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Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine

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BE NOT AFRAID OF CHANGE:[1] TIME TO ELIMINATE THE CORPORATE PRACTICE OF MEDICINE DOCTRINE

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The corporate practice of medicine doctrine is a bit of an intellectual Mobius strip. It was created as an ethical constraint by the American Medical Association ("AMA") to prevent quackery and commercial exploitation of physicians. The doctrine was codified through state law and entrenched through courts' interpretation of the general rule that all individuals must be licensed to provide medical services in the state in which they practice. The requirement that individuals must be licensed has been consistently interpreted to stand for the larger proposition that corporations cannot practice medicine. This precept reaches much farther than delivery of medical care; it also relates to payment for medical services, management of medical practices, employment and engagement of physicians, patient relations, and more. The intellectual hitch is that the laws that collectively comprise the doctrine do not create a framework that either stands alone or that has a logical conclusion, and yet courts continue to enforce it.

Simply stated, the corporate practice of medicine doctrine prevents persons or entities that are not licensed by the state in which they are located from providing physician or other medical services or from excessively influencing the delivery of those services. The modern version of the corporate practice of medicine doctrine derives from two principles: (1) any person that "practices medicine" must be licensed by the state in which she practices to provide medical services[2] and (2) health care professionals cannot assist unlicensed per-

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[1] "[B]e not afraid of greatness. Some are born great, some achieve greatness, and some have greatness thrust upon 'em." WILLIAM SHAKESPEARE, TWELFTH NIGHT, act 2, sc. 5. It is time that the states have change thrust upon them for the sake of health care efficiency, quality, and modernity.

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[2] *See, e.g.*, ARK. CODE ANN. § 17-95-401 (Lexis 2002); 225 ILL. COMP.

sons or entities in practicing unlicensed medicine, which prevents the splitting of professional fees with non-professionals.[3]

The corporate practice of medicine doctrine is manifested in three ways. First, a non-licensed person or corporation cannot employ a physician or any other health care professional to practice medicine. Second, entities that provide health care services, including partnerships, professional corporations, limited liability companies, and non-profit corporations, generally cannot be owned or controlled by non-licensed persons or general corporations. Third, licensed professionals may not divide or share a professional fee with a non-licensed person or entity, because such "fee-splitting" can be considered assisting an unlicensed person to practice medicine and could be an improper influence on the professional's behavior.[4]

The corporate practice of medicine doctrine is a relic; a physician-centric guild doctrine that is at best misplaced, and at worst obstructive, in the present incarnation of the American health care system. The corporate practice of medicine doctrine is a remnant of a time when doctors with black bags made house calls, and hospitals were a place where people went to be "bled" and to die. In increasingly inte-

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STAT. ANN. 60/3 – 3.5 (West 1998); N.J. STAT. ANN. §§ 45:9-5.1 to 45:9-6 (West 1991 & Supp. 2003); TEX. OCC. CODE. ANN. § 155.001 (Vernon 1999). Every state has some form of professional licensure statutes and/or unauthorized practice statutes; they are too numerous to list here.

[3] *See, e.g.*, IDAHO CODE § 54-1814 (Michie 2003) (stating that licensed professionals can be disciplined for splitting fees for professional services, in exchange for referrals, and for aiding an unlicensed person to practice medicine). *See also* MINN. STAT. ANN. § 147.091 (West 1998 & Supp. 2004) (stating that aiding unlicensed persons and fee splitting are both grounds for disciplinary action); NEV. REV. STAT. ANN. 630.305 (Michie Supp. 2001) (stating that aiding an unlicensed person in the practice of medicine is grounds for disciplinary action or denying licensure); WIS. STAT. ANN. § 448.08 (West 1998 & Supp. 2003) (stating that a licensed professional may not engage in fee sharing). Similarly, professional service corporation acts often prevent anyone but licensed professionals from owning professional corporations. *See, e.g.*, ALA. CODE § 10-4-383 (1999) (stating that each shareholder of a professional corporation must be duly licensed); COLO. REV. STAT. § 12-36-134(d) (2003) (stating that all shareholders of a professional service corporation must be licensed to practice medicine in Colorado); N.J. STAT. ANN. §§ 14A:17-3, 14A:17-5 (West 2003) (stating that only a licensed professional may organize and become a shareholder of a professional corporation); S.C. CODE ANN. §§ 33-19-101 Comments, 33-19-130, 33-19-200 (Law. Co-op. 1990) (stating that only the professionally licensed may be shareholders in a professional corporation); TENN. CODE ANN. § 48-101-610 (Supp. 2003) (stating that a professional corporations can only issue shares to a non-licensed professional if the licensing authority specifically allows).

[4] The reasoning behind the prohibition on fee-splitting is that the unlicensed person or entity is not bound by the same rules of law and ethics as the health care professional, and, therefore, should not share in the fees generated from professional services. This is also true of lawyers. *See, e.g.*, MODEL CODE OF PROF'L RESPONSIBILITY EC 3-8 (1980).

grated health care delivery systems, the corporate practice of medicine doctrine does nothing to improve quality, efficiency, or accountability. Also, in this era of managed care reimbursement, where physicians are forced to bear the risk of providing patients too much time or too many services, the time has come to realize and accept that physicians are, in fact, influenced by financial gain (or loss). This is not to condemn physicians for being influenced by monetary issues; it is simply an important and essential observation that physicians have become inextricably intertwined with health care-financing and health care-providing corporations that do—and must—influence medical decision-making.

This article focuses on three key reasons that the corporate practice of medicine doctrine should be laid to rest. First, the motives for creating the corporate practice of medicine doctrine are long gone; it has been some time since physicians have been able to operate as a guild of autonomous providers of health care. The delivery and financing of health care places physicians in an integrated system that is only frustrated by the corporate practice of medicine doctrine. Second, it is disingenuous to pretend that physicians are not influenced by financial gain. This is handily evidenced by the federal and state prohibitions against physician self-referral and by the exodus from Medicare and Medicaid that is the result of ever-decreasing reimbursement rates. Third, the corporate practice of medicine doctrine does nothing to advance error-free, high quality health care and may actually inhibit improving the quality of health care. Recent reports by the Institute of Medicine demonstrate and emphasize this point.

In order to overcome the many manifestations of the state-based corporate practice of medicine doctrine, this article proposes federal legislation to effectuate alignment among the states on this issue. The goal is not to preempt states' oversight of licensure and health care quality, but simply to allow all doctors, whatever their venue, to practice in an integrated environment that will benefit patients and facilitate the continued development of this increasingly complex, specialized, and interconnected health care delivery system.

I. HISTORICAL BACKGROUND OF THE CORPORATE PRACTICE OF MEDICINE DOCTRINE

A. AMA Ethical Guidelines

The prohibition against corporations practicing or influencing the practice of medicine was conceived by the AMA in 1847 not only to

protect the public, but also to protect the profession of medical doctors.[5] At the time, medical doctors struggled to separate themselves from so-called "irregulars," faith healers, and other "quacks" who professed to cure human ailments.[6] As a part of the effort to differentiate medically trained doctors, the AMA created ethical guidelines to garner the respect of the general public. The AMA also issued pronouncements by its Judicial Council that served to guide the medical community and impress upon the public the seriousness and viability of the medical profession. These pronouncements contained warnings against the practice of medicine by a corporation, regardless of its intent, structure, or form.[7] The pronouncements also formed the foundation for building a guild of professional medical doctors who were to behave and treat one another differently than those who did not belong to this guild.[8]

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[5] The AMA Principles of Medical Ethics 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 profession.

AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS, ch. 3, art. 6, sec. 2, *reprinted in* AM. MED. ASS'N, AMERICAN MEDICAL DIRECTORY 15 (15th ed. 1938). For discussions of the AMA's attempt to distinguish itself from "sectarianism and quackery," as well as to regulate medical education, see also Jeffrey F. Chase-Lubitz, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445, 449-50 (1987); Adam M. Freiman, Comment, *The Abandonment of the Antiquated Corporate Practice of Medicine Doctrine: Injecting a Dose of Efficiency into the Modern Health Care Environment*, 47 EMORY L.J. 697, 699-700 (1998); Brian Monnich, Note, *Bringing Order to Cybermedicine: Applying the Corporate Practice of Medicine Doctrine to Tame the Wild Wild Web*, 42 B.C. L. REV. 455, 467-68 (2001).

[6] *Cf.* JAMES C. ROBINSON, THE CORPORATE PRACTICE OF MEDICINE: COMPETITION AND INNOVATION IN HEALTH CARE 27-28 (1999) (discussing the formal and informal tools employed by professionals to sanction unorthodox colleagues); *see also* Chase-Lubitz, *supra* note 5, at 448-49 (describing the 19th century as a highly competitive period for doctors trying to distinguish themselves and gain respect).

[7] The AMA Judicial Council noted:

> It was decided long ago that the practice of law by a corporation was against public policy and the same has been prohibited by law in many states. The relations between patient and physician are more intimate than are those between client and attorney. It is impossible for that intimacy of relationship to exist between and [sic] individual and a corporation and if it is against public policy for a corporation to practice law, how much more so must it be for a corporation to practice medicine.

AM. MED. ASS'N, 1922 REPORT OF THE JUDICIAL COUNCIL (interpreting Section 6 of the Principles of Medical Ethics), *abstracted in* PRINCIPLES OF MEDICAL ETHICS 40 (1960).

[8] *See* Timothy Stoltzfus Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 825, 827-28 (1995). Jost

The prohibition preventing physicians from practicing what was literally "corporate medicine" was a reaction by the AMA to at least three business formats that had emerged in the late 1800s. In the first, businesses were hiring physicians to provide full-time medical care for their employees.[9] This occurred most often in the industrial setting, wherein a large employer such as a railroad, plant, mine, or factory would hire a physician or group of physicians to provide care for employees and their families.[10] This was sometimes dubbed "contract practice."

In the second format, general business corporations, fueled by the ambition of entrepreneurs, hired staffs of physicians and marketed physicians' services to the general public.[11] Such entrepreneurs profited from the staff physicians' services without obtaining medical licensure themselves. Physicians were employed by laypersons who had no medical experience and who were not bound by medical or ethical restraints, and who were thus reputed to be motivated solely by profit.[12]

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writes that the "regulation of health care professionals in the United States is primarily a product of the late nineteenth century. . . . During this early period licensure authority was often delegated by statute to the medical societies and was generally guild-like in nature." *Id.* *See also* BUREAU OF MED. ECON., AM. MED. ASS'N, ECONOMICS AND THE ETHICS OF MEDICINE 8 (1936) (stating that organized medicine was modeled on the ethics and form of historical guild associations).

[9] *See generally* Alanson W. Willcox, *Hospitals and the Corporate Practice of Medicine*, 45 CORNELL L.Q. 432, 464-66 (1959-60) (providing a history of these employer-operated medical operations). In response to such industrial employment, the AMA revised the Principles of Medical Ethics to read:

> It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group, or individual . . . 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.

AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS, ch. 3, art. 6, sec. 5, *reprinted in* AM. MED. ASS'N, AMERICAN MEDICAL DIRECTORY 15 (15th ed. 1938).

[10] Willcox, *supra* note 9, at 464.

[11] *See* Francis J. Serbaroli, *Origins of the Corporate Practice of Medicine Prohibition in Public Policy and Medical Ethics*, HEALTH L. & BUS. SER. (BNA) No. 2800.03 (1999).

[12] The trend also included forming corporations to employ other professionals, such as lawyers. An important New York case revoked the certificate of incorporation of an entity that employed and marketed the services of lawyers. *See In re* Co-operative Law Co., 92 N.E. 15 (N.Y. 1910). The *Co-operative Law* court wrote, "[a] corporation can neither practice nor hire lawyers to carry on the business of practicing law for it any more than it can practice medicine or dentistry by hiring doctors or dentists to act for it." *Id.* at 16. The law surrounding legal practice has developed in

The third format involved the creation of hospitals by public agencies and by private philanthropists. Those who created hospitals sought to centralize the provision of health care and to employ physicians, but both actions would have resulted in a loss of autonomy for physicians.[13] When hospitals were first created, some courts would not entertain the idea that the hospital was itself providing medical services. For instance, a Missouri court in 1907 could not imagine that hospitals (or other corporations) were practicing medicine because hospitals were a conduit for physicians to treat patients.[14] Nevertheless, the AMA perceived hospitals to be a threat to physicians' autonomy.

Each of these business formats inspired a fear of loss of control over physicians' services and a fear of control over physicians' income, patient-load, methods of treatment and diagnosis, and patient relationships in general.[15] To address these concerns, the AMA drafted ethical guidelines that attempted to distinguish physicians as a new, unique breed of medical professional and that reflected a struggle for recognition of physicians as the sole source of legitimate medical services. The AMA sought to establish the autonomy of medical doctors as independent decision-makers who cared for nothing but the scientific treatment of patients.[16] The AMA thus trafficked in self-regulation of physicians in order to improve clinical practices, expose quacks, and expel those unworthy of carrying the title "physician" because of moral turpitude or deficient medical practices.[17]

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analogous ways to the law surrounding the practice of medicine, including preventing lawyers from practicing across state lines. States have started to revisit this prohibition for lawyers. *See, e.g.*, Henry Gottlieb, *Court Panels Urge Doing Away with Parochial Practice*, 170 N.J. L.J. 925 (2002) (reporting that two committees of the New Jersey Supreme Court have endorsed proposals by the American Bar Association that would facilitate inter-state legal practice in certain situations).

[13] *See generally*, ROBINSON, *supra* note 6, at 20 (explaining how doctors in hospitals run by philanthropists and public agencies had limited independence).

[14] *See* State *ex inf.* Sager v. Lewin, 106 S.W. 581, 583 (Mo. Ct. App. 1907) (stating that corporations running hospitals "do not practice medicine, but they receive patients and employ physicians and surgeons to give them treatment. No one has ever charged that these corporations were practicing medicine.").

[15] *See* Chase-Lubitz, *supra* note 5, at 446-47 (explaining that the corporate practice of medicine doctrine sprang up at the turn of the 20th century as a way to keep physicians free from corporate control).

[16] *See* Freiman, *supra* note 5, at 701-03 (describing the actions the AMA took in response to corporate involvement in medicine).

