

**PATIENT CARE AND
PROFESSIONAL RESPONSIBILITY:**
IMPACT OF THE CORPORATE PRACTICE OF
MEDICINE DOCTRINE AND RELATED LAWS
AND REGULATIONS



NHLA/AAHA

(A MERGED ORGANIZATION OF THE NATIONAL HEALTH LAWYERS ASSOCIATION AND THE
AMERICAN ACADEMY OF HEALTHCARE ATTORNEYS)

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—from a declaration of the American Bar Association

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PREFACE

In the Public Interest

On behalf of the 1996-97 Public Interest Committee and the entire NHLA/AAHA leadership, I am delighted to be able to share this report with you. The report was generated by discussions held among twenty-four talented and articulate industry leaders at the Colloquium on *Patient Care and Professional Responsibility: Impact of the Corporate Practice of Medicine Doctrine and Related Laws and Regulations*. The Colloquium was held February 28–March 1, 1997, as an essential component of the Association’s mission “to serve as a public resource on selected healthcare legal issues.”

Through the invaluable support over the years by the Association’s membership, several non-partisan forums have been held for representatives from major constituency groups to debate and examine a full range of issues in the public interest. Most recently, participants at the Colloquium on *Patient Care and Professional Responsibility* grappled with the profound changes relating to patient care and the physician/patient relationship that are taking place, particularly within the managed care environment. Using the Corporate Practice of Medicine Doctrine (“Doctrine”) as the starting point for discussion, participants examined significant policy, economic and regulatory issues and the complex competing demands on physicians as they address the practical realities of patient care and professional responsibility.

The Colloquium was designed to meet the following objectives:

- To provide a neutral forum that promotes a frank exchange of views and analyses among various constituency groups with differing, and sometimes adverse, points of view. To explore the basis for these differences and identify ways and means of accommodating the differences in the course of pursuing their respective missions to serve the public interest.
- To crystallize the intersection of policy, business and regulatory issues in an effort to have a constructive impact on the substantive debate over these issues.
- To create opportunities for representatives of different groups to identify shared goals and interests and to develop potential collaborative working relationships.
- To publish a report based on the findings of the Colloquium. To disseminate the report to NHLA/AAHA members, participating constituency groups, policy and law makers, academicians and others in order to educate key players in the debate and those who are charged with advising clients on these matters.





- To provide an environment throughout the Colloquium that allows for the free exchange of views and articulation of tensions while preserving confidentiality and appropriate anonymity for Colloquium participants in the written report.

The Doctrine has resurfaced as a key component in the debate over the proper balance between market incentives and cost efficiency on the one hand and patient and professional rights on the other. In a sense, the Doctrine exemplifies the tension between traditional values and modern realities in healthcare. Should the Doctrine, as historically defined, be reinstated throughout the country? Should it be eliminated? Or should it be modified in some way that helps address the challenges of our changing healthcare system?

The purpose of the Colloquium, in gathering the impressive industry leaders listed on pages 13–14 of this report, was to attempt to ascertain through collegial discussion and exchange, the relevance of the Doctrine and its potential impact on the future of the healthcare system.

It is our hope that the Colloquium Report will illuminate the findings of this unique gathering in such a way that the areas of consensus, points of tension, and even the unresolved issues that were identified will have a valuable and practical impact on the substantive debate. To best utilize the enormous talents of those who volunteered their time to participate in the Colloquium, three core issue areas were identified for discussion: (1) policy issues; (2) business and economic issues; and (3) regulatory and enforcement issues. Each core issue area was accompanied by framing questions for discussion and exploration. This report uses those framing questions to organize, summarize and distill the spirited exchange between the participants and, at times, the intensity of both consensus and dissension.

I hope that you will find the Colloquium Report useful, informative and of some value in your professional lives, as all of us in the healthcare industry strive to do our part in making the system work better, more efficiently and cost-effectively while preserving the fundamental values inherent in serving the public interest.

Douglas A. Hastings, Esquire
1996-97 Chair
Public Interest Committee

ACKNOWLEDGMENTS

It is with deep gratitude that the Association recognizes the commitment and support of those volunteers and Association members whose dedication to the public interest resulted in the Colloquium on *Patient Care and Professional Responsibility: Impact of the Corporate Practice of Medicine Doctrine and Related Laws and Regulations* and the publication of the Colloquium Report. In addition, the Association is indebted to the generous contributors, listed on the inside back cover of this Report, without whose support the Colloquium and Report would not have been possible.

Members of the Board of Directors and, in particular, those who served on the 1996–97 Public Interest Committee devoted countless hours in bringing this public interest Colloquium to fruition. Special thanks go to Eugene Tillman, Esquire, 1996–97 President of the Board of Directors, and to Douglas A. Hastings, Esquire, Chair of the Public Interest Committee, whose leadership was an essential component in bringing the Colloquium from concept to reality.

