AMA's concern over commercialism is manifest in the unambiguous language of the 1934 provision's prohibition against lay entities profiting from physicians' services.<sup>118</sup> This kind of profit splitting, states the provision, lowers the dignity of the medical profession and creates unfair competition.<sup>119</sup> Commercialism also might lead to lay involvement in physicians' decisionmaking and to interference with the

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It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy.

Laufer, *supra* note 95, at 519 (quoting *Principles of Medical Ethics of the AMA*, ch. III, art. VI, § 5, published in *AMERICAN MEDICAL DIRECTORY* 15 (15th ed. 1938)).

114. See *supra* note 111 and accompanying text.

115. Before being struck down by the Federal Trade Commission in 1979, see *infra* notes 220-47 and accompanying text, the substance of both provisions was included in the Judicial Council's *Opinions and Reports*, its periodical of authoritative ethical interpretations. See *In re American Medical Ass'n*, 94 F.T.C. at 899.

116. See J. BURROW, *supra* note 35, at 124, 128; see also Laufer, *supra* note 95, at 518.

117. See *supra* note 84 and accompanying text. According to Mr. Laufer, the economic realities of the Depression compelled many physicians to consider contract work. In 1934 the Judicial Council warned that "many of the members of the AMA are straining at their ethical leashes." Laufer, *supra* note 95, at 519 (construing *Report of the Judicial Council*, 102 J.A.M.A. 1497 (1934)).

118. See *supra* note 113 and accompanying text.

119. *Id.* The Minority Report of the Committee on the Costs of Medical Care expresses similar concerns. See *supra* note 106 and accompanying text.

fidelity of the doctor-patient relationship.<sup>120</sup> While these concerns are not stated expressly in the 1934 provision, they may be implied from language warning that direct profiting is detrimental to the public welfare and is against public policy.<sup>121</sup> Commercialism by lay entities threatened physicians' status, financial security, and professional autonomy. After their long struggle to establish these characteristics as norms of the profession,<sup>122</sup> physicians would not allow them to be put at risk.

In contrast to the definitive prohibition against any form of commercial contract practice, the 1933 provision regulates non-commercial contract arrangements by proscribing only those arrangements with undesirable features.<sup>123</sup> The features deemed unethical represent familiar concerns of the profession. The 1933 provision condemns contracts that create more than "reasonable competition" in a community.<sup>124</sup> The provision also disallows the competitive practices of solicitation to obtain patients and underbidding to obtain contracts.<sup>125</sup> Furthermore, the 1933 provision evidences concern for professional autonomy. The provision prohibits contracts in which conditions of employment prevent physicians from rendering adequate services.<sup>126</sup> Finally, by requiring that patients be free to choose their physicians,<sup>127</sup> the provision limits the amount of outside interference with the doctor-patient relationship.

Although the list of unethical features in the 1933 provision may appear comprehensive, the AMA actually granted great discretion to the local societies judging the contract schemes. The 1933 provision states that contracts should be considered on their merits and in view of the surrounding circumstances.<sup>128</sup> The provision also states that the ethical nature of contracts must be determined with regard to their ultimate effect on the public.<sup>129</sup> Even within the provision's list of criteria, enough ambiguities exist to justify the broad range of conclusions reached by local societies on contract schemes. Minds reasonably could differ on what consti-

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120. See Laufer, *supra* note 95, at 518.

121. See *supra* note 113.

122. See *supra* notes 13-65 and accompanying text.

123. See *supra* note 111.

124. See *id.* (clause 4).

125. See *id.* (clauses 1 & 2).

126. See *id.* (clause 6).

127. See *id.* (clause 5).

128. See *id.* (concluding paragraph).

129. See *id.*

tutes "adequate compensation,"<sup>130</sup> "reasonable competition,"<sup>131</sup> or "sound public policy."<sup>132</sup>

By permitting discretion at the local level, the AMA allowed some members of the profession to practice through contracts and corporations. In particular, the AMA's system of ethical restrictions permitted nonprofit and public corporations to offer physicians' services.<sup>133</sup> Simultaneously, the AMA articulated sufficient objective criteria to check overreaching contract arrangements<sup>134</sup> and succeeded in establishing the general perception that corporations were unhealthy for medicine.

## B. Legal Restraints

### 1. Medical Practice Acts

Legal restraints, in the form of state medical practice acts and public policy considerations, provide a second barrier to the corporate practice of medicine. Courts have cited state medical practice acts as implying a prohibition against corporate medical practice.<sup>135</sup> While some statutes are more explicit than others with regard to corporate involvement in medicine, few articulate an actual prohibition.<sup>136</sup> Most medical practice acts are simple licensure stat-

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130. See *id.* (clause 3).

131. See *id.* (clause 4).

132. See *id.* (clause 7).

133. See Laufer, *supra* note 95, at 519; see also *supra* notes 110-11 and accompanying text.

134. For a compilation of AMA enforcement activities concerning contract practice, see *In re American Medical Ass'n*, 94 F.T.C. at 899-907.

135. See, e.g., *Parker v. Board of Dental Examiners*, 216 Cal. 285, 14 P.2d 67 (1932); *People v. United Medical Serv., Inc.*, 362 Ill. 442, 200 N.E. 157 (1936); *State v. Winneshiek Corp. Burial Ass'n*, 237 Iowa 556, 22 N.W.2d 800 (1946); *People v. Woodhury Dermatological Inst.*, 192 N.Y. 454, 85 N.E. 697 (1908); see also Willcox, *supra* note 2, at 436.

136. See CAL. BUS. & PROF. CODE § 2400 (West Supp. 1987) The California statute provides:

Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the Division of Licensing may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic. This provision does not apply to professional corporations, see *id.* at § 2402 (West Supp. 1987), which are entities wholly owned by licensed physicians organized solely to provide the medical services of the owners. Professional corporations, in turn, are subject to certain restrictions on the contractual relationships they may have with other corporations. See CAL. CORP. CODE § 13408.5 (West Supp. 1987).

See also COLO. REV. STAT. § 12-36-134(7) (1985) (providing that corporations other than those authorized under the professional corporation provisions "shall not practice

utes that list the qualifications needed to obtain a license and require that no person practice without one.<sup>137</sup> Courts that derive a rule against corporate practice from this type of statutory language hold that a corporation, because of its nonpersonal nature, cannot meet the qualifications of the licensure statute and, therefore, may not practice medicine.<sup>138</sup>

In 1936 the Illinois Supreme Court, in *People v. United Medical Service, Inc.*,<sup>139</sup> interpreted the language of the state's medical practice act to prevent a for-profit corporation<sup>140</sup> from providing medical services through its clinic.<sup>141</sup> The Illinois act prohibited unlicensed persons from practicing medicine.<sup>142</sup> Licensure required passage of a state medical examination and certification that the applicant was at least twenty-one years old and of good moral character.<sup>143</sup> The court maintained that the legislature intended these licensure provisions to allow only individual persons to obtain a medical license.<sup>144</sup> The court stated that United Medical Service, "owing to its corporate character," could not acquire a license to practice medicine.<sup>145</sup>

United Medical Service argued that the employment of licensed physicians by a corporation that receives the patients' fees does not mean that the corporation is practicing medicine.<sup>146</sup> The contract for payment between the corporation and the patient did not, United Medical Service contended, interfere with the relationship between the doctor and patient.<sup>147</sup> The court responded that this view was against the weight of precedent, which held that the

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medicine"); OHIO REV. CODE ANN. § 1701.03 (Page 1985) (providing that corporations may be formed for any purpose "other than for carrying on the practice of any profession," subject to the statutory exception for professional corporations).

137. *Satellite and Commercial Medical Clinics, Report of the Board of Trustees: Part II*, 253 J.A.M.A. 1314, 1315-17 (1985) [hereinafter *Trustees Report: Part II*].

138. See Willcox, *supra* note 2, at 438-39; Note, *Cooperation in Medicine*, 35 MINN. L. REV. 373, 385 (1951).

139. 362 Ill. 442, 200 N.E. 157 (1936).

140. United Medical Service provided examination and treatment services for all physical and mental ailments by physicians and surgeons licensed by the State of Illinois. Persons desiring the services of the clinic paid a fixed fee to the corporation, which then paid the doctors their compensation. The corporation also advertised that it was organized for profit. *Id.* at 445, 200 N.E. at 159.