[17] ROBINSON, *supra* note 6, at 16. The effects of the AMA's guidelines can be seen in physician employment contracts even now, which often contain provisions for termination in the event of criminal action, performance below accepted medical standards, or upon evidence of moral turpitude. *See, e.g.*, AM. MED. ASS'N, AMERICAN MEDICAL ASSOCIATION ANNOTATED MODEL PHYSICIAN EMPLOYMENT

The guidelines, and lobbying by the AMA, greatly affected state legislation. States were counseled to license medical doctors, not only to regulate the sources of medical care for unknowing consumers,[18] but also to establish medical doctors as the sole legitimate professionals for the provision of health care. The result was a plethora of laws and regulations regarding licensure of persons to become doctors, and, indirectly, legitimization of limiting the practice of medicine to physicians. Additionally, states were encouraged to prohibit fee-splitting, a derivative of the corporate practice of medicine doctrine that prevented payments for referrals, whether from a physician or from a corporation. The prohibition against fee-splitting also prevented physicians from sharing their reimbursement for services with any nonlicensed person or entity. The prohibition grew out of a desire to prevent corporations from profiting from the professional services of physicians, as with the second scenario described above, in which nonlicensed individuals or businesses were able to share in physicians' professional income. The president of the AMA, Dr. William J. Mayo, wrote in 1906 that fee-splitting was a "pernicious practice" and a "crying evil" that had to be eradicated.[19]

B. State Licensure, Law, and Case Law

As early as the 1870s, physicians successfully lobbied for licensure statutes.[20] At that early stage of the medical profession, medical colleges were not accredited, and becoming a physician required nothing more than a degree from a college that called itself a medical school.[21] Initial state laws simply required a diploma to practice medicine.[22] Within a few decades, however, states had created licensing boards empowered by statute to review diplomas and reject candidates for licensure that appeared unworthy.[23] States also created independent state examinations as prerequisites to licensure.

At the AMA's urging, states created statutory licensure requirements that only permitted natural persons to be licensed to practice

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AGREEMENT 15 (2000), *at* http://www.ama-assn.org/ama/upload/mm/46/model_physician_aug.pdf.

[18] *See* Freiman, *supra* note 5, at 700-01 (explaining how the AMA's successful lobby for state statutes allowed it to gain further control over the medical profession through medical education reform).

[19] William J. Mayo, M.D., *The Medical Profession and the Issues Which Confront It*, 46 JAMA 1737 (1906). This was the same Dr. Mayo who is the namesake of the Mayo Clinic.

[20] Chase-Lubitz, *supra* note 5, at 451.

[21] *Id.*

[22] *Id.*

[23] *Id.* at 451-52.

medicine.[24] Such laws demanded that individuals seeking licensure must qualify, for example, by obtaining a degree from an accredited medical school, passing a state examination, performing an internship and residency, and demonstrating physical and mental soundness. Inherent in such requirements was the implication that corporations could not achieve such goals.[25]

The state licensure requirements were accompanied by a push from the AMA in the early 1900s to reform medical schools. Upon their inception, medical schools did not have a system of accreditation or any way to differentiate themselves from the schools that trained irregulars.[26] The AMA created entrance requirements, instituted a uniform curriculum, and standardized the duration of study.[27] The effect was to raise the bar for medical school applicants and entrants, which influenced the quality of students and, thus, the prestige of the medical profession as a whole. This contributed to the perception of physicians that arose in the early 1900s—and that remains today—of the physician as an omniscient healer and autonomous health care provider.[28]

Most medical practice acts are simply licensure statutes that list the qualifications needed to obtain a license to practice medicine, and they require that no person practice medicine without a license.[29]

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[24] *See* Glenn E. Bradford, J.D. & David G. Meyers, M.D., *The Legal and Regulatory Climate in the State of Missouri for Complementary and Alternative Medicine – Honest Disagreement Among Competent Physicians or Medical McCarthyism?*, 70 U.MO. K.C. L. REV. 55, 61 (2001) (noting that many blame the AMA for the resurgence of licensure laws at the turn of the twentieth century).

[25] *Cf.* ROBINSON, *supra* note 6, at 13 (explaining that the corporate practice of medicine doctrine assumes that corporate hospitals have different objectives than physicians and reflects America's historical distrust of big business).

[26] *See* Bradford & Meyers, *supra* note 24, at 62 (noting that many medical schools were found to be substandard in 1910, and the new regulations forced them out of business).

[27] *Id.* at 62 n.47, *citing* Abraham Flexner, *Medical Education in the United States and Canada,* Carnegie Foundation for the Advancement of Teaching, Bulletin No. 4 (1910) (stating that in 1904 the AMA established a Council on Medical Education with a mandate to elevate the standards of medical education).

[28] That this was the goal of the AMA is clear; the Principles of Medical Ethics uses language that is microcosmic of this, including such phrases as "dignity of professional practice" repeatedly. *See, e.g.*, AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS, ch. 3, art. 6, sec. 5, *reprinted in* AM. MED. ASS'N, AMERICAN MEDICAL DIRECTORY 15 (15th ed. 1938).

[29] Some states have explicitly prohibited the corporate practice of medicine. *See, e.g.*, CAL. BUS. & PROF. CODE § 2400 (West 2003) (stating that corporations have no professional rights, privileges, or powers); COLO. REV. STAT. § 12-36-134(g)(IV)(7) (2003) (stating that corporations shall not practice medicine); OHIO REV. CODE ANN. 1701.03 (West Supp. 2003) (stating that no corporation can exercise control over the professional clinical judgment of a licensed practitioner).

Licensure statutes were given teeth in the corporate practice of medicine context by judicial determinations that, because they pertain inherently and explicitly to individuals, such laws preclude corporations from engaging in medical practice in any sense of the word.[30] The general idea was that corporations did not have the characteristics necessary and inherent to practicing medicine because, for example, they could not attend medical school, obtain licenses to become physicians, or treat patients.[31]

Also, policy played a part in creating and extending the corporate practice of medicine doctrine.[32] The major concerns were threefold. First, it was argued that if corporations were permitted to employ physicians, physicians' loyalty would be inevitably divided between their employer and their patients.[33] Second, non-professionals' control

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[30] *See, e.g.*, Neill v. Gimbel Bros., Inc., 199 A. 178 (Pa. 1938). The Supreme Court of Pennsylvania, preventing a department store from employing an optometrist, wrote:

> A corporation as such cannot possess the personal qualities required of a practitioner of a profession. Its servants, though professionally trained and duly licensed to practice, owe their primary allegiance and obedience to their employer rather than to the clients or patients of their employer. The rule stated recognizes the necessity of immediate and unbroken relationship between a professional man and those who engage his services.

Id. at 181.

[31] *See, e.g.*, People v. Painless Parker Dentist, 275 P. 928, 930-31 (Colo. 1929) (holding that a corporation cannot qualify for licensure because it is not a natural person, and that hiring licensed dentists qualified as engaging in the practice of dentistry and was, therefore, prohibited). *Cf.* Ezell v. Ritholz, 198 S.E. 419 (S.C. 1938) (noting that even optometrists, because they were working as agents for a nonlicensed entity, were not "practicing 'in the due course of their private professional practice'"). That court captured the sentiment of many state courts contemplating the corporate practice of medicine doctrine, writing:

> If [corporate practice] were sanctioned the logical result would be that corporations and business partnerships might practice law, medicine, dentistry or any other profession by the simple expedient of employing licensed agents. And if this were permitted professional standards would be practically destroyed, and professions requiring special training would be commercialized, to the public detriment. The ethics of any profession is based upon personal or individual responsibility. One who practices a profession is responsible directly to his patient or his client. Hence he cannot properly act in the practice of his vocation as an agent of a corporation or business partnership whose interests in the very nature of the case are commercial in character.

Id. at 424.

[32] *See, e.g.*, Barton v. Codington, 2 N.W.2d 337, 346 (S.D. 1942) ("Being convinced that the practice of the learned professions by a profit corporation tends to the commercialization and debasement of those professions . . . such a mode of conducting the practice is in contravention of the public interest and is against public policy.").

[33] *See, e.g.*, State Bd. of Optometry v. Gilmore, 3 So.2d 708, 709 (Fla. 1941)

over medical decision-making and judgment was considered to be inherently harmful.[34] Third, commercial exploitation of physicians and their practices was deemed intrinsically unacceptable because laypersons were not subject to the licensure standards and ethical requirements by which professionals were bound.[35] Courts embraced each of these arguments when considering the corporate invasion of medicine that occurred in the early 1900s.[36]

Thus, licensure statutes acted as a foundation for court-enhanced creation of the corporate practice of medicine doctrine. Without judicial opinion and policymaking, the doctrine likely would not have become central to the structure of the health care industry. Interestingly, some state courts have begun to reject the corporate practice of medicine doctrine as a reason to, for instance, negate physicians' contracts with hospitals (which are corporate entities).[37] But such deci-

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(finding that it is illegal for an optometrist to practice in the employment of a jewelry store because of the inherent conflicting loyalties); Neill v. Gimbel Bros., Inc., 199 A. 178 (Pa. 1938) (fearing that a corporation's servants, even if professionally trained, might still owe the corporation allegiance over their patient); State *ex rel.* Loser v. Nat'l Optical Stores Co., 225 S.W.2d 263, 268-69 (Tenn. 1949) (noting that if a corporation were permitted to practice medicine that professional standards would be "practically destroyed . . . to the public detriment" because of the deceased accountability to patients).

[34] *See, e.g.*, People *ex rel.* State Bd. of Med. Exam'rs v. Pacific Health Corp., 82 P.2d 429, 430 (Cal. 1938) (noting the problem of lay control of the profession and the diminution of choice of providers if a corporation limits the public to only a particular group of doctors); Bennett v. Indiana State Bd. of Registration and Examination in Optometry, 7 N.E.2d 977, 981-82 (Ind. 1937) (stating that the relationship between the licensed optometrist and the unlicensed employer is that of master and servant which creates a pressure on the licensed practitioner to disregard the best interests of his patient); People v. Carroll, 264 N.W. 861, 863 (Mich. 1936) (noting the high degree of professional knowledge a dentist needs and arguing that separating such skill and knowledge from complete control over the practice is "evil"); State *ex rel.* Bricker v. Buhl Optical Co., 2 N.E.2d 601, 604 (Ohio 1936) (arguing that a company cannot lawfully exercise control over an optometrist or perform any act that amounts to the practice of optometry).

[35] *See, e.g.*, State v. Boren, 219 P.2d 566, 568-69 (Wash. 1950) (explaining that the state has a right to protect its citizens, who rely on the skill and ethical training of their physician, from those practicing without a license or proper examination); Funk Jewelry Co. v. State *ex rel.* La Prade, 50 P.2d 945, 945-47 (Ariz. 1935) (distinguishing professions which involved relationships of personal privacy and public health with those such as druggists, architects, and other vocations where no such relationship exists); Parker v. Bd. of Dental Exam'rs, 14 P.2d 67, 71-72 (Cal. 1932) (explaining that one must have license to show both "moral character" and proper training because of the immense control the professional has over their patient); Winberry v. Hallihan, 197 N.E. 552, 556 (Ill. 1935) (holding that no corporation shall practice dentistry without the proper license because of the legislature's right to protect the public and the medical profession itself from the untrained and unskilled).

[36] *See* cases cited *supra* notes 33-35 for examples.

[37] *See, e.g.*, Berlin v. Sarah Bush Lincoln Health Ctr., 688 N.E.2d 106, 114

sions are often limited in scope and are slow to address the structural difficulties that the corporate practice of medicine doctrine has created.

C. Manifestations in Modern Delivery of Medical Care

The AMA wanted to prevent corporations from influencing physicians in the number of patients seen and in the independent medical decisions that the AMA believed should be entirely free of layperson and corporate control.[38] The AMA was concerned that corporate practice of medicine would require physicians to carry excessive caseloads that would diminish the quality of care physicians would be able to provide. Further, the AMA was fearful that corporations would hinder the independent judgment of doctors by allowing laypeople to make decisions affecting health care delivery, such as which patients to see and the amount of services to provide. These concerns increased the development of aspects of the profession that resembled a guild strong on professionalism but weak on discipline.[39]

While the doctrine may seem too outdated to be enforced, the statutes and regulations that form the doctrine remain in current statutory compilations and, like a sleeping dragon, need only a slight stimulus to be set into action. For instance, a California court relatively recently found that the corporate practice of medicine doctrine, as manifested in that state, prohibits a hospital from employing physicians, even though they may have an independent contractor relationship.[40] Other states have refused to eradicate the doctrine, but they

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(Ill. 1997) (finding that a "duly-licensed hospital possesses legislative authority to practice medicine by means of its staff of licensed physicians and is excepted from the operation of the corporate practice of medicine doctrine"). Thus, with the corporate practice of medicine doctrine inapplicable, the employment agreement between the hospital and the physician was not unenforceable due to the hospital's status as a corporate entity. *Id.*

[38] Monnich, *supra* note 5, at 467-68.

[39] *See* ROBINSON, *supra* note 6, at 17 (explaining that while there were many benefits associated with small-scale guilds, they also suffered from weak budgetary discipline).

[40] Conrad v. Med. Bd. of Cal., 55 Cal. Rptr. 2d 901, 907 (Cal. Ct. App. 1996) (explaining that permitting hospitals that enter into contracts with physicians who provide services to the public is not an exception to the ban on the corporate practice of medicine, but rather a clarification of the practice of treating these physicians as independent contractors). In New York, the Nutri/System corporation allegedly employed physicians on a salaried basis to conduct exams and provide medical services for weight loss customers. The attorney general obtained a consent decree against Nutri/System based in part on New York's version of the corporate practice of medicine doctrine. Bd. of Tr. Comm. on Medicolegal Problems, Am. Med. Ass'n, *Satellite and Commercial Medical Clinics: Report of the Board of Trustees: Part II*, 235 JAMA 1314, 1318 (1985).

have determined that it should not apply to the employment of physicians by hospitals.[41] Still others have established that the corporate practice of medicine doctrine will not apply to health care facilities that are licensed by the state to deliver the medical services that their licenses allow, for example hospitals, clinics, and (occasionally) managed care entities.[42] In order to understand the multi-layered status of the corporate practice of medicine doctrine today, a review of the pro-

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[41] *See, e.g., Berlin*, 688 N.E.2d at 114. *But see* Carter-Shields v. Alton Health Inst., 777 N.E.2d 948, 956-58 (Ill. 2002) (affirming the *Berlin* holding, but limiting its reach by noting that although the "prohibition against the corporate practice of medicine is inapplicable 'when a corporation has been sanctioned by the laws of this state to operate a hospital,'" this exception does not extend to unlicensed, charitable, nonprofit health organizations). The Court stated:

> Our decision in *Berlin* stands for the proposition that the proscription against the corporate practice of medicine is, at root, animated by the public policy purpose of safeguarding the public health and welfare by protecting the physician-patient relationship from lay interference with the physician's professional judgment. The exercise of control or influence over the medical decisionmaking of a physician by a lay, unlicensed corporation results in a division of the physician's loyalty between the often divergent interests of the corporation and the patient. We determined in *Berlin* that the public policy purpose underpinning the corporate practice doctrine would not be adversely affected by carving out a narrow exception for an entity, such as a hospital, that must meet certain professional criteria established by the legislature to become a licensed health-care provider. Indeed, our decision in *Berlin* repeatedly emphasized the role of licensing in the genesis and development of the corporate practice doctrine.

Id. at 957. Thus, the court found that an unlicensed, nonprofit entity was subject to the corporate practice of medicine doctrine and refused to uphold a restrictive covenant between a physician and a nonprofit healthcare center (in which laypersons had ownership interests and management power). *Id.* at 958.