And finally, the Association extends profound thanks to the Colloquium participants themselves, listed on pages xi–xii of this Report. Their keen intelligence and dynamic interaction are testament to those in the health industry who struggle to reconcile market forces and the inexorable drive toward cost containment with humanism and the general welfare of the health of the American community. Surely without their dedication, there would not have been the opportunity to inform the debate on these critical issues that are fundamental to the quality of healthcare delivery in the United States.



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I. OVERVIEW AND BACKGROUND



Introduction

Why convene some of the country's leading healthcare experts to debate a decades old doctrine that is rarely enforced? Many public policy and legal issues relevant to the way healthcare is being delivered, organized and paid for today led the 1996–97 Public Interest Committee of NHLA/AAHA to select the Corporate Practice of Medicine Doctrine (“Doctrine”) and its impact on patient care and professional responsibility as the topic for the Association’s 1997 public interest Colloquium.

Few sectors in the United States economy are changing as rapidly as the \$1 trillion healthcare industry. The changes are causing a realignment of all relationships in healthcare delivery—including the traditional one between doctors and their patients.

In the past decade alone, the healthcare sector has undergone a historic transformation. Healthcare delivery has shifted from an inflationary fee-for-service system, in which physician clinical judgment and patient freedom of choice were relatively unquestioned, to a competitive system that is oriented toward prevention of disease, cost efficiency, limits on choice and accountability. Buyers of healthcare services, frustrated by years of soaring health expenditures, want patient healthcare to be better managed, costs to be contained, guidelines and protocols to be developed and used by physicians and outcomes to be identified and reported.

Although its enforcement is erratic throughout the U.S., for many the Doctrine has come to symbolize the growing tensions between the traditional values in which twentieth century medical practice was built and the realities it faces in a managed care environment. The Doctrine arose out of fears that corporate involvement in medical practice would hinder physician independence and clinical judgment and commercialize the practice of medicine. The potential result—patient access to needed medical care could be jeopardized.

Throughout much of this century, the Doctrine has made an important contribution to keeping the practice of medicine in the hands of licensed clinicians. In recent years, there has been an erosion in faith over whether its historic rationale—that of protecting patients from industrialized style medical abuses—holds much sway in the contemporary healthcare market setting. The debate over its utility has been triggered by the increasing blurring of lines between the delivery, organization and financing of medical care. The question is whether the more



than sixty-year-old Doctrine can be a useful mechanism for promoting medical professionalism and uncompromised patient care in the health-care environment of the late 1990s and beyond.

It is the ambiguity over the Doctrine's purpose coupled with its role in preserving the basic rights and interests of patients that spurred the Association to ask a broad spectrum of healthcare experts to analyze its scope, enforcement and appropriateness in the current marketplace. There is widespread interest about the Doctrine's effect on the structuring of relationships between physicians and other healthcare providers and payors. The Colloquium's objective was to weigh the pros and cons of having the Doctrine eliminated, modified or simply reinvigorated and the impact those actions would have on physicians, patients, hospitals, HMOs, insurers and managed care entities.

With a new crop of healthcare players vying for a share of the health-care market, a debate over the Doctrine's relevance is timely and practical. The Darwinian pressures of the 1990s healthcare market are spurring unusual collaborations that some worry are threatening the autonomy of physicians and the freedom of patients to get necessary medical care.

These collaborations are linked to a variety of motivations. Nonprofit hospitals are merging with each other at a rapid rate and some are relinquishing their charitable roots by merging with for-profit institutions to acquire needed capital; hospitals are looking to align with insurers to assure a steady stream of patients; drug manufacturers are buying specialty physician groups to vertically integrate; physician practice management companies are aggregating with physician practices to broker services and consolidate practice overhead; and the traditional solo practitioner is looking to partner with entities that provide the technology and the capital needed to compete and preserve patients. To comply with state and federal fraud and abuse laws, many hospitals and other providers prefer to employ physicians.

The Doctrine has affected the structure of healthcare organizations attempting to compete today. The Doctrine has reemerged in several court decisions throughout the 1990s. Even with its inconsistent enforcement, it continues to govern relationships between physicians and other healthcare players, including hospitals, HMOs, physician practice management companies and managed care organizations.

A debate over the Doctrine raises important legal policy, economic and enforcement issues. Does the Doctrine protect the public from abuses? Do patients have responsibilities as well as rights that should be reflected in the Doctrine? Are patients, physicians and the community harmed by the lack of universal enforcement? Would continued and

consistent enforcement of the Doctrine improve the health of patients? Are there alternative mechanisms that could replace the Doctrine? Is it an appropriate and cost efficient and meaningful tool for preserving the sanctity of the physician/patient relationship?

This Colloquium addressed several issues. One of the most critical issues centered on whether physicians will be able to make independent clinical decisions if the Doctrine is not enforced. Physician discretion to prescribe and provide treatment is more limited in an organized system of care in which quality concerns must be balanced with cost containment objectives. More than 80% of working Americans are now in some form of “managed” care, compared with 29% in 1988. The fundamental public interest question is whether physicians working in a managed care setting can prevent their fiscal responsibilities from interfering with their loyalty to their patients.