141. *Id.* at 444, 458, 200 N.E. at 158, 164.

142. *Id.* at 453, 200 N.E. at 162.

143. *Id.* at 453-54, 200 N.E. at 162.

144. *Id.* at 454, 200 N.E. at 163.

145. *Id.*

146. *Id.* at 455, 200 N.E. at 163.

147. *Id.*

practice of a profession requires more than the ability to employ competent persons.<sup>148</sup> A corporation, the court noted, does not have the qualities necessary to practice medicine.<sup>149</sup>

In *Parker v. Board of Dental Examiners*<sup>150</sup> the California Supreme Court also relied on the language of a state licensing statute to disallow corporate practice.<sup>151</sup> The court held that a for-profit dental services corporation was illegally practicing dentistry. "The letter of the statute," the court stated, "authorizes *persons* only to engage in the *practice* of dentistry."<sup>152</sup> Similar to the *United Medical Service* court, the *Parker* court found that the whole system of state licensing laws requires the licensee to possess consciousness, learning, skill, and good moral character. The court noted that none of these characteristics can be attributed to an artificial entity.<sup>153</sup>

Some commentators,<sup>154</sup> in addition to a minority of courts,<sup>155</sup> have pointed to a fundamental problem with basing the corporate practice prohibition on statutes that limit licensing to individuals. One commentator has noted that little sense exists in extrapolating a legislative intent to outlaw corporate practice from statutes that unambiguously apply to individuals.<sup>156</sup> Medical practice acts typically refer only to "persons;" they do not mention corporations. Thus, that commentator argues that the only sound conclusion is

148. *Id.*

149. *Id.* at 455-56, 200 N.E. at 163. The court justified its holding with a partial quotation from a case it had decided one year earlier. That quotation, employed frequently by courts to explain why a corporation could not be licensed to practice a profession, is as follows:

To practice a profession requires something more than the financial ability to hire competent persons to do the actual work. It can be done only by a duly qualified human being, and to qualify something more than mere knowledge or skill is essential. The qualifications include personal characteristics, such as honesty, guided by an upright conscience and a sense of loyalty to clients or patients, even to the extent of sacrificing pecuniary profit, if necessary. These requirements are spoken of generically as that good moral character which is a prerequisite to the licensing of any professional man. No corporation can qualify.

*Dr. Allison, Dentist, Inc. v. Allison*, 360 Ill. 638, 641-42, 196 N.E. 799, 800 (1935).

150. 216 Cal. 285, 14 P.2d 67 (1932).

151. *Id.* at 295, 14 P.2d at 71.

152. *Id.* (emphasis in original).

153. *Id.*

154. See, e.g., Willcox, *supra* note 2, at 437-42; Note, *Right of Corporation to Practice Medicine*, 48 YALE L.J. 346, 348 (1938); Note, *supra* note 138, at 385.

155. See *Bartron v. Codrington County*, 68 S.D. 309, 2 N.W.2d 337 (1942); see also *People v. Woodbury Dermatological Inst.*, 192 N.Y. 454, 85 N.E. 697 (1908).

156. See Willcox, *supra* note 2, at 438.

that no statutory rule exists regarding corporate practice.<sup>157</sup> Few courts, however, actually have interpreted licensing statutes in this manner.<sup>158</sup>

## 2. Public Policy Considerations

Policy considerations, according to commentators and courts, provide the best rationale for a prohibition against corporate practice. Commentators advocating a prohibition generally advance three considerations: (1) lay control over professional judgment; (2) commercial exploitation of the medical practice; and (3) division of the physician's loyalty between patient and employer.<sup>159</sup> According to one court, legislatures drafted medical practice acts to protect the public from "medical quacks and charlatans"<sup>160</sup> and "to insure the quality and competency of the practitioner."<sup>161</sup> The three evils noted above are thought to be prohibited implicitly by the legislative purpose of protecting the public.<sup>162</sup>

One commentator<sup>163</sup> has argued against a broad prohibition on corporate involvement in medicine, noting, "As long as the doctors are properly licensed and their professional activities are not interfered with by unlicensed persons, the purpose of the statutes is

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157. *Id.* at 439.

158. The South Dakota Supreme Court in *Bartron* did conclude that "prevention of corporate practice was not in contemplation by the legislature" when it enacted the medical practice act. *Bartron*, 68 S.D. at 320, 2 N.W.2d at 342. The provisions at issue essentially were the same as those in *People v. United Medical Serv., Inc.*, 362 Ill. 442, 200 N.E. 157 (1936), discussed at *supra* notes 139-49 and accompanying text, and *Parker v. Board of Dental Examiners*, 216 Cal. 285, 14 P.2d 67 (1932), discussed at *supra* notes 150-53 and accompanying text. See *infra* notes 165-69 and accompanying text.

159. See Willcox, *supra* note 2, at 442-43; Note, *Group Health Plans: Some Legal and Economic Aspects*, 53 YALE L.J. 162, 169 (1943). For cases considering the problem of lay control, see *People v. Pacific Health Corp.*, 12 Cal. 2d 156, 82 P.2d 429 (1938), *cert. denied*, 306 U.S. 633 (1939); *Bennett v. Indiana State Bd.*, 211 Ind. 678, 7 N.E.2d 977 (1937); *People v. Carroll*, 274 Mich. 451, 264 N.W. 861 (1936); *State v. Buhl Optical Co.*, 131 Ohio St. 217, 2 N.E.2d 601 (1936). For cases considering the problem of commercial exploitation, see *Silver v. Lansburgh & Bros.*, 111 F.2d 518 (D.C. Cir. 1940); *Funk Jewelry Co. v. State*, 46 Ariz. 348, 50 P.2d 945 (1935); *Parker v. Board of Dental Examiners*, 216 Cal. 285, 14 P.2d 67 (1932); *Winberry v. Hallihan*, 361 Ill. 121, 197 N.E. 552 (1935); *State v. Boren*, 36 Wash. 2d 522, 219 P.2d 566 (1950). For cases considering the problem of divided loyalty, see *State Bd. of Optometry v. Gilmore*, 147 Fla. 776, 3 So. 2d 708 (1941); *Neill v. Gimbel Bros.*, 330 Pa. 213, 199 A. 178 (1938); *State v. National Optical Stores Co.*, 189 Tenn. 433, 225 S.W.2d 263 (1949); *State v. Superior Court*, 17 Wash. 2d 323, 135 P.2d 839 (1943).

160. *Garcia v. Texas State Bd. of Medical Examiners*, 384 F. Supp. 434, 437 (W.D. Tex. 1974), *aff'd*, 421 U.S. 995 (1975).

161. *Id.* at 438.

162. See Note, *supra* note 154, at 347-48.

163. *Id.* at 348.



fully effected, for no one without proper qualifications is then directly or indirectly administering to the public."<sup>164</sup> According to that commentator, lay officers and directors of a medical corporation should be able to supervise administrative facets of the business.

Most courts have been reluctant to distinguish between a physician's professional services and a lay person's administrative duties in a corporation that employs physicians. Instead, courts have held that corporations are illegally practicing medicine based solely on their employment of physicians. In *United Medical Service*<sup>165</sup> the corporation argued unsuccessfully that owning a clinic that employs licensed physicians and collects the fee charged to patients does not constitute the practice of medicine.<sup>166</sup> In *Parker*<sup>167</sup> the corporation attempted to distinguish the professional side of its business from the management side. In that case the corporation argued that a license was not needed to manage the "business side" of a dentistry practice.<sup>168</sup> The *Parker* court disagreed, finding that the law does not divide the practice of dentistry into distinct departments.<sup>169</sup>

A minority of courts, however, have accepted the distinction between the professional and management facets of a medical corporation. In *State Electro-Medical Institute v. State* the Nebraska Supreme Court, interpreting a medical practice statute virtually identical to the Illinois statute discussed in *United Medical Service*, separated the professional aspects from the administrative aspects in a for-profit medical service corporation.<sup>170</sup> The court found that the intent of the statute was to assure that those persons practicing medicine have sufficient personal qualifications. The court, however, noted that "[m]aking contracts is not practicing medicine"<sup>171</sup> and, thus, no restrictions exist if one is not actually diagnosing or treating disease.<sup>172</sup>

In *State ex rel. Sager v. Lewin* the Missouri Court of Appeals construed its state medical practice act as granting corporations

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164. *Id.*

165. 362 Ill. 442, 200 N.E. 157 (1936); see *supra* text accompanying notes 139-49.