[42] *See, e.g.*, N.J. ADMIN. CODE tit. 13, § 35-6.16(f)(4) (2003). The Code states that a physician may be a shareholder or employee of a general business corporation if the corporation has:

> a designated medical director licensed in this State who is regularly on the premises and who . . . is responsible for licensure credentialing and provision of medical services. . . . [And] [t]he corporation is licensed by the New Jersey Department of Health as a health maintenance organization, hospital, long or short-term care facility, ambulatory care facility or other type of health care facility or health care provider . . . "

Id. See also St. Francis Reg'l Med. Ctr., Inc. v. Weiss, 869 P.2d 606, 618 (Kan. 1994) (holding that a licensed hospital can provide healthcare and contract for the service of physicians, even though an unlicensed one may not); Bing v. Thunig, 143 N.E.2d 3, 6-9 (N.Y. 1957) (holding that doctors and nurses in charitable hospitals are no longer exempt from liability by claiming independent contractor status because they are now considered an integral part of the hospital system); People v. John H. Woodbury Dermatological Inst., 85 N.E. 697, 698-99 (N.Y. 1908) (explaining that unlike hospitals and dispensaries who may practice through their licensed agents, a dermatology institute was guilty of the unlawful practice of medicine for advertising medical services without a license).

competition intervention performed by the Federal Trade Commission nearly thirty years ago is beneficial.

1. The Federal Trade Commission Challenges the AMA

The structure and enforcement of the corporate practice of medicine doctrine has been greatly influenced by a 1979 order of the Federal Trade Commission. Though many have observed that the guild-like nature of professional self-regulation is almost inherently anti-competitive, the Federal Trade Commission was the first to effectively challenge the private club that had been constructed and reinforced by the AMA.[43] The Federal Trade Commission determined that the AMA's Principles of Medical Ethics and the 1971 Opinions and Reports were inherently anti-competitive because they prevented physicians from adopting "more economically efficient business formats in particular situations . . . ."[44] This conclusion was based upon the requirements in the AMA ethical guidelines that stated such tenets as, "[i]t is unprofessional for a physician to dispose of his services under conditions . . . which interfere with reasonable competition among physicians of a community" and "any insurance arrangement must be open to all local providers."[45] It has been noted that the AMA stated (without irony) that it deliberately drafted certain ethical precepts to prevent providers from being divided into factions that would compete based on price.[46]

The Federal Trade Commission further observed that the AMA's ethical guidelines could prevent physicians from associating with health maintenance organizations ("HMOs"), which had been recognized and exalted by Congress as effective cost-management systems in the HMO Act of 1973.[47] This was an unsurprising interpretation of the AMA's requirement that all insurance companies pay for the services of all physicians in a given geographic area in the same way. The Federal Trade Commission ordered the AMA to modify the ethical restrictions on physicians' contractual arrangements and payment structures so that they would comply with federal antitrust laws.[48]

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[43] For a thorough and classic discourse on the history of the medical profession and the guild that the AMA created for medical doctors, see PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 418-19 (1982).

[44] *In re* Am. Med. Ass'n, 94 F.T.C. 701, 1017-18 (1979).

[45] *Id.* at 1011 n.59, 903.

[46] *See* Charles D. Weller, *"Free Choice" as a Restraint of Trade in American Health Care Delivery and Insurance*, 69 IOWA L. REV. 1351, 1356 (1984) (quoting AM. MED. ASS'N, ORGANIZED PAYMENTS FOR MEDICAL SERVICES 142 (1939)).

[47] *Id. See also* 42 U.S.C. § 300e-10 (2000) (originally enacted as the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, § 2, 87 Stat. 931).

[48] *See In re* Am. Med. Ass'n, 94 F.T.C. at 1018. Section 6 of the 1957 Prin-

Even though the Federal Trade Commission's decision did not affect state licensure laws or statutory professional guidelines, the AMA's ethical guidelines were a cornerstone of the development of state professional licensure law and case law, and the mandated modifications to the AMA's ethical standards impacted interpretation and enforcement of the corporate practice of medicine doctrine. Now, the AMA's Code of Medical Ethics ("Code") can only reiterate the existing state prohibitions against the corporate practice of medicine, though the AMA would have it otherwise; the Code cannot enforce the professional autonomy of physicians and prevent them from affiliating with corporate entities.[49] The Code now states that "[a] physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services."[50] Given the major changes in language and the attendant manifestations of attitude, it is not surprising that some argue that the Federal Trade Commission's order "weakens the foundation upon which the corporate practice of medicine doctrine was built."[51]

Perhaps as an indirect result of the 1979 FTC order, the age-old concerns of the AMA have come to fruition through managed care organizations and the reimbursement system that HMOs and their offspring have shaped. Patients who are HMO enrollees no longer freely choose their physicians; they are limited to a panel of physicians that have been contracted by the corporation that is authorized to act as an HMO. Conversely, HMOs contractually require physicians

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ciples of Medical Ethics prevented physicians from providing services under conditions that might prevent the physician from exercising medical judgment with complete freedom or that might deteriorate the quality of medical care. *See* Chase-Lubitz, *supra* note 5, at 475, *citing In re* American Medical Ass'n, 94 F.T.C. 701, 896 (1979). Though the language of the 1957 Principles of Medical Ethics was not particularly anti-competitive, the interpretation of the section advanced by the AMA's Judicial Council contained language that restricted practicing under a contract with any type of corporation, prohibited lay entities from profiting in any way, declared salaried positions in hospital emergency rooms to be unethical, and set forth a number of other restrictions on contractual arrangements. *See Id.* at 476-77, *citing In re American Medical Ass'n*, 94 F.T.C. at 896-907. Thus, the Federal Trade Commission found the AMA's restrictions had anti-competitive effects. *Id.*

[49] *See* Burt Schorr, *Reagan's Medicaid Plan Stirs Fears of Two-Class Health-Care System*, WALL ST. J., Feb. 24, 1981, § 2, at 29 (stating that, according to its executive vice president, the AMA remained "violently opposed" to the removal of guild free choice requirements in Medicaid), *cited in* Weller, *supra* note 46, at 1357 n.31.

[50] AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS princ. 6, *reprinted in* CODES OF PROFESSIONAL RESPONSIBILITY 267 (Rena A. Gorlin ed., 3d ed. 1994), *available at* http://www.ama-assn.org/ama/pub/category/2512.html

[51] Chase-Lubitz, *supra* note 5, at 478.

to treat any patient that is a member of that HMO, which inherently diminishes the decision-making power and choice of physicians.[52] Further, the per member/per month payment system encourages physicians to see as many patients as possible in as little time as possible to maximize the economies of scale.

Thus, looking only at the snapshot that HMOs provide in the health care system, it is apparent that the AMA's initial vision has been thwarted and that corporations have become a major part of the practice of medicine and the provision of health care services. It is also illuminating to consider the role of physicians in the integrated medical care settings that exist in modern medicine.

2. An Increasingly Integrated Health Care System

The classic image of the physician with his black bag making house calls feels as quaint as a Norman Rockwell image in the current incarnation of the practice of medicine. Solo practitioners and small group practices increasingly are falling by the wayside as larger group practices and affiliations with hospitals become the norm, if for no other reason than the need for cost savings.[53] Not only has this trend been inevitable due to economies of scale, it is also encouraged by some of the major health care policymaking bodies today. Physicians are just one of many categories of health care professionals, and it has become more difficult to assert that physicians should benefit from the guild-like protections created by the AMA. Certified registered nurses, nurse practitioners, nurse anesthetists, physician assistants, physical therapists, chiropractors, podiatrists, occupational therapists, and home health aides are all developing sub-professions that involve limited licensure and fill a need in a specialty. Each one also chips away at the central and indispensable role of the physician created by the AMA.[54]

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[52] Some states have recognized that physicians have lost their voice in the health care market and are pondering allowing physicians to form unions for the purpose of contracting with managed care organizations. *See, e.g.*, N.J. STAT. ANN. § 52:17B-196 (West 2003) (enacted Jan. 8, 2002) (allowing physicians to negotiate jointly with insurance carriers). As an example of the marginalization of physicians, the Supreme Court recently reversed the Eleventh Circuit, thus forcing physicians to arbitrate their claims against a health maintenance organization, even though originally brought under the Racketeer Influenced and Corrupt Organizations Act ("RICO"). Contractual provisions were interpreted by the Court to permit arbitration of these claims. PacifiCare Health Systems, Inc. v. Book, 155 L. Ed. 2d 578 (2003). This decision highlights the power imbalance between physicians and HMOs and (perhaps) the need for physicians to act in concert in today's health care system.

[53] *See* Jost, *supra* note 8, at 832.

[54] *See* Kathleen O'Dell; *System a strain for doctors going it alone, Independents say patients need choice; hospitals say they have it*, NEWS LEADER, Main Sec-

Further, the provision of medical care now requires a complex network of specialized providers, most of which are corporations, each of which must be licensed by the state or states in which they function to perform a particular health care service. No uniformity exists among states for recognition of different types of corporate entities that may "practice medicine." Most health care entities are state-licensed (though many states have abandoned certificate of need requirements). Physicians and other health care practitioners must function within this network and are integral to delivery of care in each setting.

The demise of indemnity insurance has forced physicians and other medical care providers to think of the bottom line.[55] Physicians have been hauled into participation in managed care organizations, but they are loath to continue to participate both because of the loss of autonomy and because payments are too low to deal with the administrative burden of the 'slow-pay no-pay' game.[56] Nevertheless, physicians are forced to continue to participate because managed care organizations dominate health care payment markets.[57] So long as this is true, it is undeniable that corporate control, or, at least, influence, is central to physician reimbursement and is not going to cease influencing the delivery of care in the near future.

Thus, independent medical decision-making may be a relic, not only because of the number and variety of players in the health care arena, but also due to the methods of reimbursement now existing.[58] Despite contractual clauses that condemn and prevent any influence over medical decision-making by physicians, managed care organizations wield great power over the amount and level of care that is given by virtue of their payment methodology. Capitation forces physicians to bear the risk of providing more services to patients, whether the

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tion, A, December 22, 2002 (describing the struggle certain physicians have chosen to undertake in order to "beat the system").

[55] *See, e.g.*, George C. Harris & Derek F. Foran, *The Ethics of Middle-Class Access to Legal Services and What We Can Learn from the Medical Profession's Shift to a Corporate Paradigm*, 70 FORDHAM L. REV. 775, 813-14 (2001) (discussing the shift to managed care that resulted from escalating healthcare costs as a cause for physicians being forced to consider finances more than they had to under true indemnity insurance).

[56] *See* Sabin Russel, *Doctors in State Fleeing HMOs, Consumer Advocates Alarmed by Trend*, SAN FRANCISCO CHRONICLE, February 9, 2003, at A1.

[57] *See* Harris & Foran, *supra* note 55, at 817-20 (discussing the impact that HMOs have had on modern physician practice).

[58] *See* Jost, *supra* note 8, at 831 (stating that dramatic changes have occurred in healthcare finance that have created dramatic changes in the practice of modern medicine).

services are medically necessary or elective.[59] The HMO Act of 1973 would not have been enacted if the federal government did not calculate that physicians are influenced by the reimbursement they receive, or more importantly, do not receive, for their services. While physicians are now required to be the "gatekeepers" of medical care, they are no longer the exclusive providers of patient care needs.[60]

II. THE UNAVOIDABLE INFLUENCE OF PROFIT

The point is simple yet profound: everyone who works hard for their money is influenced by financial gain, including physicians. But the AMA created guidelines that were based in the premise that, were it not for the undue influence of corporations and unlicensed individuals, physicians would be "pure" medical care providers who could never be improperly influenced by monetary gain. Such a premise is easily dispelled upon inspecting just one example: the federal prohibition against physician self-referral, known as the "Stark Law," and the state laws that parallel its proscriptions.[61] Also, physicians' exodus from participation in Medicare and Medicaid due to decreasing reimbursement cannot be ignored.

A. The Ethics in Patient Referrals Act

The Ethics in Patient Referrals Act, commonly called the Stark Law (named after Fortney "Pete" Stark, the Congressman who created the statute) is a civil law that essentially sets the floor for physicians' financial transactions insofar as physicians receive Medicare or Medicaid as reimbursement for the services affected by those financial relationships. The law was written to apply specifically to physicians and

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[59] Capitation is a payment system that HMOs created; physicians receive a fixed amount of money per HMO member per month. This forces physicians to bear the risk of overutilization, though many complain that capitation has lead to a system of severe underutilization. *See* Gordon D. Schiff, M.D. & Quentin D. Young, M.D., *You Can't Leap a Chasm in Two Jumps: The Institute of Medicine Health Care Quality Report*, 116 PUB. HEALTH REP. 396 (2001) (stating that capitation promotes underuse). Even the term "medically necessary" is a loaded one due to its repeated and denoted use in Medicare law and regulations. *See, e.g.*, 42 U.S.C. § 1395y(a) (2000), which states, "[n]otwithstanding any other provision of this subchapter, no payment may be made under part A or part B of this subchapter for any expenses incurred for items or services . . . which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member . . . ."

[60] *See* George P. Smith, II, *Distributive Justice and Health Care*, 18 J. CONTEMP. HEALTH L. & POL'Y 421, 424 (2002) (describing physicians as "gatekeepers" in the "health care distribution industry").

[61] 42 U.S.C. § 1395nn (2000).

not to other health care providers. The Stark Law draws upon the definition of physician as it is delineated in Medicare law, which includes medical doctors, osteopaths, chiropractors, dentists, podiatrists, and optometrists.[62]

The body of federal proscriptions that is generically and collectively referred to as the Stark Law actually consists of several statutes and multiple regulations that, as of publishing this article, are still being completed. The law prohibits the referral of Medicare and Medicaid patients by a physician to an entity for the provision of certain designated health care services if the physician (or an immediate family member) has a prohibited ownership interest in, or a compensation arrangement with, the health care entity, unless an exception applies.[63] A "compensation arrangement" means any arrangement involving any remuneration, direct or indirect, between the referring physician and the provider; an "ownership or investment interest" includes any kind of equity or debt arrangement.[64] The exceptions to the Stark Law have been divided into categories that correspond to the financial relationships: compensation arrangement exceptions, ownership or investment interest exceptions, and exceptions that apply to both compensation arrangements and ownership or investment interests.[65]

This is, notably, a strict liability law; a physician need not intend to violate the Stark Law in order to violate its prohibitions. Being close to compliance will not protect a financial arrangement; physicians must comply with every element of an exception in order to be protected from liability under the Stark Law. The implication is that

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[62] *Id.* § 1395nn(a); 42 U.S.C. § 1395x(r) (2000).