In today’s managed care environment, where there are more restraints on patient choice of doctors and treatment options, very real concerns are stimulating debate among state legislators, Congress, the public and the healthcare industry about managed care’s effect on the sanctity of the relationship between physicians and patients. The Doctrine represents key issues of patient care and professional responsibility that confront those engaged in the business and regulation of healthcare on a daily basis. As physicians and patients adapt to the transition of medicine from a cottage industry to an industrial model, the debate over the Doctrine’s future essentially centers on who will control the delivery of healthcare and ultimately shape the character of the physician/patient relationship.

Historical Perspective

Although it is hard to imagine today, doctors have not always engendered professional respect. In the nineteenth century, physicians struggled with professionalism in an environment in which they competed for patients, not only among themselves, but also with charlatans and so-called healers. Many people at that time considered medicine a less than noble profession and there was much skepticism about physician know-how. The medical profession’s often aggressive reliance on futile and sometimes fatal antidotes failed to distinguish physicians from quacks and others whose training was less rigorous.¹

By the late 1800s, the first licensing statutes were passed to improve the financial stature of physicians and allow them to exercise control over medical practice. By 1905, all but three states required medical school



¹ Vanderbilt Law Review, Vol. 40, No. 2, March 1987, The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry.



graduates to hold an acceptable diploma and pass an independent state exam. In the early 1900s, the licensing requirements had a desired effect on professionalism, particularly in boosting the quality of those who became physicians.²

Simultaneously, however, a new threat to autonomy arose as a growing number of corporations became involved in medicine. During the industrial revolution, companies hired doctors to treat employees and dependents for health problems. In the early 1900s, railroads, mining companies and lumber mills routinely employed physicians for a salary to care for their workers. Smaller industries hired independent physicians to provide care to employees for a set rate per worker per month. Under both cases, the corporation steered patients to physicians. Corporations also employed their own doctors to provide certain medical services to company employees and later subcontracted with independent doctors to do the same.

Critics raised many concerns about so-called contract practice, arguing that corporate medicine would force doctors to treat too many patients and thus threaten quality. Also, the prospect of fixed salaries and fees were in conflict with the traditional fee-for-service system physicians favored. The key criticism centered on the issue of “allowing lay people to make policy decisions concerning which patients a doctor could see and the amount of services a doctor could provide.”³

Organized Medicine Reacts

Although some physicians viewed these early employee arrangements as a dependable means of income in a highly competitive market, organized medicine led by the American Medical Association (“AMA”), believed that the preservation of physician autonomy required a firewall between commercial pressures. The AMA in 1912 directly challenged the corporate practice issue by developing a set of ethical principles that declared it “unprofessional” for physicians to be under corporate or industrial control because of the potential adverse effects on patient care.

The AMA principles condemned any contract that forced physicians to perform under conditions that would prevent the rendering of adequate service and thwart competition among physicians. In 1934, the AMA also condemned arrangements in which a lay entity directly profited from physician compensation for services delivered. These principles existed throughout the 1970s.

² *Id.*

³ *Id.*

The Doctrine's Origins

The working definition of the Doctrine for purposes of the Colloquium was the following:

The prohibition against any person or entity other than a licensed physician/dentist/optometrist holding him, her or itself out as a provider of diagnoses, treatment or care of patients, billing in the name of such non-licenses entity for such diagnosis, treatment or care of patients, and/or ownership or other control of professional medical, dental, or optometric delivery systems by non-licensed persons or entities.

The Doctrine was spawned in the early 1930s by states as part of a series of legal restraints against corporate medicine. States required physicians to be licensed and to meet certain standards to practice medicine. States also enacted medical practice acts that barred fee-splitting by physicians and non-physicians to protect the public from possible abuses stemming from corporate practice. Today, about twenty-five states bar fee-splitting. However, a June 1996 survey by the National Health Lawyers Association found that approximately thirty states lack specific Corporate Practice of Medicine statutes on their books.

Essentially, the Doctrine bans unlicensed individuals and companies from engaging in the practice of medicine, and thus controlling patient care, by employing licensed professionals such as doctors or dentists. Its intent was to assure that only persons with medical licenses could actually deliver medical care and that lay persons would not influence professional decisions involving treatment. Professional or medical service corporations can employ physicians; in fact, in most states with a Corporate Practice of Medicine law on the books, this is only one of a few exceptions to the practice of medicine in a corporate format.

The theory held that a prohibition on corporate medicine would protect consumers from possible abuses because commercial medical care ultimately divides physician loyalty. The ban stemmed from concerns that a corporation's overriding business motive would likely be incompatible with a physician's overarching commitment to serve patients.

As early as 1936, the Illinois Supreme Court in *People v. United Medical Service, Inc.* held that the state's medical practice act prevented a for-profit corporation from providing medical services through its clinic because the state barred unlicensed persons from practicing medicine. Although United Medical Service argued that employment of physicians does not mean the corporation is practicing medicine, the court said the corporation doesn't have the qualities to practice.