166. *United Medical Serv.*, 362 Ill. at 455, 200 N.E. at 163.

167. 216 Cal. 285, 14 P.2d 67 (1932); see *supra* text accompanying notes 150-54.

168. *Parker*, 216 Cal. at 295, 14 P.2d at 71.

169. *Id.* at 296, 14 P.2d at 72.

170. *State Electro-Medical Inst. v. State*, 74 Neb. 40, 103 N.W. 1078 (1905); see *State Electro-Medical Inst. v. Platner*, 74 Neb. 23, 103 N.W. 1079 (1905).

171. *State Electro-Medical Inst.*, 74 Neb. at 43, 103 N.W. at 1079.

172. *Id.* at 43, 103 N.W. at 1079.

the same rights as individuals to contract with physicians to provide medical care.<sup>173</sup> The court found support in private hospitals' ability to incorporate to furnish medical services through licensed physicians. "No one has ever charged," the court stated, "that [hospitals] were practicing medicine."<sup>174</sup> Another case distinguishing the corporate practice of medicine from the employment of physicians by corporations is *Group Health Association v. Moor*.<sup>175</sup> In that case the United States District Court for the District of Columbia did not apply the corporate practice rule to an arrangement in which a health association employed physicians. The court concluded that the physicians were independent contractors rather than agents of the corporation.<sup>176</sup>

Critics of corporate practice also point to the commercial exploitation of the medical profession that results from the corporate employment of physicians. These critics argue that by allowing lay-controlled corporations to provide medical services, lay people not subject to the physicians' ethical code would be free to solicit patients and advertise competitively.<sup>177</sup> In *Bartron v. Codington County*<sup>178</sup> the South Dakota Supreme Court concluded that the practice of a profession by a for-profit corporation tended to commercialize and debase that profession.<sup>179</sup> The court recognized that investors would exert pressure to promote actively the sale of professional services in order to obtain a profitable return on the investment. The court noted that the final result would be too great an emphasis on the financial aspects and profitability of the practice.<sup>180</sup>

One commentator suggests that while restricting commercialism is a valid concern, it does not justify prohibiting all medical corporations. Rather, this commentator argues, the state should employ its regulatory powers over corporations and over medicine to eliminate commercialism in medicine.<sup>181</sup> The commentator also suggests that states might rely on the AMA to police questionable

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173. 128 Mo. App. 149, 106 S.W. 581 (1907).

174. *Id.* at 155, 106 S.W. at 583.

175. 24 F. Supp. 445 (D.D.C. 1938), *aff'd sub nom.* *Jordan v. Group Health Ass'n*, 107 F.2d 239 (D.C. Cir. 1939).

176. *Id.* at 446.

177. *See, e.g.*, *People v. Pacific Health Corp.*, 12 Cal. 2d 156, 159, 82 P.2d 429, 430 (1938); *People v. United Medical Serv., Inc.*, 362 Ill. 442, 455, 200 N.E. 157, 163 (1936).

178. 68 S.D. 309, 2 N.W.2d 337 (1942); *see supra* text accompanying note 158.

179. *Id.* at 329, 2 N.W.2d at 346.

180. *Id.* at 327-28, 2 N.W.2d at 346.

181. *See Note, supra* note 154, at 350.

professional activity.<sup>182</sup>

Finally, critics have alleged that a physician's division of loyalty between patient and employer is cause for prohibiting the employment of physicians by corporations.<sup>183</sup> The fidelity of the physician-patient relationship has long been viewed as crucial to the practice of medicine. The introduction of a third party into that relationship could divert the physician's loyalty from the patient to the third party compensating the physician. Consequently, the physician might be more concerned with the interests of the corporation's investors than with the interests of the physician's patient.<sup>184</sup>

#### IV. RECENT APPLICATIONS OF THE CORPORATE PRACTICE PROHIBITION

Health law practitioners note that in recent years corporate practice prohibitions generally have been ignored;<sup>185</sup> those who might bring corporate practice charges have accepted the inevitable movement toward greater corporate involvement in medicine.<sup>186</sup> Nevertheless, the existence of corporate practice laws in many states threatens innovations in medical practice.<sup>187</sup> According to one health law attorney, corporate practice laws "are 'legal landmines,' remnants of an old and nearly forgotten war, half-buried on a field fast being built up with new forms of health

182. *Id.*

183. See Hansen, *Laws Affecting Group Health Plans*, 35 IOWA L. REV. 209, 213 (1950); Willcox, *supra* note 2, at 442-43.

184. See Hansen, *supra* note 183, at 213.

185. See Punch, *Freestanding Centers' Growth Raises Questions About Corporate Practice Laws*, MODERN HEALTHCARE, May 15, 1984, at 32 (noting that states have not been enforcing the corporate practice prohibition "simply because it became the established custom not to enforce it"); see also Rosoff, *The "Corporate Practice of Medicine" Doctrine: Has its Time Passed?* 12 HEALTH L. DIG. 1, 3-4 (Supp. Dec. 1984).

186. See Rosoff, *supra* note 185, at 3-4; see also Punch, *supra* note 185 at 32 (quoting the executive director of the National Association of Freestanding Emergency Centers, who states that "in the near future, states' medical practice acts will be amended (to permit corporate practice) or repealed because they're not consistent with the changing times").

187. See Rosoff, *supra* note 185, at 4; see also Entin, *Emergicenters: A Health Care System in Evolution*, 5 J. LEGAL MED. 399, 430 (1984) (pointing out that the prohibition against the corporate practice of medicine must be considered when establishing emergicenters); Roble, Knowlton & Rosenberg, *Hospital-Sponsored Preferred Provider Organizations*, 12 L. MED. & SOC'Y 204, 207 (1984) (noting that state corporate practice prohibitions must be considered when establishing preferred provider organizations); Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, 24 STAN. L. REV. 644, 653 (1972) (noting that before enactment of the federal HMO enabling legislation, state corporate practice prohibitions would have restricted the development of HMOs).

care organizations.”<sup>188</sup> Individuals attempting to establish new modes of health care delivery occasionally detonate a corporate practice landmine. Some notable examples have arisen recently in Texas, California, and New York.

#### A. Texas

In *Garcia v. Texas State Board of Medical Examiners*<sup>189</sup> the United States District Court for the Western District of Texas upheld provisions of the Texas Medical Practice Act against a challenge that the Act denied plaintiffs certain constitutional rights.<sup>190</sup> Plaintiffs in *Garcia* wished to incorporate a lay-controlled, non-profit organization that would provide medical services to low-income persons through salaried physicians.<sup>191</sup> The Texas Secretary of State refused to issue a corporate charter because the incorporators were not licensed to practice medicine as required by the state’s medical practice act.<sup>192</sup>

In affirming the Secretary’s denial of a corporate charter, the court relied on earlier state cases<sup>193</sup> that found corporations to be engaged unlawfully in the practice of medicine when the corporation employed physicians to treat patients, but required the patients to pay the medical fees directly to the corporation.<sup>194</sup> The court noted that the medical profession is a “complex, esoteric” discipline, the “administration of which by the ignorant or untrained, historically and inevitably leads to the exploitation of a

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188. Rosoff, *supra* note 185, at 4.

189. 384 F. Supp. 434 (W.D. Tex. 1974).

190. *Id.* Plaintiffs claimed that their right to equal protection under the fourteenth amendment and their right to assemble under the first amendment were violated because Texas law kept plaintiffs from organizing “in corporate form for the purpose of treating or offering to treat the sick” and injured. *Id.* at 436.

191. *Id.*

192. *Id.* The operative statute was TEX. REV. CIV. STAT. ANN. art. 4509a (Vernon 1976), recodified at TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.01(a) (Vernon Supp. 1987), which required that all incorporators of a nonprofit corporation organized for the delivery of health care to the public be persons licensed by the Texas State Board of Medical Examiner. For a discussion of the reliance on medical practice acts to find a corporate prohibition, see *supra* notes 135-58.

193. See *Watt v. Texas State Bd. of Medical Examiners*, 303 S.W.2d 884, 887 (Tex. Civ. App. 1957) (holding that state statute prohibiting a doctor from permitting another to use the doctor’s license to practice medicine was violated when a physician performed medical services for salary and fees for his services were paid to a clinic not owned by physicians), *cert. denied*, 356 U.S. 912; *Rockett v. Texas State Bd. of Medical Examiners*, 287 S.W.2d 190, 191 (Tex. Civ. App. 1956) (same).