[63] 42 U.S.C. § 1395nn; 42 C.F.R. §§ 411.350-389 (2002). "Stark I" was created in 1989, with an effective date of January 1, 1992, and prohibited referrals by physicians for clinical laboratory services to clinical laboratories that were owned by the referring physician. Stark I, Pub. L. No. 101-239, § 1877, 103 Stat. 2236 (1989). The Omnibus Budget Reconciliation Act of 1993 added ten designated health services to the prohibition in Stark I, thereby creating "Stark II." OBRA, Pub. L. No. 103-66, § 13562(h)(6), 107 Stat. 604 (1993). The regulations pertaining to Stark I were proposed in 1992 and published as final regulations in 1995. Stark I Regulations, 60 Fed. Reg. 41,914 (Aug. 14, 1995). The regulations pertaining to Stark II were published in 1998 (the "1998 Draft Regulations," 63 Fed. Reg. 1646 (Jan. 9, 1998)), and "Phase I" of the final Stark II regulations became effective on January 4, 2002. 66 Fed. Reg. 856 (Jan. 4, 2001). Half of the 1998 Draft Regulations became effective on January 4, 2002. *Id.* The Stark II Phase II regulations were published in the spring of 2004, and as of the publication of this article, their meaning was still being deciphered. *See* 66 Fed. Reg. 17933 (April 6, 2004). Physicians (or their attorneys) still rely on the preamble and other language from the 1998 Draft Regulations to decipher elements of the Stark Law.

[64] 42 U.S.C. §§ 1395nn(a)(2), 1395nn(h)(1) (2000).

[65] 42 U.S.C. §§ 1395nn(b)-(e) (2000); 42 C.F.R. §§ 411.350-389.

no amount of good intent can compensate for the inherent wrong of physicians referring to themselves for patients' care and the improper financial gain that they receive from such self-referring.[66] Further, the Stark Law, unlike other fraud prevention statutes (like the federal anti-kickback statute, which applies to all health care providers that accept Medicare and/or Medicaid and anyone else involved in the fraud), was designed to apply *only* to physicians.[67] The mere fact that physicians' compliance with the Stark Law is mandatory shows nothing if not distrust of the financial motives of physicians.[68]

In addition to the federal proscriptions, many states have laws forbidding fee-splitting, meaning that physicians cannot pay for referrals or receive remuneration for providing certain services or items.[69]

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[66] *See generally* Jean M. Mitchell & Elton Scott, *Physician Ownership of Physical Therapy Services: Effects on Charges, Utilization, Profits, and Service Characteristics*, 268 JAMA 2055 (1992). The authors of this article were commissioned by the Florida legislature to study physicians who held interests in "joint ventures," meaning an ownership or investment interest between a referring physician and freestanding entities that provided physical therapy services. Mitchell and Scott found that physicians in Florida who held interests in joint ventures had higher utilization rates, charges per patient, and profits, but that the same physicians hired fewer licensed therapists and the licensed therapists spent less time with each patient. *Id.* at 2057-59. *See also* TIMOTHY STOLTZFUS JOST & SHARON L. DAVIES, THE LAW OF MEDICARE AND MEDICAID FRAUD AND ABUSE 214-18 (2002) (describing the reasons that the Stark law was implemented, including fears of overutilization, improper motivation for profit-making, decreased quality of care, and unnecessary medical services).

[67] *But see* 42 U.S.C. § 1320a-7b(b) (2000). The federal anti-kickback statute makes it a crime to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce the referral of business for which payment may be made by a federal health care program. The statute has been interpreted to cover *any* arrangement where one purpose of the solicitation was to obtain remuneration in return for a referral of services, or one purpose of the payment was to induce further referrals. United States v. Kats, 871 F.2d 105, 108 (9th Cir. 1989) (*citing* United States v. Greber, 760 F.2d 68, 72 (3d Cir. 1985). Violation of the statute constitutes a felony punishable by a fine of up to $25,000 and/or imprisonment for up to five years, exclusion from Medicare and Medicaid, and administrative sanctions. Importantly, however, the anti-kickback statute contains a *mens rea* element that the Stark Law lacks. To avoid criminal liability, a healthcare provider need only voluntarily comply with a statutory or regulatory safe harbor. Further, even without safe harbor compliance, the government must show that the defendant had the requisite intent to violate the statute. Thus, in many ways, the law that applies to physicians only is a more difficult law with which to comply and a harsher method of reducing health care fraud.

[68] *See generally* Thomas S. Crane et al., *Phase I of Stark II Final Rule Analysis; Phase II Release Date Uncertain*, 10 HEALTH L. REP. (BNA) 193 (Feb. 1, 2001) (providing an overview of the issues raised in the Stark Law and final rule).

[69] *See, e.g.*, ALA. CODE § 34-24-360(10) (2002); N.J. ADMIN. CODE tit. 13 § 35-6.17(c) (2003); N.M. STAT. ANN. § 61-6-15(D)(16) (Michie 1999 & Supp. 2002) (repealed effective July 1, 2004); N.Y. EDUC. LAW § 6509-a (McKinney 2001); N.Y. COMP. CODES R. & REGS. tit. 8, § 29.1(b)(4) (2001); VT. STAT. ANN. tit. 26, §

Such laws apply to all physician activities, regardless of the source of reimbursement, because they are part of the statutory licensure structure for physicians and other professionals. Some of these laws closely follow the language of the federal anti-kickback statute and Stark Law, while other states' statutes contain different language that can be broader and more encompassing than the federal prohibitions.[70] The basic prohibition is the same, however: physicians cannot pay other physicians for referring patients, and non-licensed individuals or entities cannot share in the professional fees generated by physicians. The state laws have some similarities in penalties, such as imposition of civil fines and penalties; criminal penalties; and actions against the licensee such as revocation of the license, fines, censure, or reprimand, any of which may be imposed if fee-splitting has occurred.[71] In addition to the statutory prohibitions, many professional associations for physicians prohibit fee-splitting in their membership codes of conduct, and expulsion may result if fee-splitting occurs.[72]

The fee-splitting laws also prohibit sharing reimbursement from professional services with an unlicensed person or entity, which is tied into the corporate practice of medicine doctrine. Again, the pretense is that physicians would not be motivated by money if it were not for the improper influence of non-physicians, whether individuals or corporations, because they do not answer to the state. If corporate influence were the only issue, however, there would be no reason to prohibit self-referral if physicians would not otherwise be influenced by financial gain.

1354(12) (Supp. 2003).

[70] Some states have been waiting for the Stark regulations to be finalized so that they can modify and align their statutory schemes to mirror the federal laws.

[71] *See* statutes listed *supra* note 69. Fee-splitting can also trigger the federal anti-kickback statute and the Stark Law, depending on the scheme and the reimbursement that is the subject of the fee-splitting. *See* 42 U.S.C. § 1320a-7b(b); 42 U.S.C. § 1395nn.

[72] The American College of Surgeons forbids its members to split fees. The Statements on Principles mandate, "[f]ee splitting as an inducement to refer a patient to another physician is unethical. The premise for referral must be quality of care. Violation of this tenet disqualifies an applicant. If a surgeon who is already a Fellow violates this principle, it is a cause for expulsion from Fellowship." AM. COLL. SURGEONS, STATEMENTS ON PRINCIPLES, princ. III(C), *available at* http://www.facs.org/fellows_info/statements/stonprin.html (last modified Oct. 1997). In fact, the membership oath requires surgeons to denounce fee-splitting. AM. COLL. SURGEONS, *Fellowship Pledge*, *available at* http://www.facs.org/memberservices/2bfacs.html (last modified Aug. 19, 2002).

B. Further Evidence: Decreasing Participation in Medicare and Medicaid

Evidence that is becoming less anecdotal and more statistical shows that physicians are rejecting participation in Medicare and Medicaid (though exodus from Medicaid is not new because reimbursement rates are notoriously low) not only due to the administrative hassles, but also because of impossibly low, and decreasing, reimbursement rates.[73] Hospitals and other health care providers are

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[73] *Bleak Outlook: Physician Executives Nationwide Reconsider Medicare Participation*, MODERN PHYSICIAN, Jan. 1, 2003, at 12 (noting that physicians are being forced to drop Medicare participation due to yearly cuts in reimbursement rates and escalating costs of health care services). The article in Modern Physician recounts the following dialogue :

> Thomas Scully, the CMS administrator, tells Modern Physician his agency has not yet noted a decline in the number of physicians participating in Medicare, but he believes one is coming.
>
> "My guess is once they take a 4.4% reduction, we're going to see a large wave of very upset doctors" Scully says. "I hope doctors will stay in, because I think Congress will fix it. But they have every right in the world to be angry."
>
> Scully says CMS has scrubbed the payment formula and made every adjustment it could, noting that the original cut planned for 2003 was 5.7% rather than 4.4%.
>
> "I've done back flips to try and find a way to not do this," he says. "When we started talking to doctors' groups a year ago, the cuts were even bigger. I'm sure the AMA would argue we could do more, but we've pushed it as far as we can."

The figures are alarming, but the stories behind them are not mere hyperbole. Community doctors-generalists and specialists, rural and urban, in practices large and small-who make up the raw numbers of physicians contemplating dramatic action, will spend the coming year trying to keep their doors open and halt the downward financial spiral.

Id. See also Barbara Martinez, *Some Doctors Say They May Stop Seeing Medicare Patients After Cuts*, WALL ST. J., Jan. 15, 2002, at B1 (referencing both anecdotal and statistical evidence of doctors who considered ending their participation in the Medicare program because of reduced reimbursement); *Politics & Policy Medicare: AMA Says Scheduled Cuts Would Harm Access to Care*, AM. POLITICAL NETWORK–AM. HEALTH LINE, Oct. 16, 2002; Kim Norris, *Doctors Warn of Medicare Cutbacks: AMA Says Patients Might Be Dropped If Aid Dries Up*, DETROIT FREE PRESS, Oct. 16, 2002, at 1D (explaining that nearly half of doctors surveyed by the American Medical Association considered leaving the Medicare program, and nearly one quarter have limited or are planning to limit their participation); Jennifer Silverman, *Next Medicare Cut: 40% of Doctors May Opt Out: Pay Set to Drop 4.4% Further*, FAM. PRACTICE NEWS, October 15, 2002. This exodus from federal health care programs may be temporarily thwarted due to the slight increase that Congress mandated after the Department of Health and Human Services ("HHS") determined that it could not avoid a decrease due to its statutory mandate. The statutory mandate was modified by the Medicare Modernization Act, which created a 1.5% increase in payment for 2004 and 2005. *See* Pub. L. No. 108-173 § 601 (2003), 117 Stat. 2066 (2003).

also opting not to participate in Medicare or Medicaid, especially so-called "boutique" outpatient facilities.[74] Even the Mayo Clinic has decided it will no longer accept assignment of Medicare reimbursement and will become a non-participating provider.[75] Non-participation is different than opting out of Medicare, a formal process by which the physician agrees to totally reject Medicare reimbursement for a period of two years and that allows the physician to be reimbursed only by a private contract between the physician and the patient. Opting out is still rather rare. Non-participation is no longer unusual, though, as it forces the physician to receive lower Medicare reimbursement but allows the physician to "balance-bill" the patient, which is otherwise prohibited.[76]

A recent on-line survey by the AMA found that 48% of the physicians surveyed either have limited the number of Medicare patients they will see or plan to impose limits soon due to the decreasing reimbursement rates for physicians.[77] Further, 61% of primary care physicians and 44% of specialists surveyed stated that they would be forced to place limitations on the number of Medicare patients that they treat due to the planned cuts in physician reimbursement rates by Medicare.[78] While this trend was stemmed by the emergency increase in physician reimbursement rates, the informal poll was telling. Physicians recognize that the business of medicine is changing, but the problem is that the need for medical care is unchanging.[79]

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[74] *See* Adrian E. Hirsch, *The Search for Nurses*, THE GREATER BATON ROUGE BUS. REP., Jan. 7, 2003, at 44, 45 (reporting that hospitals that choose not to participate in Medicare and Medicaid have greater flexibility in compensation packages and less paperwork, giving them competitive advantages).

[75] Sarah Skidmore, *Ready or Not, Patients Take on Medicare from Mayo: Mayo Clinic's Medicare Status Changes Tomorrow*, FLORIDA TIMES-UNION, Dec. 31, 2002, at E1; *see also Medicare Rates Won't Meet Costs, HMOs Say*, WASH. POST, Jan. 18, 2002, at A4 (describing the trend of managed care plans leaving the Medicare program due to insufficient government payments).

[76] Generally, participating physicians cannot obtain payment from Medicare patients except for the requisite co-payment or deductible. Otherwise, participating physicians must accept the Medicare calculus for payment, which is generally lower than the physician's actual cost of providing care. *See, e.g.*, 42 U.S.C. § 1395w-4(g) (2000).

[77] AM. MED. ASS'N, NEW AMA SURVEY -- ABOUT HALF OF PHYSICIANS WILL LIMIT THE NUMBER OF MEDICARE PATIENTS THEY TREAT IN 2003 (describing the significant number of physicians limiting the number of patients they see, because of government payment cuts), *at* http://www.ama-assn.org/ama/pub/article/1616-7207.html (Jan. 23, 2003).

[78] *See Half of Surveyed Doctors to Limit Medicare Patients*, 12 HEALTH L. REP. (BNA) 169 (Jan. 30, 2003) (reporting the results of an online survey by the AMA).

[79] *See, e.g.*, AM. MED. ASS'N, THE BUSINESS OF MEDICINE: A COLORADO CARDIOLOGIST SPEAKS OUT ABOUT MEDICARE, MEMBERSHIP AND MORE (discussing the

Such dramatic reactions were temporarily alleviated by House Joint Resolution 2, which prevented further reductions in Medicaid reimbursement for physicians, and by the Medicare Modernization Act, which gave physicians an increase in reimbursement for 2004 and 2005 rather than the usual yearly decrease.[80] These measures only place a tiny bandage on the gaping wound, however, because the rate of reimbursement simply has not increased at the pace that the cost of medical care has risen.[81] In fact, despite the increase in reimbursement that Congress pushed through for this calendar year, the update must be maintained and projected forward in order to prevent a boomerang decrease in physician payments in 2006 and 2007 that will result from the immediate increases in reimbursement.[82] Because financial concerns are an on-going issue, and because of the limitations placed on their financial relationships with other health care providers, physicians will have to continue to find ways to cut corners and cut costs.

The undeniable conclusion is that physicians, regardless of strenuous objections to the contrary, are influenced by financial gain. Allowing them to be engaged by corporations that are not *per se* licensed to practice medicine would not change this fact. On the other hand, limiting the corporate practice of medicine doctrine's reach could help to advance the effort to improve quality of care.

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difficulties that doctors face in caring for patients amidst rising health care costs), *at* http://www.ama-assn.org/ama/pub/article/3216-7144.html (last updated Jan. 7, 2003).

[80] *See, e.g.*, Pub. L. No. 108-7, § 3 Division G, 117 Stat. 11 (2003) (allocating funds to the states under the Social Security Act for unanticipated costs for Medicaid). The Medicare Prescription Drug, Improvement and Modernization Act instituted a 1.5 % increase rather than a 4.4% decrease. *See* Pub. L. No. 108-173 § 601 (2003), 117 Stat. 2066 (2003).