In 1938, the California Supreme Court viewed the Doctrine as a means to protect physicians from the pressures of the commercial marketplace. In *People v. Pacific Health Corp.*, the court ruled that “the evils of divided loyalty and impaired confidence would seem to be equally present whether the doctor received benefits from the corporation in the form of salary or fees.” The court argued that “any freedom of choice is destroyed, and the elements of solicitation of medical business and lay control of the profession are present whenever the corporation seeks such business from the general public and it turns it over to a special group of doctors.”

Over the years, the Corporate Practice of Medicine ban has been upheld through state licensing laws; professional corporation, medical or dental practice statutes; fee-splitting laws; case law; and attorneys’ general opinions. Courts and attorneys general have held that corporations and other business entities cannot be allowed to control decisions about patient care because they have not been trained, have not taken the Hippocratic Oath and lack human compassion.

The Doctrine’s Application

Because the Doctrine is state driven, its application has varied. Few states actually bar the Corporate Practice of Medicine via a single law. Some states carefully delineate the statutory basis for having and enforcing the corporate practice prohibition. Others have created judicial or statutory exemptions from the Doctrine for professional or medical service corporations, nonprofit hospitals, HMOs and medical schools. For example, California, which still enforces a Corporate Practice of Medicine prohibition, exempts public hospitals and clinics operated by university medical schools.

New Jersey also has been a tough enforcer of the Doctrine, but in recent years has proposed permitting employment of licensed practitioners by a wide variety of health entities including HMOs, hospitals, nursing homes and ambulatory care facilities as long as the medical director is licensed and regularly present. Hospitals and other providers have pushed for exemptions from the employment ban. They claim that employing a physician helps them more easily comply with state and federal fraud and abuse laws and results in the most integrated form of care.

In general, courts and attorneys general rely on a mixture of vehicles, including licensing statutes, professional practice acts and public policy to determine whether a delivery arrangement violates the tenets of the Doctrine.



Many states allow physicians to incorporate into a business as long as the only shareholders and directors or trustees are licensed physicians. On the public policy front, federal and state laws permit HMOs to employ physicians. For example, in 1993 California amended the Knox-Keene Health Service Act to allow HMOs and other managed care plans to employ and enter into contracts with physicians.

Arkansas, which has a corporate practice ban, allows some physicians to be employed directly by hospitals as medical directors or as directors of risk management programs. Some hospitals employ doctors as radiologists and anesthesiologists. Colorado, which also has a corporate practice ban, exempts hospitals and provider networks. Some hospitals have established outpatient departments with employee physicians; other hospitals have set up hospital-owned clinics staffed by physicians employed by a professional corporation that contracts with the hospital.

Many of the exemptions have been directed at nonprofit hospitals. For example, North Dakota in 1991 enacted a law permitting only nonprofit hospitals to employ physicians as long as the hospital vowed to preserve the independent judgment of that physician.

In *Conrad v. Medical Board of the State of California*, a state appellate court ruled that municipal and county hospital districts are barred from employing physicians because the exceptions to the state's medical practice act do not apply. The reason: many hospital districts include for-profit institutions that could benefit financially from employing physicians.

The Doctrine's Relevance Today

Although recent judicial decisions signal that the Doctrine is regaining favor, some experts are questioning whether it holds much relevance to contemporary healthcare practice. At question is whether the Doctrine's goal was to protect the sacred physician/patient relationship and to remove the possibility of financial influence from healthcare delivery or whether the goal was to block non-licensed, non-regulated persons from hiring and entering into financial relationships with physicians.

Application of the Doctrine's enforcement powers has waned over the past few decades and in some cases has even disappeared. In many states, corporate practice prohibitions have been ignored because "it became the established custom not to enforce it."⁴

4 Modern Healthcare, May 15, 1984, "Freestanding Centers' Growth Raises Questions about Corporate Practice Laws."



However, the Doctrine has paradoxically emerged as a powerful legal tool in other states. A number of states and advocacy groups remain strong proponents of the Doctrine and what its historical lineage represents. Free-market advocates claim it stymies competition. Despite erratic and sometimes non-enforcement by states, free-market advocates contend that its existence hinders innovation. One health attorney has labeled it a “legal landmine, remnants of an old and nearly forgotten war.”⁵

The Effect on Competition

The Federal Trade Commission (“FTC” or “Commission”) has been a strong opponent of the Doctrine. Since the 1970s, the FTC has been examining the competitive effects of a Corporate Practice of Medicine ban. The Commission claims that a bar can impair the functioning of a market and “injure” consumers. The FTC has maintained that restricting corporations from these kinds of practices can thwart development of “innovative” healthcare-related delivery venues that lower prices for consumers.