194. See *Garcia*, 384 F. Supp. at 437.

naive public."<sup>195</sup> The court held that the state medical practice act was rationally related to the state's legitimate interest in preserving "the vitally important doctor-patient relationship, and preventing possible abuses resulting from lay person control of a corporation employing licensed physicians on a salaried basis."<sup>196</sup> The possible abuses indicated by the court included interference with the doctor-patient relationship, emphasis on budget considerations rather than patient care, and lay supervision over medical procedures.<sup>197</sup>

### B. California

California recently reaffirmed its prohibition on the corporate practice of medicine. In 1980 the California Attorney General noted that California courts repeatedly have held that a commercial entity that engages physicians to provide medical services to parties contracting with the entity is practicing medicine without a license.<sup>198</sup> The Attorney General gave two reasons for preventing commercial entities from practicing medicine through physicians: (1) the limitation of licensing to individuals; and (2) the interference with the physician-patient relationship by the corporation.<sup>199</sup>

In 1982 the California Attorney General's office was asked to render an opinion on the legality of a general business corporation that contracts with another entity to provide physicians to treat employees of that entity.<sup>200</sup> These general business corporations, known as industrial medical corporations, are lay-controlled entities that contract with physicians to do pre-employment examinations and to treat employment-related injuries sustained by employees of government agencies and large corporations.<sup>201</sup> The physicians are not employees of the medical corporation; they are independent contractors paid on a fixed-fee basis.<sup>202</sup>

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195. *Id.* at 438.

196. *Id.* at 439.

197. *Id.* at 440.

198. 63 Op. Cal. Att'y Gen. 723 (1980) (LEXIS, States library, CAAG file). The California Attorney General included as support the following cases: *People v. Pacific Health Corp.*, 12 Cal. 2d 156, 82 P.2d 429 (1938), *cert. denied*, 306 U.S. 633 (1939); *Parker v. Board of Dental Examiners*, 216 Cal. 285, 14 P.2d 67 (1932); and *Pacific Employers Ins. Co. v. Carpenter*, 10 Cal. App. 2d 592, 52 P.2d 992 (1935).

199. 63 Op. Cal. Att'y Gen. 723.

200. *See* 65 Op. Cal. Att'y Gen. 223 (1982) (LEXIS, States library, CAAG file).

201. *Id.*

202. *Id.*

The Attorney General ruled the arrangement unlawful.<sup>203</sup> He relied on the early corporate practice cases<sup>204</sup> and reiterated their rationale to find a corporation's presence "incongruous in the workings of a professional regulatory licensing scheme which is based on personal qualification, responsibility and sanction."<sup>205</sup> Furthermore, the Attorney General voiced concerns over the damage to the doctor-patient relationship caused by corporate involvement, noting that the presence of a corporation "would give rise to divided loyalties on the part of the professional and would destroy the professional relationship into which it was cast."<sup>206</sup> The Attorney General reached this conclusion despite the independent contractor status of the physicians.<sup>207</sup>

Commentators have argued that the corporate practice prohibition should not apply to a physician's independent contractor arrangement with a corporation because in this arrangement the corporation cannot exercise control over the physician's relationship with a patient.<sup>208</sup> Most hospitals, as a matter of course, engage physicians as independent contractors. California, however, still relies on a pair of fifty-year-old cases<sup>209</sup> holding that the evils of corporate involvement are present whether physicians are employees or independent contractors of a corporation that provides medical care to the general public.<sup>210</sup>

As recently as 1983 a California Court of Appeals faced the corporate practice doctrine in a context analogous to medical practice. In *California Association of Dispensing Opticians v. Pearle Vision Center, Inc.*<sup>211</sup> the court affirmed a trial court's decision to issue a preliminary injunction to prevent Pearle from operating re-

203. *Id.*

204. The California Attorney General cited *People v. Pacific Health Corp.*, 12 Cal. 2d 156, 82 P.2d 429 (1938), *cert. denied*, 306 U.S. 633 (1939), and *Pacific Employers Ins. Co. v. Carpenter*, 10 Cal. App. 2d 592, 52 P.2d 992 (1935).

205. 65 Op. Cal. Att'y Gen. 223 (1982) (LEXIS, States library, CAAG file).

206. *Id.*

207. *Id.* at n.4.

208. See Note, *supra* note 159, at 167; Note, *Corporations—Hospitals Illegally Engaged in the Corporate Practice of Medicine*, 25 *FORDHAM L. REV.* 143, 144-45 (1956); see also *Group Health Ass'n v. Moor*, 24 F. Supp. 445, 446 (D.D.C. 1938) (holding that "[i]t is true that a corporation can act only through its agents and employees, but the physicians with whom the plaintiff makes contracts are rather in the position of independent contractors, and the plaintiff does not in any way undertake to control the manner in which they attend or prescribe for their patients").

209. See *supra* notes 201 & 208.

210. See 65 Op. Cal. Att'y Gen. 223 n.4 (1982) (LEXIS, States library, CAAG file).

211. 143 Cal. App. 3d 419, 191 Cal. Rptr. 762 (1983).

tail ophthalmic dispensing outlets.<sup>212</sup> The court noted the state's historic policy against lay interference with the treatment decisions of healing arts practitioners.<sup>213</sup> The court examined Pearle's franchise agreement and found that the corporation exercised extensive control over the franchisee's/optometrist's practice—both its treatment decisions and its financial operations.<sup>214</sup> This evidence of control established to the court's satisfaction that Pearle intended to practice the profession of optometry.<sup>215</sup> In upholding the lower court's injunction, the appeals court pointed to the destructive effect of corporate practice on the fidelity of the doctor-patient relationship and noted the potential for commercial exploitation.<sup>216</sup>

### C. New York

New York's Attorney General recently obtained a consent decree against Nutri/System, Inc. based in part on the corporate practice prohibition.<sup>217</sup> Nutri/System, an operator of franchised weight control centers, had been employing physicians on a salaried basis to conduct physical examinations and other medical services for enrollees.<sup>218</sup> Furthermore, before the consent decree, the corporation decided which medical services would be provided to consumers and directed physicians to perform the services.<sup>219</sup>

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212. *Id.* at 434-35, 191 Cal. Rptr. at 773.

213. *Id.* at 427, 191 Cal. Rptr. at 768 (citing *Parker v. Board of Dental Examiners*, 216 Cal. 285, 14 P.2d 67 (1932)).

214. *Pearle Vision Center*, 143 Cal. App. 3d at 427, 191 Cal. Rptr. at 768. Pearle required that only Pearle frames and lenses be stocked, that optical goods meet the company's specifications, and that the optometrist's choice of laboratory be approved by Pearle. The franchisor also exercised financial control over the optometrist. Franchisees were required to pay a substantial percentage of gross income as a franchise fee and advertising contribution. Franchisees also had to employ Pearle's "system" in operating the practice and were subject to periodic audits by the company. *Id.*

215. *Id.* at 434, 191 Cal. Rptr. at 773.

216. *Id.*

217. See *Trustees Report: Part II*, *supra* note 137, at 1318. Details of the consent decree are not available.

218. *Id.*

219. *Id.*

## V. DEMISE OF THE CORPORATE PRACTICE PROHIBITION

A. *Abolition of Ethical Restraints: American Medical Association v. Federal Trade Commission*

Despite the above instances of the doctrine's enforcement, more telling events indicate a bleak future for the corporate practice prohibition. The doctrine suffered a significant blow when the Federal Trade Commission (FTC) ordered<sup>220</sup> the AMA to modify its ethical restrictions on physicians' contractual arrangements to bring them in line with federal antitrust laws.

In 1975, the year the FTC initiated its action, the AMA was operating under the 1957 version of its *Principles of Medical Ethics*.<sup>221</sup> The ethical provision at issue, Section 6, stated that a physician should not provide services under conditions that might prevent the physician from exercising medical judgment with complete freedom or that might deteriorate the quality of medical care.<sup>222</sup> On its face, the language contained in the ethical provision posed little threat to physicians' freedom to contract. The authoritative interpretation of the Section, however, which was formulated by the AMA's Judicial Council<sup>223</sup> and articulated in the 1971 edition of the Council's *Opinions and Reports*,<sup>224</sup> contained language virtually identical to the 1933 and 1934 provisions restricting contract-style practices.<sup>225</sup> Much like the 1933 provision,<sup>226</sup> Opinion 3 of Section 6 listed the types of contractual arrangements deemed unethical by the Judicial Council.<sup>227</sup> These included ar-

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220. [1979-1983 Transfer Binder] Trade Reg. Rep. (CCH) ¶ 21,955 (1982).