[81] This is accepted as a true statement for all types of health care providers, not just physicians. *See, e.g.*, Lisa M. Fairfax, *Doing Well While Doing Good: Reassessing the Scope of Directors' Fiduciary Obligations in For-Profit Corporations with Non-Shareholder Beneficiaries*, 59 WASH. & LEE L. REV. 409, 417-18 (2002) (discussing the decline in reimbursement as a significant force behind the conversion of hospitals to for-profit). *See also* Miriam L. Clemons, *Don't Shoot the Messenger: Independent Physicians and Joint Payment Contracting Using the Messenger Model*, 32 U. MEM. L. REV. 927, 933-34 (2002) (citing falling reimbursement as a cause for the failure of physician practice integration, and thus as a means to counteract the decline through collective bargaining).

[82] *See* Markian Hawryluk, *Physicians Fight to Preserve Pay Increase in Medicare Bill*, A.M. NEWS, July 14, 2003 (noting a view that increased reimbursement is key to ensuring patients' access to physicians who serve the Medicare population), *available at* http://www.ama-assn.org/amednews/2003/07/14/gvl10714.htm.

III. NEUTRAL TO NEGATIVE IMPACT ON QUALITY OF CARE

It is important to understand the ways in which the corporate practice of medicine doctrine is not just outdated but also potentially damaging to the development and growth of health care delivery systems. This section will discuss three areas that demonstrate the ways in which the doctrine impacts on larger, national health care issues. First, the Institute of Medicine has written three reports that provide support for rethinking the corporate practice of medicine doctrine within the context of overhauling the system of American health care delivery. Second, within the important and highly publicized topic of fraud and abuse prevention, the Department of Health and Human Services Office of the Inspector General (the "OIG") has recognized the need for all health care providers to cooperate as part of an interconnected system. Third, medical malpractice law and general tort law theory have been evolving in a direction that ties physician liability to the oversight and responsibility of hospitals. Each of these developments strongly suggests that unification, not division, is the future of health care delivery and development.

A. Institute of Medicine Reports

The Institute of Medicine (the "IOM") was established by the National Academy of Sciences (the "NAS") to secure the services of eminent members of relevant professions to examine public health policy matters, and it acts under the authority given to the NAS by its Congressional charter to identify issues of medical care, research, and education.[83] As such, the IOM is considered a knowledgeable and unbiased source of information (and perhaps illumination) for many issues in the health care system.[84] Two recent monographs issued by the IOM, *To Err Is Human* and *Crossing the Quality Chasm*, and their follow-up reports, have been the subject of much press due to their dire descriptions of the quality of American health care and the number of medical errors that occur in the American health care system. While the two reports do not directly address the corporate practice of medicine doctrine, they provide strong support for rethinking the corporate practice of medicine doctrine due to the suggestions they make

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[83] *See* INST. OF MED., *at* http://www.iom.edu/about.asp (last visited Feb. 21, 2004) (describing the formation and mission of the Institute of Medicine of the National Academies).

[84] *See* INST. OF MED., MORE ABOUT THE INST. OF MED., *at* http://www.iom.edu/subpage.asp?id=4091 (last visited Feb. 21, 2004) (describing the characteristics of the Institute and the nature of its work).

for unifying and strengthening the "systems" of American health care delivery.

1. To Err Is Human

The focus of this monograph is patient safety.[85] The IOM advocates moving away from placing blame on individuals for lapses in medical care and moving toward a "systems" approach in order to modify the conditions that contribute to errors.[86] The IOM notes that the safety problem does not result from bad people, it results from a faulty health care system.[87] Thus, the IOM concludes that the system itself must be made safer by ensuring quality from the top down.[88] This means instituting error-free systems at the highest level and integrating efforts of all health care providers, whether corporations or individuals. For instance, the IOM suggests that health care organizations implement interdisciplinary educational programs to reduce errors so that all personnel, from the highest level of professional to the least skilled staff member, understand how to work as part of the whole to effectuate better treatment for the patient.[89] Such a recommendation recognizes the interconnectedness of health care delivery and does not allow for artificial barriers to patient care.

The point is further reinforced when the IOM describes that errors occur in all health care settings, but more often than not, an institution is involved.[90] Thus, system-wide efforts are necessary to make health care an error-free proposition.[91] The IOM makes the point that all of health care delivery, at every level of operation, from the microcosm of the operating room to the larger multi-hospital corporate conglomerate, is a system.[92] Because the IOM focuses on patient safety as

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[85] William C. Richardson, *Preface* to COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM, at ix-x (Linda T. Kohn et al. eds., 2000) [hereinafter TO ERR IS HUMAN].

[86] *See id.* at 156-57, 166-69, 173-74.

[87] *Id.* at 49, 169.

[88] *Id.* at 156-57.

[89] *Id.*

[90] This idea had been discussed before the IOM issued TO ERR IS HUMAN. *See, e.g.*, Jost, *supra* note 8, at 845 (stating that error is "inevitable and ubiquitous" and therefore cannot be eradicated by regulation alone).

[91] *See id.* at 849-67. *See also* TO ERR IS HUMAN, *supra* note 83, at 49-68.

[92] In discussing why errors occur, the monograph notes,

> Systems can be very large and far-reaching, or they can be more localized. In health care, a system can be an integrated delivery system, a centrally owned multihospital system, or a virtual system comprised of many different partners over a wide geographic area. However, an operating room or an obstetrical unit is also a type of system. Furthermore, any element in a system probably belongs to multiple systems. For example, one operating

"freedom from accidental injury," a patient-based perspective on medical errors, the IOM can see the health care delivery system from a different perspective than those who are constantly mired in its intricacies.[93] And what the IOM sees is the need for a combined effort.

Thus, the IOM recommends that health care entities and the physicians and other professionals affiliated with them make continually-improved patient safety a conscious goal through establishing patient safety programs that include, among other things, interdisciplinary, team-oriented training programs that incorporate proven methods of team management.[94] The IOM specifically recommends that reporting and analysis methods be developed within organizations so that safety can be part of the system, and it strongly recommends against blaming individuals.[95]

The fundamental concept is that health care providers must work as a multidisciplinary unit, as part of a whole system, in order to effectuate change toward safer health care delivery. Nowhere did the IOM encourage physicians to act as independent individuals who should reject the influence of corporations; in fact, the corporate structure is viewed as an important element in the systems-based approach that the IOM adopts.[96] It is an approach that has had proven results in other industries, and the IOM makes a strong argument for systems-based operations in health care as well.[97] Integration, not individual, is the key to the IOM's analysis, the antithesis of the foundation of the corporate practice of medicine doctrine.

2. Crossing the Quality Chasm

In a related study, the IOM discussed more broadly how the health care delivery system can be redesigned in order to innovate and

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> room is part of a surgical department, which is part of a hospital, which is part of a larger health care delivery system . . . . When large systems fail, it is due to multiple faults that occur together in an unanticipated interaction, creating a chain of events in which the faults grow and evolve.

Id. at 52.

[93] *See id.* at 57-58 (explaining that, although others may define patient safety as a relative concept, the absolute capability of the system to permit safe care is paramount).

[94] *Id.* at 156, 173-74.

[95] *Id.* at 156-57 (stating that the majority of errors are not reported due to individuals' fear of punishment).

[96] *See id.* at 165-69. *See also* Jost, *supra* note 8, at 838 (observing that advances in technology and general industry reorganization have made it possible for non-professional managers to oversee the provision of health care in a way that promotes quality of care).

[97] *See* TO ERR IS HUMAN, *supra* note 85, at 159-62 (discussing the utility of safety systems in high risk industries such as chemical processing and mining).

improve care. *Crossing the Quality Chasm* articulated the goal of building a stronger, higher-quality health care system capable of delivering modern health care to all Americans.[98] Part of the agenda for achieving that goal, according to the IOM, requires cooperation among clinicians, meaning that "[c]linicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care."[99] As with the suggestions in *To Err Is Human*, it is clear that the health care delivery system envisioned by the IOM is one of increased integration.[100] The IOM asserts that the new paradigm must go beyond "prerogatives and roles" to embrace "good communication among members of a team, using all the expertise and knowledge of team members and . . . sensibly extending roles to meet patients' needs."[101]

The IOM also recognizes that all currently-existing payment methods affect behavior and quality of care.[102] For instance, while fee-for-service reimbursement raises concerns about overuse, capitation payments raise concerns about under-use. Essentially, the IOM argues that no current payment method properly aligns financial in-

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[98] COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 4 (2001) [hereinafter CROSSING THE QUALITY CHASM].

[99] *Id.* at 8-9. This is just one part of the ambitious agenda set forth by the IOM. The agenda also includes such goals as:

- That all health care constituencies, including policymakers, purchasers, regulators, health professionals, health care trustees and management, and consumers, commit to a national statement of purpose for the health care system as a whole and to a shared agenda of six aims for improvement that can raise the quality of care to unprecedented levels.
- That clinicians and patients, and the health care organizations that support care delivery, adopt a new set of principles to guide the redesign of care processes. . . .
- That health care organizations design and implement more effective organizational support processes to make change in the delivery of care possible. . . .

Id. at 5 (showing that increased integration and cooperative functioning are integral to the IOM's vision of improved healthcare delivery).

[100] *See id.* at 28, 138-39 (arguing that the current health care delivery system is both decentralized and poorly organized, and requires collaboration and interdependence to promote safety and quality). The IOM notes that the current structure of the health care system rewards individual competence and "protect[s] professional prerogatives and separate roles," whereas the system should reward "cooperation and teamwork," and thereby discourage the establishment of individual fiefdoms. *Id.* at 83.

[101] *Id.* (citing Roger J. Bulger, *The Quest for the Therapeutic Organization*, 283 JAMA 2431 (2000)) (discussing the benefits of a team-based approach to health care).

[102] *Id.* at 17.

centives with the goal of quality improvement, and, accordingly, all health care reimbursement systems should be re-examined.[103] These observations comport with the assertions in this article that, despite the AMA's protests, physicians (and all health care providers) are influenced by financial gain or loss. The IOM makes a strong point that current payment policies should be wholly revised to positively influence health care providers in order to "align[] . . . payment incentives with quality improvement."[104] It is an important observation because not all financial influence is inherently malevolent. Properly aligned, physicians and corporate entities have the potential to positively affect patient care.

The alignment of incentives is also important, according to the IOM, because the current health care system is too decentralized and too complex for patients to navigate.[105] The study shows that health care delivery processes are complex and lack fluidity, requiring a variety of "handoffs" that slow down the process of providing care and that decrease safety.[106] According to the IOM, health care should be seamless; services should be provided as part of a unified whole where information and technology are available in all parts of the chain of care.[107] If the current prohibitions against corporate practice of medicine are allowed to stand, the envisioned "chain of care" will be virtually impossible to achieve.

Nowhere does the IOM suggest that doctors should function as solitary islands in the stream of health care. In both *To Err Is Human* and *Crossing the Quality Chasm*, physicians are expected to work as a cog in the wheel of an interconnected, interactive health care delivery system. Further, corporations are regarded as an inevitable part of the health care delivery system. The IOM consistently expresses that

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[103] *Id.* at 17-19. The IOM observes,

> All payment methods affect behavior and quality. For example, fee-for-service payment methods for physicians and hospitals raise concerns about potential overuse of services—the provision of services that may not be necessary or may expose the patient to greater potential harm than benefit. On the other hand, capitation and per case payment methods for physicians and hospitals raise questions about potential underuse—the failure to provide services from which the patient would likely benefit. Indeed, no payment method perfectly aligns financial incentives with the goal of quality improvement for all health care decision makers, including clinicians, hospitals, and patients.

Id. at 17.

[104] *Id.* at 17-19.

[105] *See generally id.* at 28-29.

[106] *Id.*

[107] *See id.* at 47 (discussing the importance of evidence-based practice, which requires the clinician to integrate scientific information with clinical expertise).

concern should focus on accountability at all levels for quality and safety of care, regardless of corporate structure or governance.

The IOM followed-up on *To Err Is Human* and *Crossing the Quality Chasm* in a third report on quality of health care in America entitled *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality.*[108] Congress specifically commissioned the IOM to analyze the quality of care and potential for improvement in six government-sponsored health care programs, including Medicare and Medicaid. The IOM determined that improving quality of care in the six studied programs would force improvements in the entire health care system because, together, the programs treat approximately 100 million Americans. *Leadership by Example* challenges the federal government to set the quality standard for the health care industry by rewarding improvements in quality, using health care delivery systems as models for integrating care, and increasing research and applying its results to improve quality of care.[109] Once again, the IOM encourages more active integration of health care delivery systems to improve quality of care.

B. Other Governmental Guidance

Similar ideas have been expressed in other important health care industry guidance, such as the OIG's guidance for physician corporate compliance plans.[110] The OIG is the federal agency that interprets and enforces the anti-kickback statute and other health care fraud and abuse laws through such mechanisms as Advisory Opinions, Special Fraud Alerts, and guidance for corporate compliance plans for different types of health care entities.[111] In the guidance for physician group practices, the OIG suggests strongly that physicians work with larger institutions on their corporate compliance plans to take advantage of economies of scale.[112] In its press release, the OIG wrote that

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[108] COMM. ON ENHANCING FEDERAL HEALTH CARE QUALITY PROGRAMS, INST. OF MED., LEADERSHIP BY EXAMPLE: COORDINATING GOVERNMENT ROLES IN IMPROVING HEALTH CARE QUALITY (Janet M. Corrigan et al. eds., 2003), *available at* http://www.nap.edu/books/0309086183/html/ [hereinafter LEADERSHIP BY EXAMPLE].

[109] *See id.* at 1.

[110] *See* Office of Inspector Gen., Dep't of Health and Human Services, OIG Compliance Program for Individual and Small Group Physician Practices, 65 Fed. Reg. 59434 (October 5, 2000), *available at* http://oig.hhs.gov/authorities/docs/physician.pdf.

[111] *See generally* OFFICE OF INSPECTOR GEN., DEP'T OF HEALTH AND HUMAN SERVICES, *at* http://oig.hhs.gov.

[112] The OIG acknowledged the importance of collaboration, while recognizing the potential for remuneration presented by physician participation with larger entities, by stating:

it "encourages physician practices to participate in the compliance programs of other providers, such as hospitals or other settings in which the physicians practice. A physician practice's participation in such compliance programs could be a way, at least partly, to augment the practice's own compliance efforts."[113] Thus, despite concerns about the potential for improper remuneration, the OIG recognizes the need for health care providers to work as part of an interconnected system.[114] This OIG guidance pre-dated the IOM reports on health care quality, but the two dovetail and lead to similar conclusions that physicians must be permitted to fully integrate in order to function in the current health care market.

Economies of scale and common learning about corporate compliance and other issues can drive the effort for greater quality of care and efficiency in communication. If states continue to interpret licensure laws to prevent formal or informal associations between hospitals (and other corporate health care entities) and physicians, however, such efforts will never leave the ground. Increased emphasis on enterprise liability and enterprise responsibility further augment the position that the physician cannot operate as a stand-alone health care provider in modern health care delivery.

C. Further Evidence: Movement toward Entity Liability and Entity Responsibility

Tort law has been evolving in a manner that also suggests increased integration of the delivery of health care and that ties physician services to the corporate control of hospitals and other entities.[115] By example, vicarious negligence has been accepted as a theory of

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> The OIG encourages . . . collaborative effort, where the content is appropriate to the setting involved (i.e., the training is relevant to physician practices as well as the sponsoring provider), because it provides a means to promote the desired objective . . . . However, to prevent possible anti-kickback or self-referral issues, the OIG recommends that physicians consider limiting their participation in a sponsoring provider's compliance program to the areas of training and education or policies and procedures.