The FTC’s position stems from its own studies that have found that the Corporate Practice of Medicine bar raises prices. The FTC’s main focus has not been on physicians but on optometry—where it has found that bans hiked up prices without a concomitant improvement in quality.⁶

In 1979, the FTC charged the AMA with unreasonably restraining trade under the Sherman Antitrust Act by instituting a series of “anti-competitive” ethical principles associated with corporate medical practice. The AMA viewed its updated principles as vital to preserve physician judgment and to protect patients. The FTC countered that they exceeded what was reasonably necessary and created barriers to establishing a variety of price competitive ventures by physicians with non-physicians. The FTC ordered the AMA to repeal the principles. The action was affirmed by the Second Circuit Court of Appeals and the AMA was forced to relent.

Since then, the FTC has encouraged legislatures and regulators to repeal or modify corporate or commercial practice restrictions in several states, including Maine, Texas, Kansas and Massachusetts. Most of the FTC’s attention has been on optometric issues but the Commission has begun to branch out. In 1990, it launched an investigation of medical

5 Rosoff, *Health Law Digest*, December 1984, “The Corporate Practice Medicine Doctrine: Has Its Time Passed?”

6 Bureau of Economics, Federal Trade Commission, “Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry (1980).

staffs of two Broward County hospitals in Florida for aggressively trying to prevent the Cleveland Clinic from setting up a multi-specialty facility in Fort Lauderdale. Although none of the doctors admitted to any wrongdoing, the staffs of both hospitals eventually signed consent agreements with the FTC promising to cease and desist. In a 1992 article, lawyers representing the medical staff physicians charged the FTC with encouraging the Corporate Practice of Medicine.⁷

Florida is an example of a state that requires that all practicing physicians meet minimum requirements for safe practice, but it has no provisions setting forth requirements of how physicians can be organized. Most physician practices in Florida are owned directly or indirectly by physicians in the form of professional associations, partnerships or professional associations and proprietorships. It is not uncommon for regular corporations to own medical practices in the state. Corporations and investors can invest and own medical practices that employ doctors as long as the physicians supervise and control the actual practice decision making and management. Many hospitals, walk-in clinics, chiropractors, insurers and investors have set up corporations that employ physicians.

The Employment Quandary

In 1991, the Department of Health and Human Services' ("DHHS") Office of the Inspector General ("OIG") examined the effects of state laws barring hospital employment of physicians. The study found that only five states—California, Colorado, Iowa, Ohio and Texas— flatly barred hospitals from employing physicians, although in some of those states certain types of hospitals and providers were exempted from the prohibitions. The OIG's study found that although bars on hospital employment imposed legal, recruitment and administrative burdens on institutions, these were not insurmountable hurdles and had little effect on hospital operations.

The volatile reimbursement landscape for physicians today has made employment a more attractive option. A 1997 report to Congress from the Physician Payment Review Commission estimates that the share of physicians who are employees increased to 39% in 1995, up from 36% in 1994, whereas the share of self-employed physicians dropped. A 1996 article in the *Journal of the American Medical Association* reported that 16% of employed physicians in 1994 worked in hospitals.⁸ Many physicians find comfort in the security of a salary and stable working environ-



⁷ Medical Economics, October 19, 1992.

⁸ Journal of the American Medical Association, p. 555, Vol. 276, Aug. 21, 1996.



ment provided by a hospital, an HMO or any other integrated healthcare system. In recent years, many courts and legislatures have been asked to consider the practice and employment relationships between doctors, hospitals and managed care organizations in the context of the law and the changing nature of healthcare delivery. The outcomes have varied, however.

In Tennessee, for example, a new law backed by the state's hospital association permits hospitals and hospital affiliated entities to employ physicians—a practice that has been previously prohibited by the state's Corporate Practice of Medicine Doctrine. The new law, passed in 1995, also outlines certain provisions for establishing employment relationships between hospitals and physicians. For example, the relationship cannot restrict the independent medical judgment of physicians, only reasonable limitations may be placed on the geographic and time provisions in the restrictive covenant and employed physicians must have comparable rights and protections to non-employed physicians when it comes to medical staff privileges. However, the legislation did not lift the ban on hospital employment of anesthesiologists, pathologists, radiologists and emergency physicians and it requires that service contracts with these practitioners contain protections related to notice of termination and the termination of staff privileges.

The most recent case bolstering the Doctrine occurred in Illinois when a trial court and court of appeals invoked a sixty-year-old Supreme Court case to invalidate the employment of physicians by hospitals. In *Berlin v. Sarah Bush Lincoln Health Center*,⁹ the health center sued to enforce a restrictive covenant containing a physician's employment agreement with the hospital. The physician had entered into a multi-year employment agreement with the health center that stated the doctor could not be affiliated with any competitor within a fifty-mile radius during the agreement. The physician resigned to take a position with a competitor one mile away. The health center sought to enforce the covenant but the physician argued it was unenforceable because it violated the corporate practice ban. The court agreed, asserting that only licensed physicians could practice medicine and that the center could not meet the standards under the Illinois Medical Practice Act. The court refused to enforce a hospital's employment contract with a physician, finding that the hospital may not contract directly to employ physicians to provide medical services to patients.

⁹ *Berlin v. Sarah Bush Lincoln Health Center*, 664 N.E.2d 337 (1996).