221. See *In re American Medical Ass'n*, 94 F.T.C. 701, 801 (1979). The complete 1957 version of the *Principles of Medical Ethics* is set forth in *American Medical Ass'n v. Federal Trade Comm'n*, 638 F.2d 443, 446 n.1 (2d Cir. 1980), *aff'd*, 455 U.S. 476 (1982). In its decision the FTC explains that "[p]romulgation and enforcement of this ethical code has been a significant function of the AMA since its inception." *In re American Medical Ass'n*, 94 F.T.C. at 801.

222. See *In re American Medical Ass'n*, 94 F.T.C. at 896.

223. See *supra* note 100.

224. The Judicial Council's ethical interpretations are published periodically in *Opinions and Reports*. The AMA distributes the publication to medical societies, physicians and medical students. See *In re American Medical Ass'n*, 94 F.T.C. at 802.

225. See *In re American Medical Ass'n*, 94 F.T.C. at 1011-18; see also *supra* notes 109-13 and accompanying text.

226. See *supra* note 111.

227. See *In re American Medical Ass'n*, 94 F.T.C. at 896. The list of unacceptable contract conditions reads as follows:

- (a) When the compensation received is inadequate based on the usual fees paid for the same kind of service and class of people in the same community.
- (b) When the compensation is so low as to make it impossible for competent service to be rendered.



rangements that permitted solicitation of patients and underbidding to secure contracts.<sup>228</sup> Contracts that unreasonably denied free choice of physicians<sup>229</sup> or provided for inadequate compensation<sup>230</sup> also were unacceptable to the AMA.

Likewise, Opinion 5 of Section 6 is similar to the 1934 provision.<sup>231</sup> Opinion 5 states that "a physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee."<sup>232</sup> Opinion 4 of Section 6 acknowledged that an increasing number of physicians were taking positions that permitted lay entities to profit from the physicians' services. These arrangements, the Judicial Council noted, "are in direct and unethical competition with the profession at large."<sup>233</sup> Finally, Opinion 8 declared unethical the accepting of a salaried hospital position to provide medical care in emergency room settings.<sup>234</sup>

The FTC found that the above restrictions on the contractual arrangements of physicians had three anticompetitive effects.<sup>235</sup> First, the provisions sought to limit price competition among doctors by fixing the adequacy of compensation and by prohibiting competitive bidding.<sup>236</sup> Second, the provisions inhibited competition by limiting hospitals, prepaid health plans, and lay entities to the traditional fee-for-service method of compensation and by proscribing their use of salaries and other more cost-efficient payment methods.<sup>237</sup> Last, the provisions restricted arrangements between

(c) When there is underbidding by physicians in order to secure the contract.

(d) When a reasonable degree of free choice of physicians is denied those cared for in a community where other competent physicians are readily available.

(e) When there is solicitation of patients directly or indirectly.

*Id.* (quoting Judicial Council of the AMA, *Opinions and Reports* (1971)).

228. *See supra* note 227 (clauses (c) & (e)); *supra* note 125 and accompanying text.

229. *See supra* note 227 (clause (d)); *see also supra* note 127 and accompanying text.

230. *See supra* note 227 (clauses (a) & (b)); *see also supra* note 111.

231. *See supra* note 113.

232. *In re American Medical Ass'n*, 94 F.T.C. at 896-97.

233. *Id.* at 897.

234. *Id.* For examples of instances in which the AMA utilized its ethical restrictions on contract practice, *see id.* at 899-907.

235. *Id.* at 1011-12.

236. *Id.* at 1014.

237. *Id.* at 1016. The FTC found that the AMA's purpose of permitting only fee-for-service compensation was "to retain for the physician the full profit generated by his or her services and to preclude competition by group health plans, hospitals and other organizations not directly under the control of physicians." *Id.*

physicians and nonphysicians and, therefore, prevented the creation of more economical business structures.<sup>238</sup>

Based on these findings, the FTC concluded that Section 6 of the AMA's *Principles of Medical Ethics* and the corresponding interpretations constituted an unreasonable restraint of trade.<sup>239</sup> In 1979 the FTC issued its Final Order requiring the AMA to eliminate these ethical restrictions.<sup>240</sup> The Order was appealed to the United States Court of Appeals for the Second Circuit, which approved the Order's enforcement after only minor modifications.<sup>241</sup> A divided Supreme Court affirmed the Second Circuit's decision in 1982.<sup>242</sup> The Order took effect that same year.<sup>243</sup> The Order requires the AMA to cease and desist from (1) promulgating any ethical restraints concerning the payment method employed by physicians in contracting with any entity that offers the physician's services to the public, and (2) inhibiting the development of any entity that offers physicians' services to the public by commenting on the ethical propriety of nonphysician ownership or management of that entity.<sup>244</sup> In addition, the FTC Order required the AMA to

238. *Id.* at 1017-18. The AMA argued that restrictions on physician-nonphysician collaboration were meant to prevent situations in which nonphysicians might advocate medically unsound treatment and to prevent consumers from believing that nonphysician partners have medical skills and training. *Id.* at 1017. The Commission, however, found that "[i]t is difficult to see how such sweeping ethical proscriptions are needed to prevent deception or to prevent non-physicians from having undue influence over medical procedures." *Id.* at 1018.

239. *Id.* at 1014-18.

240. *Id.* at 1036-40.

241. See *American Medical Ass'n v. Federal Trade Comm'n*, 638 F.2d 443, 453 (2d Cir. 1980). For details of these modifications, see *id.* at 452-53.

242. *American Medical Ass'n v. Federal Trade Comm'n*, 455 U.S. 676 (1982). The Supreme Court affirmed the appeals court decision per curiam by a divided vote.

243. See *supra* note 220 and accompanying text.

244. See [1979-1983 Transfer Binder] Trade Reg. Rep. (CCH) ¶ 21,955 at 22,418-19. The section of the FTC Order relevant to contract practice is stated in full as follows:

It is further Ordered that respondent American Medical Association, . . . do forthwith cease and desist from:

A. Restricting, regulating, impeding, advising on the ethical propriety of, or interfering with the consideration offered or provided to any physician in any contract with any entity that offers physicians' services to the public, in return for the sale, purchase or distribution of his or her professional services, except for professional peer review of fee practices of physicians;

B. Restricting, interfering with, or impeding the growth, development or operations of any entity that offers physicians' services to the public, by means of any statement or other representation concerning the ethical propriety of medical service arrangements that limit the patient's choice of a physician;

C. Restricting, interfering with, or impeding the growth, development or operations of any entity that offers physicians' services to the public, by means of any statement or other representation concerning the ethical propriety of participation by non-

remove all provisions inconsistent with the above requirements from the AMA's constitution and bylaws, its *Principles of Medical Ethics*, and the Judicial Council's *Opinions and Reports*.<sup>245</sup>

Although antitrust violations, not the corporate practice doctrine, provided the impetus behind the FTC action against the AMA, the Commission's Order does have important implications for the doctrine. As described earlier, the rule against corporate practice emerged from the AMA's early efforts to protect the medical profession's autonomy and prestige.<sup>246</sup> The AMA's adoption of restrictions on corporate practice into its ethical code<sup>247</sup> helped establish the prohibition against contract-style schemes as accepted doctrine. Thus, the recent abolition of these ethical restrictions greatly weakens the foundation upon which the corporate practice of medicine doctrine was built.

### B. Impact of Modern Health Care Delivery Systems

Changes in the health care industry also have contributed to the demise of the corporate practice of medicine doctrine. The industry has evolved in recent years in an environment of price sen-

physicians in the ownership or management of said organization; and

D. Inducing, urging, encouraging, or assisting any physician, or any medical association, group of physicians, hospital, insurance carrier or any other non-governmental organization to take any of the actions prohibited by this Part.

*Id.*

245. See *id.* at 22,419. Part IV of the Order sets out some of the measures required of the AMA with regard to informing its membership of the abolished ethical restraints:

It is Further Ordered that respondent American Medical Association:

...