OIG Compliance Program for Individual and Small Group Physician Practices, 65 Fed. Reg. at 59437.

[113] Office of Inspector Gen., Dep't of Health and Human Services, *News Release: Inspector General Issues Voluntary Compliance Program Guidance for Physician Practices* (Sept. 25, 2000), *available at* http://oig.hhs.gov/fraud/docs/press/phycomp.htm.

[114] *See supra* notes 59-70 and accompanying text.

[115] As recently as the 1950s, the doctrine of charitable immunity was applied to hospitals, exempting them from liability. *But cf.* Bing v. Thunig, 143 N.E.2d 3, 9 (N.Y. 1957) (noting that the rule of non-liability is "out of tune" with modern needs and declaring hospitals subject to the same rules of liability as all employers).

hospital liability through the premises of ostensible agency and apparent authority, regardless of the employment status of the offending physician (employee or independent contractor).[116] Similarly, hospitals have been held liable for patients' injuries when they have failed to credential and/or supervise physicians properly, and when they have failed to ensure that facilities and equipment necessary for patient care are reasonably available.[117] The American Law Institute historically has suggested that exclusive hospital liability would be more efficient and promote quality better when a physician negligently causes medical injury in a hospital; but this is an unpopular theory because it includes absolving physicians from legal liability.[118]

While the purpose of this article is not to advocate for entity liability, the movement toward modifying tort liability in this way provides a notable example of the ways in which physicians are no longer independent in providing health care services and how their professional fate is tied to the environment in which they practice. Even when the relationship is merely one of independent contractor (not employee), hospitals have been found to be responsible for the actions of physicians in their facilities. Hospitals provide quality assurance mechanisms, utilization review mechanisms, and systems for tracking patient care that are fundamental to many physicians' (and other health care professionals') areas of specialty. In addition to medical staff bylaws, which create a standard of care of sorts for physicians on the medical staff, hospitals often have internal quality assurance manuals and safety standards by virtue of state law, to which physicians and other health care professionals must adhere in order to provide services in the hospital.[119] It would seem to be absurd to deter-

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[116] *See, e.g.*, Sword v. NKC Hosp., Inc., 714 N.E.2d 142, 150-52 (Ind. 1999) (holding that the hospital was liable for the negligent acts of an independent contracted anesthesiologist); Gragg v. Calandra, 696 N.E.2d 1282, 1287 (Ill. App. Ct. 1998) (stating that under the doctrine of apparent authority, a hospital can be vicariously liable for the negligent acts of a physician regardless of that physician's employment status); White v. Methodist Hosp. South, 844 S.W.2d 642, 648 (Tenn. Ct. App. 1992) (allowing for the possibility that anesthesiology staff might be liable as apparent agents of the hospital).

[117] *See, e.g.*, Washington v. Washington Hosp. Ctr., 579 A.2d 177, 181-83 (D.C. 1990) (holding that the hospital was liable for injuries resulting from a lack of appropriate blood monitoring equipment that was standard in other hospitals at the time of the injury); Bellamy v. Appellate Dept., 57 Cal. Rptr. 2d 894, 896-97 (Cal. Ct. App. 1996) (permitting a claim against a hospital for professional negligence).

[118] AM. L. INST., REPORTERS' STUDY ON ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY VOL. II 113 (1991) (describing the then-current institutional framework for dealing with personal injuries and analyzing potential approaches to legal and institutional change to place tort liability at a higher level of responsibility).

[119] *See generally* ALA. CODE § 22-21-8 (1997) (incentivizing internal quality insurance mechanisms by protecting them from discovery in civil lawsuits); ARK.

mine that physicians cannot be held to these standards simply because hospitals are corporations, and yet, courts have negated contracts on similar theories.[120]

Further, hospitals directly organize and deliver health care on a daily basis, and they necessarily exercise close control over professional conduct, facilities, supplies, and bureaucratic procedures. Due to accreditation by such entities as the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"),[121] hospitals have been responsible for pursuing formal programs of institutional quality improvement, which necessarily requires the cooperation of the professionals who work in hospitals.[122] JCAHO explains its purpose as follows, "JCAHO has been accrediting hospitals for over 50 years . . . . JCAHO accreditation is a nationwide seal of approval that indicates organizations meet high performance standards. Our accreditation helps organizations improve their performance, raise the level of patient care, and demonstrate accountability in the rapidly changing health care marketplace."[123] JCAHO accreditation standards include such areas as emergency management planning, environment of care standards, medical staff standards, and patient safety standards and goals.[124]

Recognizing the need for hospitals to take a proactive, rather than reactive, stance on patient quality of care, JCAHO has recently created new standards for hospitals that go beyond reporting sentinel

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CODE ANN. § 23-76-108 (Lexis 1999) (mandating that the health care organizations maintain ongoing health care assurance program).

[120] For instance, hospitals have successfully defended against physicians' medical malpractice by asserting the corporate practice of medicine doctrine. *See, e.g.*, Rosane v. Senger, 149 P.2d 372, 374 (Colo. 1944) (noting that a hospital cannot be responsible for a physician's discharge of its professional duty). More recently, however, state courts have found that hospitals do have duties to adequately credential medical staff, ensure that they are appropriately monitored, and to uphold a proper standard of care in the hospital. *See generally* Thompson v. Nason Hosp., 591 A.2d 703, 707 (Pa. 1991); Simmons v. Tuomey Reg'l Med. Ctr., 533 S.E.2d 312, 318-20 (2000).

[121] *See generally* JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, *at* http://www.jcaho.org (last visited Mar. 1, 2004).

[122] Hospitals have long been involved in quality control through the mechanisms of "continuous quality improvement" and "total quality management," ideas that have been applied not only in the healthcare setting but also throughout industry in the United States and Japan. *See* Jost, *supra* note 8, at 838.

[123] JCAHO, HOSPITAL ACCREDITATION, *at* http://www.jcaho.org/htba/hospitals/index.htm (last visited Mar. 1, 2004).

[124] *See* JCAHO, STANDARDS FREQUENTLY ASKED QUESTIONS, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS (CAMH), *at* http://www.jcaho.org/accredited+organizations/hospitals/standards/hospital+faqs/index.htm (last visited Mar. 1, 2004).

events[125] and place the emphasis on teamwork and "effective communications among responsible care-givers" in order to prevent breakdowns in patient safety and quality of care.[126] Interestingly, in discussing the goals of improving quality of care, the president of JCAHO noted that professionals in the United States are trained to function as individuals in making day-to-day medical decisions, and that is no longer enough. The president cautioned that health care professionals need to be trained in "systems thinking and analysis" and noted that medical professionals now need to be trained "as interdisciplinary teams."[127]

Hospitals have taken the lead in quality of care issues, which is important for (at least) two reasons. First, it indicates recognition of the natural leadership role that hospitals, as some of the largest corporate health care entities, have in the American health care system. Despite the development of ambulatory surgery centers, clinics, and other sites of medical services, hospitals remain a hub in the wheel of health care. Even when physicians have competing interests in outpatient surgery centers, they must, as a practical matter, maintain staff privileges for in-patient procedures.[128] This was the thrust of the Supreme Court of Illinois' decision in *Berlin v. Sarah Bush Lincoln Medical Center*.[129] The *Berlin* court determined, given the way that health care delivery has developed (including the propagation of HMOs, employment of physicians by hospitals, and introduction of for-profit entities into health care delivery in general), that the public policy concerns that created the corporate practice of medicine doc-

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[125] The "sentinel event" reporting system was developed by JCAHO as a way to monitor serious errors or events that are detrimental to patient health and/or quality of care in the hospital setting through a system of self-reporting by hospitals. Reportable sentinel events include unanticipated patient death or permanent loss of function. The sentinel event system was launched in 1996, but JCAHO realized that the reactive system was not sufficient. *See Reducing Medical Errors: A Review of Innovative Strategies to Improve Patient Safety: Hearing Before the Subcomm. on Health of the House Comm. on Energy and Commerce*, 107th Cong. 24-28 (2002) (statement of Dennis S. O'Leary, President, The Joint Commission on Accreditation of Healthcare Organizations), *available at* http://www.jcaho.org/news+room/on+capitol+hill/oleary_test.htm.

[126] *Id.* at 26.

[127] *Id.* at 28.

[128] Interestingly, some hospitals have been denying staff privileges to physicians who hold investment interests in competing ambulatory surgery centers and specialty hospitals. *See* Reed Abelson, *Hospitals Battle For-Profit Groups for Patients*, N.Y. TIMES, Oct. 30, 2002, at C1. The OIG has solicited commentary on this recent development in the ever-evolving relationship between hospitals and health care professionals. *See* Solicitation of New Safe Harbors and Special Fraud Alerts, 67 Fed. Reg. 72894-95 (proposed Dec. 9, 2002) (to be codified at 42 C.F.R. pt. 1001).

[129] 688 N.E.2d 106, 113-14 (Ill. 1997).

trine should be inapplicable to licensed hospitals. The court found particularly influential a statement by the Kansas Supreme Court that "[i]t would be incongruous to conclude that the legislature intended a hospital to accomplish what it is licensed to do without utilizing physicians as independent contractors or employees . . . . To conclude that a hospital must do so without employing physicians is not only illogical but ignores reality."[130] The symbiotic relationships that exist today cannot be ignored and should not be limited by outdated doctrine.

Second, hospitals' leadership role in quality improvement indicates a willingness to work with other health care professionals to modify the current deficiencies in delivery of care, which should be encouraged, not blocked. In this regard, the corporate practice of medicine doctrine can do nothing but stand in the way of increased quality of care. This is not to say that we should attempt to integrate hospitals and physician groups, a trend that appears to have failed in the 1990's.[131] But we have seen that state courts are unwilling to totally eradicate the corporate practice of medicine doctrine, even when they are willing to limit its reach in obvious circumstances.[132]

The unfortunate result of states' failure to see past their limited usefulness in licensure of health care professionals is that quality of care, increased cooperation and coordination in delivery of care, and general principles of equity will continue to suffer. Thus, this article attempts to provide a tenable solution to the discord created by state law in the form of federal legislation.

IV. PROPOSAL: FEDERAL LEGISLATION

In the interest of continuing to ensure that physicians can make medically independent decisions, but also recognizing the escalating costs of health care in the United States and the need to function with

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[130] 688 N.E. 2d at 114, *quoting* St. Francis Reg'l Med. Ctr. v. Weiss, 869 P.2d 606, 618 (1994).

[131] BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 878 (4th ed. 2001) (describing the failed efforts at integration and the dramatic failures of large systems that aggressively expanded).

[132] For instance, as was discussed above, even though Illinois notoriously rejected the corporate practice of medicine doctrine for state-licensed healthcare entities in *Berlin v. Sarah Bush Lincoln Medical Ctr.*, 688 N.E.2d 106 (Ill. 1997), Illinois courts refused to extend the exception to the corporate practice of medicine doctrine created in *Berlin* to nonprofit entities that were not licensed by the state. *See, e.g.*, Carter-Shields v. Alton Health Inst., 777 N.E.2d 948, 958-59 (Ill. 2002) (invalidating a contract between a physician and a nonprofit corporation because the nonprofit was not licensed to provide healthcare to the public, even though it was a charitable nonprofit organization).

increased quality and efficiency and without hurdles or obstacles in integrated health care delivery systems, federal legislation could provide a necessary solution. Such legislation could be similar to the HMO Act of 1973 and analogous (in preemption structure) to the conditions of participation that all health care providers must meet in order to receive Medicare or Medicaid reimbursement.

A. The HMO Act of 1973

The Health Maintenance Organization Act of 1973 (the "HMO Act") was created to foster the growth of HMOs in the United States by providing loans and loan guarantees to those wishing to create federally qualified HMOs and by preempting any state laws that would frustrate the creation of federally qualified HMOs.[133] More specifically, the stated purposes of the HMO Act were to decrease the cost of medical care, move the focus of care away from provision of acute care, and attempt to distribute medical resources more equitably.[134] Given their success in California where the structure originated, Congress viewed HMOs as a panacea to alleviate the problem of escalating costs in the American medical system.[135] Interestingly, the corporate practice of medicine doctrine and its legal counterparts were cited frequently as the reason for HMOs starting slowly in the United States, and the doctrine was part of the impetus for Congress to create the HMO Act.[136]

Recognizing that state laws could create obstacles in the federal scheme, the HMO Act preempted state law only inasmuch as a state's

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[133] Pub. L. No. 93-222, 1973 U.S.C.C.A.N. (87 Stat. 914) 3033, 3121-22; *see also* William F. Megna & Charles B. Lynch, *A Patients' Bill of Rights – Be Careful What You Ask For*, NEW JERSEY LAWYER, Oct. 2001, at 34.

[134] *See* 1973 U.S.C.C.A.N. 3122. The stated general findings for the purpose of the HMO Act were:

> (1) medical care is too expensive;
> (2) the medical care system is oriented toward the provision of acute care;
> (3) medical resources are maldistributed;
> (4) health maintenance organizations (HMO's) will assist in alleviating the above-mentioned problems;
> (5) technical and resource assistance is needed to establish and operate HMO's;
> (6) the quality of medical care varies excessively. The Senate bill also stated its purpose as the improvement of the health care delivery system through the support of the creation of HMO's.

Id.

[135] *Id.*

[136] *See generally* Francis J. Serbaroli, *The Corporate Practice Prohibition and Managed Care*, HEALTH L. & BUS. SER. (BNA) No. 2800.1001 (1999) (discussing that organized medicine and the corporate practice of medicine doctrine were responsible for the sporadic growth of HMOs at their inception).

law would prevent HMOs from operating under the terms of the federal law.[137] Otherwise, HMOs are required to comply with state laws, and they are licensed to operate in each state in which they provide services. Thus, the state laws that govern HMOs were allowed to stand so long as they do not contravene the intent or language of the federal law, an excellent example of express preemption and a coexisting statutory structure.

The clear benefit of express preemption is that, instead of struggling with implied preemption and whether field preemption or conflict preemption should be applied to the statute, state licensure laws can stand without any guesswork.[138] The difficulty with express preemption is envisioning every possible permutation of the corporate practice of medicine doctrine that needs to be usurped in order for the federal law to be effective. Further, courts have widely commented

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[137] The law reads 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,
>
> (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, or
>
> (E) imposes requirements which would prohibit the entity from complying with the requirements of this subchapter, 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.

42 U.S.C. § 300e-10 (2000) (emphasis added).

[138] Under Article VI of the United States Constitution (the Supremacy Clause), Congress creates laws that automatically usurp existing state law, unless the legislation states otherwise. U.S. CONST. art. VI, § 2. Because the question of degree, meaning how much state law is preempted by the federal law, is the general problem with preemption, the proposed statute must state as clearly as possible which state laws can stand and which do not. *See generally* N.Y. State Dep't of Soc. Services v. Dublino, 413 U.S. 405, 413 (1973) (explaining the Supreme Court's refusal to void state statutes in conflict with federal laws absent clear congressional intent for preemption).