In March 1997, another appellate court in Illinois reached the same decision in *Holden v. Rockford Memorial Hospital*.¹⁰ In that case, the court noted that the healthcare industry “has changed considerably” since the Doctrine was established and that “prohibiting corporations, primarily hospitals, from employing physicians in the present day may do more harm than good.” The court concluded, however, that it was not its place to implement a new law or institute new policy surrounding the Doctrine. Instead, it would hold to a decision made more than sixty years before by the Illinois Supreme Court.



Outlook

In many ways, the struggles occurring in healthcare practice today resemble the market strains that led to the Doctrine’s birth. The changing healthcare delivery model and growing corporatization of medical care is re-igniting interest in the inherent purpose of a ban on corporate practice.

Some argue that many of the reasons that once existed for limiting corporate involvement in medicine no longer apply today and that courts and state legislatures should clarify the Doctrine’s scope to accommodate current practice. Others counter that it is a vestige of an important tenet—that physician autonomy and patient freedom of choice are foundations of medical practice that should be preserved into the twenty-first century.

The debate over the Doctrine encompasses many issues but essentially centers on one’s view of how medical care is going to be delivered in the future—whether medicine is a social good or business—and whether the Doctrine plays much of a role in charting that course. The issues that are now in question and fuel the current debate include:

- Whether business enterprises that employ physicians put their business goals ahead of patient care;
- Whether states that enforce the Doctrine have better healthcare than states that do not;
- Whether the existence and enforcement of the Doctrine provide assurance to the public that well-trained and licensed physicians are in control of healthcare;
- Whether continued enforcement inhibits innovation and deprives patients of choice;

¹⁰ *Holden v. Rockford Memorial Hospital*, 678 N.E. 2d 342 (1997).



- Whether it adds to the cost of healthcare via fees to attorneys who are paid to circumvent the Doctrine;
- Whether certain exceptions for employment are justified;
- Whether the Doctrine needs to be more uniform in scope; and
- Whether patients, practitioners and payors need more consistent and specific enforcement guidelines.

Can physicians fulfill their duties and maintain loyalties to patients in an environment in which payors and corporations are gaining control over delivery? Will physicians be able to exercise independent judgment if the Doctrine is abolished? What will happen ultimately to the quality of patient care, already seen by some as compromised, within a managed care environment? Is the Doctrine a formidable threat to non-licensed entities trying to establish health services?

It was these questions and the tensions over the merits of the Doctrine that led the 1996-97 Public Interest Committee of the Association to convene the *Colloquium on Patient Care and Professional Responsibility: Impact of the Corporate Practice of Medicine Doctrine and Related Laws and Regulations* on February 28–March 1, 1997.

II. CORE QUESTIONS

The organizers of the Colloquium identified in advance approximately two dozen core issues relating to the Corporate Practice of Medicine Doctrine and its impact on patient care and professional responsibility. The issues were divided into three core question areas: (1) policy issues; (2) economic and business issues; and (3) regulatory and enforcement issues. They served as the springboard for the day-and-a-half discussion and are listed below in their entirety. For the convenience of the reader, the core questions are repeated in Section III as they relate to the three individual summary discussions.

Issue Area #1: Policy Issues

- Definition and historic rationale of the Doctrine—comments, refinements, objections?
- What are the ostensible goals of the Doctrine?
- Does the Doctrine—as defined—accomplish the goals identified? What evidence is there that the Doctrine is fostering those goals?
- In states where the Doctrine does not exist or is not enforced, is there evidence that the Doctrine’s goals are accomplished in some other way? Are patients, physicians and/or the community harmed by the lack of enforcement of the Doctrine?
- How does the Doctrine affect the rights and responsibilities of patients?
- Does the Doctrine affect quality or patient care outcomes?
- Does the Doctrine’s effect on quality offset competitive concerns?
- At what point does corporate decision making by non-physicians compromise physicians’ professional responsibilities to their patients?

Issue Area #2: Economic and Business Issues

- Is the Doctrine appropriate and helpful in today’s managed care marketplace in which there is:
 - Significant market pressure to control healthcare costs;
 - Managed care contracting with various provider payment methodologies;
 - Organizations with internal utilization review/quality assurance programs;





- Organizations that have outcomes management systems; and/or
- Significant competition among local providers, requiring them to access capital, coordinate services and jointly seek payor contracts.
- Can and should the practice of medicine be distinguished from the management of medical practices and the management of the delivery of healthcare services in applying the Doctrine? Should the payment of a “percentage management fee” be recognized as unlawful fee-splitting and a violation of the Doctrine?
- Is there a distinction between the operations of nonprofit and for-profit providers in the existing marketplace that justifies an exemption from the Doctrine for nonprofit corporations? Should HMOs be exempt from the Doctrine?
- Should the Doctrine and professional corporation statutes be modified to permit joint professional corporation ownership and the integration and coordination of care by healthcare professionals holding different licenses?
- Is the Doctrine consistent with economic and public policy concerns that underlie state and federal anti-kickback, physician anti-referral, antitrust, reimbursement, tax-exemption and other laws and policies?