B. For a period of ten years, provide each new member of respondent and each constituent and component organization of respondent with a copy of this Order at the time the member is accepted into membership.

C. Within ninety (90) days after this Order becomes final, remove from respondent American Medical Association's *Principles of Medical Ethics* and the Judicial Council's *Opinions and Reports*, and from the constitution and bylaws and any other existing policy statement or guideline of respondent, any provision, interpretation or policy statement which is inconsistent with the provisions of Parts I and II of this Order and, within one hundred and twenty (120) days after this Order becomes final, publish in the *Journal of the American Medical Association* and in *American Medical News* the revised versions of such documents, statements, or guidelines.

*Id.*

The AMA adopted a new version of the *Principles of Medical Ethics* in 1980 after the FTC handed down the original Final Order in October 1979. This version excluded all references to economic restraints on physicians. See *supra* note 240 and accompanying text. For a full version of the 1980 *Principles*, see *American Medical Ass'n v. Federal Trade Comm'n*, 638 F.2d 443, 456 n.4 (2d Cir. 1980).

246. See *supra* notes 14-84 and accompanying text.

247. See *supra* notes 85-134 and accompanying text.

sitivity and growing competition.<sup>248</sup> One product of this evolution is the expanded provision of medical services by corporate entities.<sup>249</sup> In their efforts to provide medical services in a cost-conscious environment, corporations have introduced alternative systems of health care delivery that are inconsistent with the traditional notions of professional autonomy and that contravene the underpinnings of the corporate practice doctrine.<sup>250</sup> Two of the alternative delivery systems, health maintenance organizations (HMOs) and freestanding emergency clinics (FECs), are described below and analyzed for their impact on the corporate practice prohibition.

## 1. Health Maintenance Organizations

### a. Structure and Function

Health maintenance organizations provide comprehensive health benefits to subscribers in exchange for fixed periodic payments.<sup>251</sup> HMOs contract with a variety of health care professionals for the provision of services to subscribers. These professionals are not paid based on services performed, but at a set annual rate per HMO subscriber.<sup>252</sup>

Proponents of HMOs argue that HMOs offer a sensible alternative to the traditional fee-for-service system of payment.<sup>253</sup> Be-

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248. See Gray, *An Introduction to the New Health Care for Profit*, in *THE NEW HEALTH CARE FOR PROFIT* 1, 3-5 (B. Gray ed. 1983).

249. See Relman, *supra* note 1, at 963; P. STARR, *supra* note 13, at 428-40.

250. Bradford Gray notes that for-profit corporations are not alone in responding to a competitive health care market. Not-for-profit institutions have been "forming chains, establishing for-profit subsidiaries, selling services to other hospitals for profit, and taking on other attributes of the for-profit enterprises." Gray, *supra* note 248, at 3.

251. See J. KRESS & J. SINGER, *HMO HANDBOOK* 13 (1975); Rosoff, *The Federal HMO Assistance Act: Helping Hand or Hurdle?*, 13 *AM. BUS. L.J.* 137, 138-39 (1975); Stern, *Health Care Expansion: Provisions of the Health Maintenance Organization Act of 1973*, 8 *CLEARINGHOUSE REV.* 89, 89 (1974).

252. See J. KRESS & J. SINGER, *supra* note 251, at 15; Stern, *supra* note 251, at 89; Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 *HARV. L. REV.* 887, 890 (1977). For a sample contract between an HMO and the medical provider, see J. KRESS & J. SINGER, *supra* note 251, at 63-68.

253. See, e.g., Kissam & Johnson, *Health Maintenance Organizations and Federal Law: Toward a Theory of Limited Reformmorgering*, 29 *VAND. L. REV.* 1163, 1164 (1976); Note, *supra* note 252, at 890. For a description of the fee-for-service method as utilized traditionally by insurers, see Kissam & Johnson, *supra*, at 1164 n.4. See also Stern, *supra* note 251, at 89 (arguing that "[t]he development of HMO's as an alternative source of health care would, at its best, help to control costs, improve the accessibility, availability, and quality of care, and add a much-needed element of competition and pluralism to the health care system").

cause of their prepayment structure, HMOs operate on a fixed budget; thus, they have a strong incentive to minimize costs.<sup>254</sup> HMOs received broad federal support in the early 1970s because their inherent efficiencies were thought to answer the problem of rapidly increasing health care costs.<sup>255</sup> Furthermore, the HMOs' cost-control incentive, in theory at least, translates into better health for HMO members.<sup>256</sup> Under the fee-for-service system a physician's fees are greater when the patient is sicker and, consequently, requires more intense treatment.<sup>257</sup> In contrast, HMOs find it more profitable to keep members healthy by treating them during the early stages of illness when treatment is less expensive.<sup>258</sup> For their part, patients will want to seek early treatment because, unlike the fee-for-service payment situation, they will incur no out-of-pocket expense for the visit.<sup>259</sup> In addition to having the *incentive* to control costs, HMOs also have the *power* to control costs. Unlike fee-for-service insurers, HMOs contract directly with providers and oversee the day-to-day administration of services.<sup>260</sup>

### b. Analysis

The HMO structure incorporates many of the characteristics that the corporate practice doctrine was designed to eradicate.<sup>261</sup> HMOs have the potential to impose lay control over a physician's treatment decisions. For example, because of its fixed-budget structure, HMO management has an incentive to pressure physicians not to order expensive tests for patients that management deems to be of marginal diagnostic value. Furthermore, the HMOs' legislated privilege to solicit patients undermines the commercialism justification of the corporate practice rule. By permitting solicitation, Congress apparently did not share the concerns of the

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254. See Kissam & Johnson, *supra* note 253 at 1164; Stern, *supra* note 251, at 89.

255. See Kissam & Johnson, *supra* note 253, at 1165 n.10. See generally Note, *supra* note 252.

256. See Rosoff, *supra* note 251, at 139; see also Stern, *supra* note 251, at 89 (stating that "[b]ecause the HMO has a predetermined enrolled population and centralized medical facilities and records, it also provides the opportunity for more effective monitoring and review of the quality of care provided").

257. See Rosoff, *supra* note 251, at 139.

258. *Id.*

259. *Id.*

260. See Kissam & Johnson, *supra* note 253, at 1164 n.4.

261. See *supra* note 159 and accompanying text.

AMA establishment<sup>262</sup> and earlier courts,<sup>263</sup> which feared that free-market activities would debase the profession. Finally, inherent in the HMO structure is the risk that a physician's loyalty will be divided between employer and patient, a risk no less evident in the HMO structure than in the corporate structures held illegal under the corporate practice doctrine decades earlier.

Prior to the HMO enabling legislation passed by Congress in 1973,<sup>264</sup> HMO advocates pointed to the corporate practice rule as one of the primary legal barriers hindering HMO development.<sup>265</sup> One of the early federal HMO enabling proposals would have explicitly preempted state corporate practice rules for nonprofit HMOs.<sup>266</sup> Contrary to this earlier proposal, however, the final HMO legislation did not explicitly preempt state corporate practice prohibitions.<sup>267</sup> The legislation did supersede state laws and practices which required that a medical society approve the furnishing of services of HMOs, that physicians constitute all or part of an HMO's governing body, that all or part of the area physicians

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262. See *supra* notes 118-21 and accompanying text.

263. See *supra* notes 177-80 and accompanying text.

264. 42 U.S.C. § 300e (1982).

265. See Hansen, *supra* note 183, at 211-13; Holley & Carlson, *supra* note 187, at 657-58; Note, *supra* note 252, at 960-62.

266. See Note, *supra* note 252, at 962 n.52. The proposed legislation would have eliminated the corporate practice prohibition for nonprofit organizations on the condition that a reviewing board find the arrangements not to cause lay interference with physicians' professional acts. *Id.*

267. 42 U.S.C. § 300e-10(a) (1982). The relevant part of the HMO statute states as follows:

In the case of any entity—

(1) which cannot do business as a health maintenance organization in a state in which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise—

(A) requires as a condition to doing business in that state that a medical society approve the furnishing of services by the entity,

(B) requires that physicians constitute all or a percentage of its governing body,

(C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity, or

(D) requires that the entity meet requirements for insurers of health care services doing business in that state respecting initial capitalization and establishment of financial reserves against insolvency, and

(2) for which a grant, contract, loan, or loan guarantee was made under this subchapter or which is a qualified health maintenance organization for purposes of section 300e-9 of this title (relating to employees' health benefits plans), such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 300e of this title.