(with dismay) on the lack of clarity in most instances of express preemption, which leads courts to guess at Congressional intent and to interpret the often ambiguous language used in the statute at issue.[139]

Despite any shortcomings, the presumption in favor of state law *not* being preempted calls for express preemption in the new statute.[140] Express preemption is particularly important because medicine is an area traditionally regulated by states under their police powers; thus, courts most likely would be reluctant to read broad preemption into any law intended to remedy even a long-standing problem with state medical laws. The Supreme Court has specifically stated that, in cases where the federal government has legislated in an area that the states traditionally or historically regulate under their police powers, Congress must set forth a clear intent to preempt state law.[141]

The HMO Act is an apt analogy for the statute that will be proposed herein. Insurance is an area of the law traditionally regulated by the states, which Congress recognized and addressed by expressly preempting any state law that would prevent an HMO from operating as set forth in the HMO Act. Though the law creating the corporate practice of medicine doctrine is more varied in its sources (licensure statutes, corporate law, case law, etc.), the proposed statute must set forth the kind and degree of preemption necessary. It would be risky to rely on the Supreme Court's interpretation of Congressional intent, especially in an area that has historically been the bailiwick of state law.

B. The Example of Medicare Conditions of Participation

Another example of a coexisting federal-state statutory scheme is the Medicare Conditions of Participation.[142] To participate in Medi-

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[139] ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 377 (2d ed. 2002) (citing Lorillard Tobacco Co. v. Reilly, 533 U.S. 525, 541 (2001) and Catherine L. Fisk, *The Last Article about the Language of ERISA Preemption?: A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35 (1996)).

[140] *See Dublino*, 413 U.S. at 413 (stating that the intent to preempt must be clearly set forth by Congress, as the Court is reluctant to interpret the Supremacy Clause too broadly).

[141] *See* Medtronic, Inc. v. Lohr, 518 U.S. 470, 485 (1996) (indicating respect for States as independent sovereigns and requiring express intent to preempt state law in fields that States traditionally occupied through exercise of police powers).

[142] The Conditions of Participation are found in: Ambulatory Surgical Services, 42 C.F.R. § 416 (2003); Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans, 42 C.F.R. § 417 (2003); Hospice Care, 42 C.F.R. § 418 (2003); Conditions for Medicare Payment, 42 C.F.R. § 424 (2003); Standards for Payment to Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded, 42 C.F.R. § 442 (2003); Conditions of Participation for Hospitals, 42 C.F.R. § 482 (2003); Home Health Services, 42 C.F.R. § 484 (2003);

care, all health care providers must meet federal standards for their specific type of health care entity, called "conditions of participation." By example, a hospital must comply with the federal Hospital Conditions of Participation not only to become a Medicare Provider but also to maintain good standing in the Medicare program.[143] In addition to meeting the federal standards, a hospital must also meet state requirements for licensure, and other state-imposed standards, or the hospital cannot receive reimbursement.[144] Each of the regulatory sections that delineate conditions of participation for each type of health care entity contains similar requirements that mandate compliance both with federal standards and with state law.

Theoretically, the Medicare conditions of participation could provide an extant structure into which the federal remedy for the corporate practice of medicine doctrine might be inserted; however, such a structure would have serious limitations. First, the conditions of participation only reach certain entities that participate in Medicare, not the state laws directly, so entities that do not participate in Medicare would not be reached by an addition to the conditions of participation. Second, states would not be forced to discontinue the case law that has developed around the corporate practice of medicine doctrine, as the Medicare conditions of participation impose requirements on health care providers only. While this might prevent the use of the corporate practice of medicine doctrine as a shield (as from malpractice suits or from restrictive covenant enforcement[145]), it would not

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Conditions of Participation: Specialized Providers, 42 C.F.R. § 485 (2003); and Laboratory Requirements, 42 C.F.R. § 493 (2003).

[143] The regulatory subchapter begins, "[h]ospitals participating in Medicare must meet certain specified requirements; and . . . [t]he Secretary may impose additional requirements if they are found necessary in the interest of the health and safety of the individuals who are furnished services in hospitals." 42 C.F.R. § 482.1(a)(1).

[144] The condition of participation for hospitals reads:

> (a) The hospital must be in compliance with applicable Federal laws related to the health and safety of patients.
>
> (b) The hospital must be–
>
> (1) Licensed; or
>
> (2) Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals.
>
> (c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.

42 C.F.R. § 482.11. *See also* Home Health Services, 42 C.F.R. § 484.10-55 (2003) and Certification of Certain Health Facilities, 42 C.F.R. § 491.4 (2003).

[145] *See, e.g.*, United Calendar Mfg. Corp. v. Huang, 463 N.Y.S.2d 497 (N.Y. App. Div. 1983). In *Huang*, two physicians were able to use the corporate practice of medicine doctrine to their benefit in order to void a restrictive covenant that had been imposed by an unlicensed entity that had employed them. The court found that the contract was illegal and that the physicians could not be restricted by the unlicensed

stop state courts or regulators from reading the doctrine into existing state law or enforcing the doctrine against health care providers. Third, CMS would likely require legislative action by Congress to address corporate structures effectively in the conditions of participation; if Congress is needed for the action, then fully realized and novel legislation is the plenary and more solid route.

Nevertheless, the conditions of participation provide a solid example of effective co-regulation in the health care arena by federal and state agencies. Though current Supreme Court jurisprudence does not favor Congressional regulation in areas historically dominated by state law, practically speaking, such legislation can be successful. The next section examines whether regulating in an area traditionally left to the states is tenable.

C. Congressional Power to Create "Traditionally State" Statutes

To propose federal action without a brief discussion as to whether the medical industry can be deemed interstate commerce would be remiss.[146] But the discussion must be analyzed in two parts, as the issue is not simply whether the health care industry can be considered interstate commerce, but also whether the Supreme Court would take issue with Congress creating a statute to govern in an area that the states traditionally have regulated. The first issue is somewhat simpler to parse than the second, which has been discussed in dicta more often than not.

1. Health Care as Interstate Commerce

In the now-notorious decision, Justice Rehnquist set forth a three part test in *U.S. v. Lopez*[147] to determine whether Congress could leg-

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corporation. The court also noted that the lower court had reported the plaintiff and the defendants to the state attorney general, *id.* at 499, proving that no physician is safe unless the corporate practice of medicine doctrine is eradicated. This case was a lose-lose scenario in the end.

[146] *See generally* U.S. CONST. art. I, § 8, cl. 3. In addition, the source of Congressional authority to create legislation such as the HMO Act and the Medicare Conditions of Participation is the Spending Clause. U.S. CONST. art. I, § 8, cl. 1. The Spending Clause power could be described, without much controversy, as a simpler and broader power than Commerce Clause power, which has been narrowed and inconsistently reinterpreted since *U.S. v. Lopez*. Nevertheless, it would be difficult and impractical to create federal legislation under the Spending Clause to address the corporate practice of medicine doctrine, because the goal would be to touch all aspects of healthcare, not just those that are funded by Medicare, Medicaid, and other federal healthcare programs. Thus, the Spending Clause will not be considered here.

[147] 514 U.S. 549, 558-59 (1995).

islate in a particular area under its Commerce Clause power.[148] According to the Court, Congress may "regulate the use of the channels of interstate commerce . . . . regulate and protect the instrumentalities of interstate commerce, or persons or things in interstate commerce, even though the threat may come only from intrastate activities . . . [and] Congress' commerce authority includes the power to regulate those activities having substantial relation to interstate commerce, i.e., those activities that substantially affect interstate commerce."[149] Obviously, the most likely avenue for Congressional power is the last category enumerated in *Lopez*, activities that have a substantial effect on interstate commerce. The decision in *United States v. Morrison* is key to parsing the third part of the *Lopez* test.[150]

It is now well known that *Morrison* reaffirmed the decision in *Lopez* and narrowed Congress' power to legislate based upon findings that a seemingly non-economic activity had "substantial effects" on interstate commerce.[151] The Court in *Morrison* described four "considerations" for determining that a substantial effect on interstate commerce will be found.[152] The four considerations were an apparent attempt at a methodical approach to defining "substantial effects" on interstate commerce (an inherently nebulous concept); each of the

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[148] Legal scholars and the legal community generally recognize that the Court changed the face of Commerce Clause jurisprudence in *U.S. v. Lopez*; such a discussion is outside the scope of this article. *See generally* LaMar F. Jost, Case Note, *The Commerce Clause in the New Millennium: Enumeration Still Presupposes Something not Enumerated:* U.S. v. Morrison, 1 WYO. L. REV. 195, 210-12 (2001) (referencing the "explosion of scholarly work" spawned by the *Lopez* decision); CHEMERINSKY, *supra* note 139, at 266-68 (noting that *Lopez* was not merely an aberration, but "the beginning of a major change" in Commerce Clause jurisprudence); Symposium, *Reflections on United States v. Lopez*, 94 MICH. L. REV. 533 (1995); Nicole Huberfeld, Note, *The Commerce Clause Post-*Lopez*: It's Not Dead Yet*, 28 SETON HALL L. REV. 182 (1997).

[149] *Lopez*, 514 U.S. at 558-59 (citations omitted).

[150] 529 U.S. 598 (2000).

[151] *Id.* at 617-18 (stating that Congress may not regulate a non-economic activity based only the activity's aggregate effect on interstate commerce).

[152] The four part test is as follows. First, the Court noted that "*Lopez*'s review of Commerce Clause case law demonstrates that in those cases where we have sustained federal regulation of intrastate activity based upon the activity's substantial effects on interstate commerce, the activity in question has been some sort of economic endeavor." *Id.* at 611 (citation omitted). Second, the law being challenged should contain a jurisdictional element that limits the reach of the law to a set of activities, and which have an effect on interstate commerce. *Id.* at 611-12. Third, formal findings by Congress can allow the Court "to evaluate the legislative judgment that the activity in question substantially affect[s] interstate commerce, even though no such substantial effect [is] visible to the naked eye." *Id.* at 612 (citation omitted). Fourth, the link between the regulated activity and the effect on interstate commerce cannot be "attenuated." *Id.* (citation omitted).

four points can be met by the health care industry. First, health care is an economic endeavor for all parties involved; the Medicare system of health insurance is a microcosmic example of this assertion. All reimbursement that flows from Medicare is for items or services, which ranges from medical care, to the provision of durable medical equipment, to the purchase of pharmaceutical drugs and medical devices. Health care, unlike carrying guns in school zones or other criminal activities that have been found not to qualify as "Commerce," is indubitably an economic activity. Second, a statute could be drafted to limit its reach to certain aspects of the corporate relationships that exist in the health care industry to comply with *Morrison*. Third, should the interstate nature of health care not be readily apparent, Congress can turn to the Government Accounting Office to provide a report that would support findings for this legislation. The Supreme Court, even after *Lopez* and *Morrison*, will still seek to understand Congressional findings regarding the nature of the activity being regulated.[153] Fourth, the link between regulating corporate structures and the delivery of medical care is not attenuated. The health care industry involves shipping pharmaceuticals, medical devices, disposable materials, even human organs, and many other materials across state lines. Patients regularly travel to different states in order to obtain health care services, particularly for specialized care in areas where physicians or health care entities have established themselves as unique experts.[154] In addition, physicians are often licensed in multiple states and (with telemedicine technology advancing every day) consult not only nationally, but internationally. The multi-state nature

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[153] *See Morrison*, 529 U.S. at 614-15 (noting that Congressional findings are important in determining whether legislation fits within the Commerce Clause framework, but not to the exclusion of judicial scrutiny in instances where the exercise of Congressional power is questionable). *See also* U.S. v. Gregg, 226 F.3d 253, 261-67 (3d Cir. 2000) (noting that the findings set forth by the House and Senate committees established a rational basis upon which Congress could rely and to which the courts should defer).

[154] A related debate exists when discussing patients' willingness to travel for care: studies have shown that the more procedures that are performed by a person or entity, the better outcomes that person or entity will have. Some see this as an argument for adding a layer to the certificate of need process that still exists in some states. *See* Richard Pérez-Peña, *Study Finds Many Doctors Performing Surgery Lack Practice with Procedures*, N.Y. TIMES, Feb. 10, 2003, at B5. The articles states:

> Dozens of studies have shown that a patient has a much higher risk of serious injury or death at the hands of a surgeon or hospital that handles a particular procedure infrequently. Patient advocates . . . say the numbers point to a need for the New York State Department of Health and the hospitals themselves to limit which hospitals and doctors provide certain services.

Id. The utility of certificates of need debate is outside the scope of this article.

of medicine forces physicians to comply with often-conflicting licensure and corporate laws.

The line of cases upholding the Freedom of Access to Clinic Entrances Act ("FACE") illuminates the widely-held agreement among the circuit courts that health care is a national industry with which Congress may properly concern itself and legislate accordingly.[155] Starting with *Cheffer v. Reno*,[156] and continuing through *Norton v. Ashcroft*,[157] the federal circuit courts have consistently held, both before and after *U.S. v. Lopez* and *U.S. v. Morrison*, that Congress' Commerce Clause power is able to reach the health care industry.[158] The Supreme Court recently rejected a bid by anti-abortion protesters to examine FACE, which has left standing the agreement among the circuits that Congress has properly exercised its Commerce Clause authority in creating FACE.[159] The reasoning in the FACE line of cases has been consistent.[160] As the *Gregg* court summarized, the actions of abortion protesters were deemed properly regulated by Congress because they directly affected an economic activity, namely the provision of services by reproductive health clinics, entities that are "income-generating businesses that employ physicians and other staff to provide services and goods to their patients."[161] The court distinguished the provision of health care from the activities regulated by statutes that had been struck down by the Supreme Court in more recent decisions. Unlike the Violence against Women Act, which

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[155] The circuit courts have consistently held that FACE is valid under the Commerce Clause. *See* United States v. Gregg, 226 F.3d 253, 262 (3d Cir. 2000), *cert. denied*, 532 U.S. 971 (2001); United States v. Hart, 212 F.3d 1067, 1074 (8th Cir. 2000), *cert. denied*, 531 U.S. 1114 (2001); United States v. Weslin, 156 F.3d 292, 296 (2d Cir. 1998), *cert. denied*, 525 U.S. 1071 (1999); Hoffman v. Hunt, 126 F.3d 575, 588 (4th Cir. 1997), *cert. denied*, 523 U.S. 1136 (1998); United States v. Bird, 124 F.3d 667, 682 (5th Cir. 1997), *cert. denied*, 523 U.S. 1006 (1998); Terry v. Reno, 101 F.3d 1412, 1418 (D.C. Cir. 1996), *cert. denied*, 520 U.S. 1264 (1997); United States v. Soderna, 82 F.3d 1370, 1373 (7th Cir. 1996), *cert. denied sub nom.* Hatch v. United States, 519 U.S. 1006 (1996); United States v. Dinwiddie, 76 F.3d 913, 919 (8th Cir. 1996), *cert. denied*, 519 U.S. 1043 (1996); United States v. Wilson, 73 F.3d 675, 683 (7th Cir. 1995), *cert. denied*, 519 U.S. 806 (1996); Cheffner v. Reno, 55 F.3d 1517, 1520 (11th Cir. 1995).