Issue Area #3: Regulatory and Enforcement Issues

- Should uniform national standards and enforcement of the Doctrine be required because of the multi-state nature of the healthcare marketplace?
- If the Doctrine is eliminated, should entities with economic control assume liability for medical decision making?
- Would licensing all entities providing medical treatment serve as a substitute for the outright prohibition on the corporate practice of medicine?
- Are the true beneficiaries of the Doctrine only the patient and his or her physician or do payors (business, government and their proxies) also have a legitimate interest in the use and enforcement of the Doctrine?
- If the Doctrine is to be enforced, what penalties for its violation are appropriate to impose on physicians, other healthcare professionals and the business entities with which they contract?

III. SUMMARY OF DISCUSSIONS: CONSENSUS AND POINTS OF TENSION



The Colloquium participants included representatives from key constituency groups—institutional providers (tax-exempt and for-profit), managed care systems, insurers, medical societies, physician practice management organizations, consumer groups, federal and state governments and federal enforcement agencies. They spent one-and-a-half days discussing the fundamental driving questions at the heart of the Corporate Practice of Medicine Doctrine and its impact on patient care and professional responsibility. While grappling with the core questions, the participants attempted to discern both the major areas of agreement and disagreement. The format allowed for separate discussion of the three major issue categories (policy issues, economic and business issues, and regulatory and enforcement issues) led by facilitators, followed by small group workshops that sought to synthesize the discussion in each of these three key areas.

The following is a synopsis of their discussions. Each of the three major areas lists the relevant core questions, followed by a box summarizing the major areas of consensus and points of tension or disagreement, as well as issues that the group felt needed further exploration beyond the scope of the Colloquium.



Issue Area #1: Policy Issues

Core Questions

- *Definition and historic rationale of the Doctrine—comments, refinements, objections?*
- *What are the ostensible goals of the Doctrine?*
- *Does the Doctrine—as defined—accomplish the goals identified? What evidence is there that the Doctrine is fostering those goals?*
- *In states where the Doctrine does not exist or is not enforced, is there evidence that the Doctrine's goals are accomplished in some other way? Are patients, physicians and/or the community harmed by the lack of enforcement of the Doctrine?*
- *How does the Doctrine affect the rights and responsibilities of patients?*
- *Does the Doctrine affect quality or patient care outcomes?*
- *Does the Doctrine's effect on quality offset competitive concerns?*
- *At what point does corporate decision making by non-physicians compromise physicians' professional responsibilities to their patients?*

Major Areas of Consensus, Points of Tension and Unresolved Issues



Consensus

- Physicians should be the primary clinical decision makers but changes in the marketplace are raising legitimate concerns about whether control over clinical care is being usurped by non-physicians or lay entities.
- In states where it is in force, the Corporate Practice of Medicine Doctrine has had some effect in preventing commercial entities from employing doctors and offering their services to the public.
- The employment relationship that the Doctrine tries to address can be evaded through various legal mechanisms, thus eyeing solutions linked solely to employment concerns does not ameliorate or resolve all concerns.
- The Doctrine focuses too heavily on employment issues and thus fails to comprehensively and reliably address who is control of medical decision making. As it is currently structured, it is an insufficient response to many of the fiscal tensions in the health-care marketplace today.
- Financial incentives influencing clinical decisions exist regardless of a physician's employment status or the existence and enforcement of a Corporate Practice of Medicine law.
- The Doctrine does not address growing payor control over clinical decision making through coverage and claims policies. However, payor control over physician behavior and the ability to practice without fear of being ousted for "no cause" are major issues.



Points of Tension

- Whether the application of clinical guidelines by payors, utilization management companies and physician practice management companies that are not medically sound and not supported by the medical profession are an inappropriate intrusion into medical care.
- Whether to preserve or eliminate the Corporate Practice of Medicine Doctrine. Some participants believed if it were eliminated entirely and corporations or lay entities were free to employ physicians, a new layer of healthcare entity would emerge and this would have a significant effect on the way medicine is practiced. It would open up healthcare markets to a broad range of new corporate entrants that could employ doctors to provide care. In their view, forsaking the Doctrine, even in the employment area, would be a profound philosophical shift and would deliver the wrong message about its relevance. They wanted it retained, expanded to address such issues as inappropriate application of clinical guidelines and enforced more vigorously. In contrast, others questioned whether the Doctrine is an effective mechanism at all to address the issues influencing clinical decision making in today's healthcare arena. A vocal minority believed it should be eliminated because, although it is not enforced in most states, its existence creates a barrier to creating alternative delivery systems.
- The extent to which the Doctrine addresses fundamental issues emerging in today's healthcare system. There are a multitude of financial incentives in the system today that did not exist in the early part of the twentieth century; resolution of problems stemming from incentives in the contemporary healthcare market has little to do with the parameters of the original Doctrine.