*Id.*

participate as providers for the HMO, or that the HMO refrain from soliciting members through advertising services.<sup>268</sup>

The argument could be made that by not expressly preempting state corporate practice prohibitions, Congress intended to allow these prohibitions to stand. Given the obvious barrier that these prohibitions pose to HMO development, however, it is unlikely that Congress, if committed to the HMO alternative, intended to allow the prohibitions to stand. Congress probably concluded that the other preemption provisions were sufficient to preempt corporate practice prohibitions. According to one commentator, the HMO legislation implicitly preempts the common-law prohibition.<sup>269</sup> Thus, any application of the prohibition would conflict with the legislation so directly that preemption would appear certain.<sup>270</sup>

The 1973 HMO legislation and the subsequent proliferation and acceptance of HMOs evidence the modern disutility of the corporate practice prohibition. The legislation itself is a sweeping federal health care policy statement in favor of a corporate-based, competitive health market. The legislation eschews a medical economy dominated by independent, fee-for-service practitioners.

## 2. Freestanding Emergency Clinics

### a. *Structure and Function*

Freestanding emergency clinics, also known as primary care centers or emergicenters,<sup>271</sup> have become increasingly popular in recent years as a health care delivery alternative.<sup>272</sup> According to one account, these clinics have grown from 180 centers in 1981 to

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268. *Id.* While all of the provisions reproduced *supra* in note 267 were carried over from the Conference Committee Report into the text of the legislation, express language in the Report preempting state laws that "bar incorporated individuals or associations from providing health care services" was excluded from the HMO legislation. SEN. J. CONF. REP. No. 621, 93d Cong., 1st Sess. 55, reprinted in 1973 U.S. CODE CONG. & ADMIN. NEWS 3121, 3149-50.

269. See Kissam & Johnson, *supra* note 253, at 1218.

270. *Id.* at 1218 n.364.

271. Many FECs have stopped characterizing themselves as "emergency" centers. Instead they are calling the centers ambulatory care centers or ACCs. Even the National Association of Freestanding Emergency Centers (NAFEC) changed its name to the National Association for Ambulatory Care (NAFAC). The change was made because centers with the word "emergency" in their name often are subject to state regulation. See Riffer, *Freestanding Emergency and Surgery Centers Proliferate*, HOSPITALS, Dec. 16, 1984, at 50.

272. See Zaremski & Fohrman, *The Emergicenter: Has Its Time Arrived?*, 11 L., MED. & HEALTH CARE 4 (1983); see also Powells, *Size of FEC Market a Matter of Opinion*, HOSPITALS, May 16, 1985, at 44; Riffer, *supra* note 271, at 50.

2500 in early 1986.<sup>273</sup> Another study foresees continued growth in the number of FECs for the near future.<sup>274</sup>

Although FECs are organized according to various models, they share certain similarities. Designed to cater to the demands of the public, emergicenters offer longer hours than doctors' offices, do not require appointments, usually have short waits for service, and charge less than hospital emergency rooms.<sup>275</sup> Typically, FECs are owned by either physicians, hospitals, or investor-owned corporations.<sup>276</sup> According to an AMA report, physician-owned FECs fall into one of three organizational models.<sup>277</sup> First, a solo practitioner, a physician partnership, or a physician-organized professional corporation may form a private practice model.<sup>278</sup> Physician control in these FECs is complete. Second, a FEC formed by physicians may contract with a management services company to provide specific administrative services according to the needs of the practice.<sup>279</sup> Although the physician-owners operating under this model

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273. See Wessel, *supra* note 8, at 1, col. 1. Obtaining an accurate census of FECs is difficult because different polling groups define FECs differently. For instance, the American Hospital Association states that there exists no more than 25 true FECs—those that are open 24 hours a day, 7 days a week. See Powills, *supra* note 272, at 43.

274. See *Satellite and Commercial Medical Clinics, Report of the Board of Trustees: Part I*, 253 J.A.M.A. 645, 646 (1985) [hereinafter *Trustees Report: Part I*]. The 1983 study conducted by Orkand Corporation

projects continued dynamic growth (at declining percentage levels) in the number of freestanding centers throughout 1983, 1984, and much of 1985, with net increases leveling off at about 400 units per year beginning 1986 and continuing through 1990. On these assumptions, it estimates 1,100 centers in operation by the end of 1983, 2,900 by 1986, and 4,500 by 1990.

*Id.*

One reason for the growth of FECs is the enormous number of potential FEC patients. One estimate indicates that 60% to 85% of all patients admitted to hospital emergency rooms could be treated at emergicenters. See Entin, *supra* note 187, at 401.

275. See Entin, *supra* note 187, at 400. For a comparison of FECs to traditional health care delivery systems, see Zaremski & Fohrman, *supra* note 272, at 5-6.

276. See *Trustees Report: Part I*, *supra* note 274, at 648. The 1983 Orkand study reported that of centers responding, 73% were owned by physicians, 7% by hospitals and the remainder by nonhospital, nonphysician corporations. *Id.* According to the Trustees Report, however, ownership of FECs by publicly-held corporations is rare. *Id.* at 647. The AMA anticipates that this type of FEC will become more prevalent as business corporations, venture capitalists, and investment bankers enter the health care industry. *Id.* at 647-48. Corporate chains appear to be taking a great interest in ownership of freestanding surgical centers. As of July 1984, 57.9% of the surgical centers under construction were corporate owned. See Riffer, *supra* note 271, at 50.

277. See *Trustees Report: Part I*, *supra* note 274, at 646-47.

278. *Id.*

279. *Id.* at 646. The management services package may include site selection studies, building and equipment design, an operational plan, a staff-training system, a computerized accounting system, and an advertising program. *Id.*



purchase certain services, they still maintain ultimate control over all aspects of the practice.<sup>280</sup> Last, physicians may purchase an FEC franchise.<sup>281</sup> Under this arrangement, physicians are obligated to follow the franchisor's operations format in return for use of the franchise name. These arrangements usually require payment of a franchise fee, based on gross revenues, for a management program and advertising services.<sup>282</sup> Franchisors typically retain control over site selection, design specifications, range of services offered, and composition of center staff.<sup>283</sup> The AMA report also notes that, much like FEC franchises, some physician-owned FECs may open standardized branch offices. The physician-owners then employ other physicians on a full-time basis to staff the branches.<sup>284</sup>

Hospitals also are establishing FECs as satellites to their own operations.<sup>285</sup> Some of these centers are directly financed and managed by the hospital. Others are organized around contractual arrangements that transfer management functions to physicians, but retain actual ownership of the center in the hospital.<sup>286</sup>

Many corporate-owned FECs contract with independent contractor physicians or professional corporations to provide the FEC's medical services.<sup>287</sup> The investor-owned corporation typically maintains control over management decisions and administrative functions, but grants control over medical issues to the physicians.<sup>288</sup> In one corporate FEC chain a professional corporation leases the center from the chain and executes a "management services agreement" with the chain.<sup>289</sup> Pursuant to the agreement, the professional corporation is responsible for staffing the center and overseeing the quality of health care delivered.<sup>290</sup> The corporate owner trains support staff and appoints a full-time manager to

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280. *Id.*

281. *Id.* at 646-47.

282. *Id.*

283. *Id.* at 647.

284. *Id.*

285. *Id.* at 647-48.

286. *Id.* at 648.

287. *Id.* at 647.

288. *See id.* *But see* Punch, *supra* note 185, at 34. A spokesman for Humana Inc., owner of the MedFirst FEC chain, stated, "All medical decisions are the doctors' and all business decisions, such as staffing, are made in conjunction with the doctors." Punch, *supra* note 185, at 34.

289. *See Trustees Report: Part I, supra* note 274, at 647. The FEC chain presented is MedFirst, which is owned by Humana Inc., a publicly-held corporation.