[156] 55 F.3d at 1519-21.

[157] 298 F.3d 547 (6th Cir. 2002).

[158] *See Gregg*, 226 F.3d at 262.

[159] Norton v. Ashcroft, 298 F.3d 547 (6th Cir. 2002), *cert. denied*, 537 U.S. 1172 (2003). *See also Justices Let Stand Ruling that FACE Does Not Violate Free Speech of Protesters*, 10 HEALTH L. REP. (BNA) 168 (Jan. 30, 2003). This denial of petition for certiorari also leaves standing the decision that FACE does not violate the First Amendment rights of the anti-abortion protesters that violate its proscriptions. *See Norton*, 298 F.3d at 552-53 (describing FACE as content-neutral).

[160] *Gregg*, 226 F.3d at 261.

[161] *Id.* at 262.

sought to regulate criminal activity directed at women, or the Gun-Free School Zones Act, which sought to keep firearms away from schoolchildren, the *Gregg* court acknowledged that a "national market" exists for certain health care services in the United States.[162] That market involves operations that generate income and provides services that the protesters sought to terminate entirely.[163] Thus, although the abortion protesters' motivations were not economic, the Third Circuit concluded that the legislation appropriately regulated commerce due to the widespread effects on economic activity.[164] The circuits are in agreement on this point of law.[165]

Many of the points that were made specifically in the context of abortion clinics can apply generally to health care in the United States. For instance, the Senate Committee describing the interstate commercial activities of abortion clinics could have been describing almost any health care facility, stating, "[t]hey purchase medicine, medical supplies, surgical instruments and other necessary medical products, often from other States; they employ staff; they own and lease office space; they generate income. In short, the Committee finds that they operate within the stream of interstate commerce."[166]

Conscionable, even persuasive, arguments thus can be made that Congress would have the power under the Commerce Clause to properly legislate a cure for the corporate practice of medicine doctrine. The descriptions of the business of medicine that applied in the clinic context are equally apt in discussing other types of health care entities and the services they provide. Hospitals, nursing homes, ambulatory care facilities, physical therapy centers, psychiatric care facilities, home health agencies, hospices—all purchase medicine, medical supplies, surgical instruments, and other medical products from across the country; and they employ staff, own and lease space and equipment, and generate income. If the argument has been acceptable to the circuit courts in the heated and often non-objective world of reproductive services clinics, then they equally pass the "straight face test" in the less emotionally-charged corporate practice of medicine arena. The discussion cannot end here, however, because the proposed statute would regulate in an area traditionally governed by states.

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[162] 226 F.3d at 266, n.4.

[163] *Id.* at 262 (explaining how anti-abortion protestors goal when violating FACE is to "temporarily and permanently interrupt the operations of reproductive health facilities and prevent individuals from accessing their services").

[164] *Id.* at 262-63.

[165] *Id.* at 261 (noting that the Third Circuit was one of the last appellate courts to examine FACE and that the court was aligning with the other circuit courts in its decision that FACE was a proper exercise of Congress Clause power by Congress).

[166] *Id.* at 264, citing S. REP. NO. 103-117, at 31 (1993).

2. Areas Traditionally Regulated by the States

An issue that has often arisen in Commerce Clause jurisprudence, but that is rarely the determining factor in the Court's holding, involves whether the federal government is attempting to legislate in an area that states traditionally regulate. The Court has been more likely to strike down federal legislation as overreaching the bounds of Commerce Clause power if Congress has attempted to usurp areas traditionally covered by the police powers of the states, such as family law, criminal law, or public health. The current trend in Supreme Court opinions seems to be to discuss this as a motivating but not determining factor, generally due to the opinion in *Garcia v. San Antonio Metropolitan Transit Authority*.[167] Again by example, *Lopez* and *Morrison* called into question all federal statutes that regulate areas traditionally governed by the states.[168] As a result, many statutes that fall within the states' police power, such as the Child Support Recovery Act,[169] have the potential to be subject to challenge. This is not simply due to the limiting nature of *Lopez* and *Morrison* vis-à-vis appropriate exercises of Commerce Clause power; the potential for this type of statute to be called into question derives from a long history of the Court challenging federal power to regulate areas traditionally reserved for the states. In many ways, this is the heart of the debate about the limits of federalism.[170]

In one of the most famous discussions of federal encroachment on state sovereignty, *Garcia v. San Antonio Metropolitan Transit Authority*, the Court determined that jurisprudential decisions cannot be made based on historical state functions and, therefore, to strike down federal legislation based upon fear of intruding in the states' traditional domain is an untenable method of reasoning through federalism and Commerce Clause issues.[171] In discussing the need to overrule

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[167] 469 U.S. 528 (1985) (holding that attempts to draw the boundaries of state regulatory immunity in terms of "traditional governmental functions" is both unworkable and inconsistent with established principles of federalism).

[168] *See, e.g.*, Daniel Robert Zmijewski, *The Child Support Recovery Act and Its Constitutionality after* U.S. v. Morrison, 12 KAN. J.L. & PUB. POL'Y 289 (2003) (analyzing whether *Lopez* and *Morrison* would invalidate Congress' use of the Commerce Clause to regulate the traditional state-governed area of family law).

[169] 18 U.S.C. § 228 (2000).

[170] *See Morrison*, 529 U.S. at 615 (stating "the concern that we expressed in *Lopez* that Congress might use the Commerce Clause to completely obliterate the Constitution's distinction between national and local authority seems well founded.").

[171] 469 U.S. at 546-47. *Garcia* was arguably overruled by subsequent legislation, but the fundamental discussion and analysis remain pertinent. *See* 42 U.S.C. § 2000d-7 (2000) (denying a sovereign immunity exception to any state who receives federal funding and violates a federal anti-discrimination law).

National League of Cities v. Usery,[172] the Court scrutinized the impossibility of defining "traditional" or "historical" state functions and the difficulty that federal courts had in applying the *Usery* standard.[173] The Court rejected the use of historical state roles as too gray to be useful or knowable, because history exists as a spectrum of state governance and power.[174] Conversely, the Court also rejected the notion of traditional or historical federal regulation in an area, drawing on the milestone transformation that the federal government underwent during the New Deal and the important expansion of the federal government's power to create legislation protective of civil rights starting in the 1960s.[175] The Court thus rejected a "sacred province of state autonomy." [176] Given the outright rejection of the "historical state domain" argument in *Garcia*, it is no surprise that this theory exists now only as a bolster for other Commerce Clause discussions. Nevertheless, more recent cases have spent enough time exploring historical state functions that the topic is not moot.[177]

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[172] 426 U.S. 833 (1976), *overruled by Garcia*, 469 U.S. at 557.

[173] *Garcia*, 469 U.S. at 543-47.

[174] The Court wrote:

> The most obvious defect of a historical approach to state immunity is that it prevents a court from accommodating changes in the historical functions of States, changes that have resulted in a number of once-private functions like education being assumed by the States and their subdivisions. At the same time, the only apparent virtue of a rigorous historical standard, namely, its promise of a reasonably objective measure for state immunity, is illusory. Reliance on history as an organizing principle results in line-drawing of the most arbitrary sort; the genesis of state governmental functions stretches over a historical continuum from before the Revolution to the present, and courts would have to decide by fiat precisely how longstanding a pattern of state involvement had to be for federal regulatory authority to be defeated.

Id. at 543-44 (footnotes omitted).

[175] *See id.* at 544, n.10.

[176] *Id.* at 554 (citing EEOC v. Wyoming, 460 U.S. 226, 236 (1983)).

[177] To briefly review an example, the Court in *Morrison* buttressed its analysis with a discussion of traditional state government roles. The heart of the rejection of the Violence against Women Act was that the behavior regulated, as characterized by the majority, was not in any way related to economic activity. 529 U.S. at 613. To strengthen the point, the majority wrote, "[w]e accordingly reject the argument that Congress may regulate noneconomic, violent criminal conduct based solely on that conduct's aggregate effect on interstate commerce. The Constitution requires a distinction between what is truly national and what is truly local." *Id.* at 617-18. The majority further noted that the aggregate effects on commerce argument, without an economic effect, could not be permitted because it would allow Congress to regulate "family law and other areas of traditional state regulation since the aggregate effect of marriage, divorce, and childrearing on the national economy is undoubtedly significant." *Id.* at 615-16. Of course, in a strongly worded and notorious dissent, Justice Souter criticized the majority for returning to the pre-New Deal form of jurisprudence, when a formalistic distinction between economic and non-economic activities

Admittedly, health care has been an area traditionally left to the states, but unlike violent crime, health care is considered an industry, a marketplace, and a profession, and is certainly an economic activity. Thus, even taking the majority in *Morrison's* federalism analysis at face value, it can be distinguished in this article's discussion because health care is *not* non-economic activity. One need only review the discussion in the FACE line of cases to recall that the circuits are in agreement on this point.[178]

The reasoning in this area is circular. If a power is enumerated in the Constitution, then Congress may exercise it. If a power is not enumerated, then it is reserved to the states. But if the power has been subject to fluctuating jurisprudence, or if arguments can be made for both fitting within an enumerated power and being relegated to an area that the states traditionally regulate, then the question is answered by a matter of perspective and interpretation, not by clear constitutional language. This conundrum was well described in *New York v. U.S.*, where the Court notes that the Tenth Amendment is "essentially a tautology."[179]

Despite the jurisprudential inconsistencies, a reasonable conclusion can be reached that Congress would have the power under the Commerce Clause, despite federalism concerns, to legislate in the field of the corporate practice of medicine doctrine. The next section ponders how such legislation could be drafted.

D. Creating a New Statutory Scheme

Much attention is being given to improving the quality of health care, containing costs, driving out fraud, and furthering the capitalist vision of the health care industry. It has become clear that the corporate practice of medicine doctrine is a shadowy, unknowable doctrine that is outdated and potentially obstructive. The doctrine creates a disparate system of state-based law that prevents physicians from fully integrating into health care delivery, which is, more and more, an interstate and national industry. Therefore, though the goal may have once been to ensure reliable medical care, the doctrine cannot promote quality of care today. The exclusive and independent nature of this

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in Commerce Clause jurisprudence lead to the court-packing plan and to jurisprudence that was inevitably overturned. *See id.* at 644-47. Justice Souter not so subtly accused the majority of returning to an unworkable economic/non-economic distinction to serve their personal viewpoints on federalism. *Id.* at 644-45. While Justice Souter may be correct, the accusations do not help the current analysis, which must focus on the majority's interest in traditional state roles.

[178] *See supra* notes 154-63 and accompanying text.

[179] 505 U.S. 144, 156-57 (1992).

guild doctrine is such that those who are protected by it will be inherently prevented from full participation in a national health care system. Further, given the federal and state governments' emphasis on fraud and abuse prevention and enforcement, physicians have quite clearly shown themselves to be influenced by financial incentives. Finally, the states seem to be unable to disentangle themselves from their individual corporate practice of medicine fiefdoms. Without the federal government's intervention, this doctrine will continue to hobble health care delivery and development.

A federal statute addressing the corporate practice of medicine doctrine would need to define "practicing medicine" to include individuals and corporate entities, regardless of a state's definition of "practicing medicine." The statute should clearly state that it is not intended to preempt state licensure law, but it would allow local rules of licensure and practice ethics to remain. The statute would function not unlike the Medicare Conditions of Participation, which add a layer of programmatic requirements that work in conjunction with state licensure law but that also allow states to make individualized determinations about issues that are traditionally within the realm of state police power.[180] Unlike the Medicare Conditions of Participation, this statute would not find the Constitutional basis of authority in the Spending Power; it would be grounded in Congress' authority to legislate under the Commerce Clause. Acknowledging that reliance on Commerce Clause power can be a tricky proposition, it is not farfetched given recent jurisprudence, as the discussion above has described.

The statute could fit in title 42 of the United States Code because it regulates public health and welfare, or title 18 of the United States Code, because it regulates commerce. By way of example, the act could read as follows:

> An Act to amend the Public Health Service Act to provide assistance and encouragement for the establishment of relationships between health care providers and to prevent interpretation of certain state laws from interfering in the relationships between physicians and other health care providers, whether they be persons, corporations, or other legal entities.
>
> Be it enacted by the Senate and House of Representatives of the United States of America in Congress Assembled:

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[180] See the discussion of Medicare conditions of participation, *supra* note 144 and accompanying text.

Section 1: This Act may be cited as the "Health Care Provider Unification and Quality Improvement Act."

Section 2: The Public Health Service Act is amended by adding after Title __ the following new title:

(a) Definitions:

For purposes of this subchapter,

(1) "Corporate practice of medicine" means any state law, set of laws, regulations, or common law that limits the practice of medicine to individuals and that interprets such laws to indicate that only individuals, and not corporations or other corporate entities, can practice medicine.

(2) "Health care provider" means any individual licensed to practice medicine, including medical doctors, doctors of osteopathy, nurse practitioners, physical therapists, occupational therapists, chiropractors, dentists, podiatrists, physician assistants, and any other person that is required to obtain a license to hold him or herself out as a health care practitioner.

(b) Corporations are hereby permitted to engage in the practice of medicine through duly licensed health care professionals and to contract with health care professionals to the extent necessary to obtain such services and to deliver health care in the most efficient and quality-conscious method.

(c) Each law that regulates the corporate practice of medicine is hereby preempted to the extent that such law conflicts with the provisions of this subchapter. This subchapter shall not be read to prevent states from licensing physicians or other health care providers, or to preempt state law of corporations, or to preempt state licensure standards for health care professionals or health care entities that function to protect the general health and welfare of state residents.

(d) This act shall not be interpreted to limit the proscriptions of or supercede any existing federal fraud and abuse prevention statute, including but not limited to 42 U.S.C. § 1320a-7b(b) and 42 U.S.C. § 1395nn.

(e) This act is effective as of ___, 200_.

Admittedly, this language is not perfect, but it would be a start in the right direction. (Doubtless the statute's provisions would be added to some omnibus legislation that would change its structure and context.) Whether the law would be a part of Title 18 or Title 42 is not important. What is important is to finally take the step that has been suggested for over two decades now. Though many have expressed frustration with the corporate practice of medicine doctrine, none have described a universal remedy. This could be the solution that is needed.

CONCLUSION

Given all of the debate and concern about quality of care, health care cost containment, and effectuating a health care system that is closer to the market-driven model of other systems in this country, the time has come to rid ourselves of this archaic doctrine. It does nothing to advance quality of care; its premise is outdated; and, given the federal government's dogged focus on fraud and abuse enforcement, it is disingenuous to continue to pretend that physicians are not influenced by financial gain. The corporate practice of medicine doctrine is the black sheep of licensure law, a convoluted interpretation of statutes that no longer legitimately protect the public. Federal statutory interference could help to end this wild ride.