290. *Id.* The corporation also indicates that physicians retain discretion over acceptability of support staff, determine which hospitals should be utilized by patients, and establish their professional fees. *Id.*

oversee the center's administration.<sup>291</sup> The corporate-owner controls site selection, advertising, finances, purchases of supplies and equipment, and the FEC's hours of operation.<sup>292</sup>

Under the financial structure of a corporate-owned FEC, the professional corporation pays a percentage of the gross revenues to the parent firm as a fee for advertising, management services, and leasing of the facility.<sup>293</sup> Principals of the professional corporation are compensated as shareholders.<sup>294</sup> Physicians employed by the professional corporation are paid a salary and, in addition, may receive a benefit package or a percentage of their own fee-for-service billings.<sup>295</sup> Physicians working part-time at the FEC are paid by the hour.<sup>296</sup>

### b. Analysis

The commercial nature of FECs<sup>297</sup> raises stark conflicts with the corporate practice of medicine doctrine. Corporate-owned FECs pose the most obvious problem. These FECs defy all public policy bases for the corporate practice prohibition.<sup>298</sup> First, a great deal of lay influence is present in the operation of a FEC practice. Corporate owners of FECs argue that they exercise no control over physicians' medical decisions.<sup>299</sup> Nevertheless, the required management services agreement, which guarantees the full-time presence of a corporation-appointed manager and provides for almost every aspect of the FEC's administration,<sup>300</sup> imposes on the physician the kind of lay control that the corporate practice doctrine would prevent.<sup>301</sup> Second, although the doctrine was designed to

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291. *Id.*

292. *Id.* Note that the Humana spokesman presents a division of responsibility between physicians and corporate owners much different from that presented in the Trustees Report. See *supra* note 288.

293. See *Trustees Report: Part I, supra* note 274, at 647.

294. *Id.*

295. *Id.*

296. *Id.*

297. One commentator has characterized FECs as first aid stations designed around a business ethic rather than a medical ethic. See Robbins, *Ethical Questions Surrounding "Neighborhood Emergency Centers": Balancing Access with Quality*, 8 J. EMERGENCY NURSING 264 (1982).

298. See *supra* note 159 and accompanying text.

299. See *Trustees Report: Part I, supra* note 274, at 647 (stating that the operating agreements negotiated between corporations and FEC medical staff "seek to achieve a division of authority along business management/medical management lines"); see also *supra* note 288 and accompanying text.

300. See *supra* notes 289-92 and accompanying text.

301. See *supra* notes 163-69 and accompanying text.

eliminate commercialism in medicine, FECs typically are run for profit.<sup>302</sup> Third, corporate ownership raises the issue of divided physician loyalty<sup>303</sup> because the physician has a duty to the patient to provide necessary care, but also is obligated to the parent corporation to create revenue. Some individuals argue that because corporate-owned FECs contract with group practices or professional corporations rather than employ physicians directly, FECs avoid corporate practice prohibition laws.<sup>304</sup> This logic, while it may skirt corporate practice prohibitions in some jurisdictions,<sup>305</sup> fails to appreciate that lay investors realize profits from the professional efforts of physicians. Thus, FECs create a situation that the corporate practice prohibition traditionally was designed to prevent.

Hospital-owned and physician-owned FECs also create situations that conflict with the various bases of the corporate practice doctrine. In the pursuit of profit, hospitals, themselves corporate entities, may exercise an excessive amount of control over FEC physicians and, thus, be deemed to be practicing medicine. Physician-owners, while maintaining greater autonomy over their FEC practices than corporate-owned FECs, become subject to their own conflicting interests. The AMA Board of Trustees has stated that "[t]he commercial motivations of for-profit enterprise conflict with professionalism to the extent that they result in the subordination of a physician's fiduciary obligations to patients to his own financial self-interests."<sup>306</sup>

Health law practitioners recognize the conflict between FECs and the corporate practice doctrine.<sup>307</sup> These practitioners acknowledge that in many jurisdictions corporate practice prohibitions have gone unenforced for many years,<sup>308</sup> yet disagree over

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302. See Entin, *supra* note 187, at 401; Zaremski & Fohrman, *supra* note 272, at 5. See generally *Trustees Report: Part I*, *supra* note 274, at 645-46; *Trustees Report: Part II*, *supra* note 137, at 1314-15.

303. See *Trustees Report: Part II*, *supra* note 137, at 1314; Veatch, *Ethical Dilemmas of For-Profit Enterprises in Health Care*, in *THE NEW HEALTH CARE FOR PROFIT* 125, 131 (B. Gray ed. 1983).

304. See Punch, *supra* note 185, at 34. The AMA's associate general counsel stated, "You can circumscribe [corporate practice laws] very easily by setting up a for-profit corporation which contracts with group practices of physicians . . ." See also Entin, *supra* note 187, at 432 (explaining that an agreement between a corporation and a group of physicians, clearly identifying the physicians as independent contractors, will minimize the risk of corporate practice violation).

305. See *supra* notes 170-72 and accompanying text.

306. *Trustees Report: Part II*, *supra* note 137, at 1314.

307. See Entin, *supra* note 187, at 430-32; *Trustees Report: Part II*, *supra* note 137, at 1315-19; Punch, *supra* note 185, at 32-34.

308. Punch, *supra* note 185, at 32. William H. Roach, Jr., a health law attorney with

whether the proliferation of FECs will spark renewed interest in applying the doctrine.<sup>309</sup> Some believe that freestanding emergency centers can be structured to avoid any corporate practice concerns.<sup>310</sup> Others believe that as competition increases among FECs, either the FECs will attack one another with charges of corporate practice<sup>311</sup> or the states will invoke corporate practice prohibitions to protect the autonomy of local physicians.<sup>312</sup> One case concerning a multichain FEC has already reached the courts. In *Flashner v. Schemberger*<sup>313</sup> a former physician-partner in the Flashner Medical Partnership, which operates twenty-five FECs in three states, sued the partnership for inducing him to violate corporate practice prohibitions.<sup>314</sup>

The controversy over FECs provides an opportunity for the states to align the corporate practice doctrine with the realities of the modern health care industry. The proliferation of FECs indicates that commercialized medicine is becoming increasingly accepted. Even the AMA Board of Trustees, although concerned about physicians' professional autonomy, accepts the existence of for-profit enterprises in medical practice.<sup>315</sup> States should facilitate the development of FECs and similar health care delivery systems by amending their medical practice acts to reflect the corporate-physician relationships now deemed acceptable. In addition, courts

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the Chicago firm of Gardner, Carton & Douglas, notes that states overlook instances in which corporate practice prohibitions are violated. *Id.* The AMA's associate general counsel stated that except for Texas, corporate practice prohibitions were not being enforced anywhere. *Id.* at 34.

309. *See id.* at 32.

310. *See supra* note 304 and accompanying text.

311. Punch, *supra* note 185, at 32.

312. *Id.* The executive director of NAFEC (presently NAFAC) stated, "Every state has a medical practice act stating that corporations can't practice medicine. When the [FEC] chains roll out, the question arises as to how much control the local physicians have in practicing medicine . . ." *Id.*

313. *See* Rosoff, *supra* note 185, at 4.

314. *Id.*

315. Both parts of the AMA Board of Trustees Report on FECs indicate a general willingness to accept the existence of for-profit enterprises in medical care. *See Trustees Report: Part I, supra* note 274, at 645; *Trustees Report: Part II, supra* note 137, at 1314. The Report discusses the regulatory and legal status of FECs, but does not condemn commercialism. Instead, the Board of Trustees leaves the issue of commercialism to individual practitioners:

Noting that it is, in the final analysis, the professional responsibility of each physician to acknowledge the primacy of patient and public welfare, the Board concluded that the disruptive influence of commercialism on the physician-patient relationship may be mitigated by physicians' reaffirmation of commitment to the ideals of professionalism. *Trustees Report: Part II, supra* note 137, at 1315.

dealing with corporate practice cases must reexamine the doctrine's public policy bases rather than rely on precedents developed before the advent of a competitive and commercialized health care economy.

## VI. CONCLUSION

The corporate practice of medicine prohibition arose in response to fears that corporate involvement in medicine would restrict physicians' independence and commercialize medical practice. The AMA, the medical profession's organizing body, enacted ethical restrictions against corporate practice. Courts applied the prohibition against corporate practice based on broad interpretations of state medical practice acts and for reasons of public policy. In recent years few cases have arisen concerning the doctrine. As corporate involvement in health care intensifies, however, invocation of the corporate practice prohibition becomes more likely. This prohibition threatens the development of nontraditional health care delivery systems in many states. For innovation of delivery systems to continue, state courts and legislatures should modify corporate practice prohibitions to reflect current views on physician autonomy and the role of commercialism in medicine.

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