Unresolved

- How to define the Corporate Practice Medicine Doctrine. There remained ambivalence about whether to view the law broadly to encompass an array of regulatory strategies aimed at control over physician's clinical practice, or whether to keep the definition narrowly focused on how states apply it.
- The employment of physicians by non-physicians does potentially affect the quality of patient care. But how significant a difference it makes is unclear. At present, there are no data on that issue.





Colloquium participants began by proffering a definitional framework in which to debate the merits of the Corporate Practice of Medicine Doctrine. All participants agreed that growing interest in the Doctrine's relevance is emblematic of the tensions now enveloping the payors and the deliverers of medical care.

But there were varying positions on how it should be defined. One participant said defining corporate medical practice was like defining pornography—"it's hard to define but you know it when you see it."

Some experts view the Doctrine as a simple ban on corporations employing physicians; others see it as way to avert the commercial exploitation of medical care.

For purposes of discussion, the Colloquium defined it as a bar against non-licensed persons doing a number of things, including holding themselves out as a healthcare provider, billing and collecting professional fees and owning or controlling professional medical, dental or optometric delivery systems.

There was agreement among Colloquium participants that the Doctrine's origins stemmed from the recognition that medicine is antithetical to business. It was also acknowledged that the Doctrine's beginnings were linked to a self-interest motive by physicians, who at the time were eager to form a guild designed to exclude non-medical providers from their turf.

California is one of a handful of states where the Doctrine has been supported in case law and enforced, so it arose early in the discussion. One participant who favored retaining the Doctrine acknowledged that it is an "imprecise and imperfect" legal tool to address the financial and treatment pressures doctors are grappling with today. California's medical society is working to update the Doctrine so it fits into current medical practice while still preserving its inherent mission. Other state medical societies would prefer to leave the law murky, according to one Colloquium participant.

California's law bans lay persons, organizations and corporations from practicing medicine and employing physicians or other healthcare practitioners. It also bars most lay persons, organizations and corporations from engaging in the business of providing healthcare services indirectly by contracting with healthcare professionals. The ban does not, however, apply to physician partnerships or to professional medical corporations and the state also exempts certain HMOs and hospitals. HMOs can employ physicians under the state's Knox-Keene Act but corporate conflicts are starting to arise from that allowance. One participant noted

that it has become common for an HMO contract in the state to include clauses delineating precisely how many patients physicians will see per hour.

In recent years, there have been growing efforts to find ways to refine the Doctrine to accommodate the new types of healthcare hybrids that are developing in California while still retaining the Doctrine's core purpose. The California Medical Association ("CMA") has set up a technical advisory committee to examine the principles of the Doctrine and the various financial and contractual arrangements now in place between hospitals, doctors and others. That committee concluded that certain aspects of delivery required complete physician control, others required that physicians have at least shared control with a lay entity and, in some cases, physician involvement was irrelevant. CMA's board has agreed to support the corporate practice bar but will interpret it to permit arrangements between physicians and lay entities if the governance of those adhere to the policies the advisory committee laid out. CMA's policy calls for medical decisions to be made by physicians who are responsible for patients, not individuals who make the business decisions for the entity. Even if a business decision-maker is a licensed physician, that physician would only qualify as "active" if that person predominately practiced medicine.

Although some viewed the Doctrine as a deterrent to corporate medical practice, others saw it as little more than a licensing law that is easy to circumvent. Nevertheless, most Colloquium members acknowledged that the Doctrine can create "an impediment" to creating innovative delivery networks.

Is the Doctrine really designed to prevent the commercial exploitation of medicine?

Many Colloquium participants emphasized that the crux of the debate about the Doctrine's viability is not about corporate structure or corporate employment of physicians per se but whether parsimonious payors and the mechanism for paying practitioners are inappropriately influencing physician judgment. Some participants held the view that the corporate venue that the physician selects to practice medicine in is less relevant than the compensation system set up to cover treatment costs stemming from practice.

These are questions all healthcare stakeholders are grappling with today and are linked to the tenets of the Corporate Practice of Medicine Doctrine. The questions that permeated the discussion on policy issues included: At what point do the economic constraints of a corporation





that pays for care interfere with medical judgment? When do benefit or coverage decisions conflict with the ability of physicians to make sound treatment decisions for their patients?

Although the Doctrine is directed at curbing corporate or lay person employment of doctors, participants were uneasy about focusing solely on the employment component of the Doctrine in the context of issues of concern to practitioners today. One participant noted that the medical profession is not uniformly opposed to employment. He described the view of corporate employment among physicians as schizophrenic; some support it, others oppose it.

Another participant indicated that nearly half the physicians in the U.S. today are employed. He added that they are not all employed by other physicians. When the Corporate Practice of Medicine Doctrine emerged, the railroad physicians and the mine physicians did not necessarily have their clinical judgment distorted by their employment relationship in a way that was unacceptable to patients, he added.

Many statutes on the books today are primarily employment-oriented, but do they have other goals or objectives beyond the effect on physician judgment?

The majority of Colloquium members held the view that policy makers should look beyond the employment relationship when assessing the value of the Doctrine. Other participants countered that employment was an important piece of that puzzle because it unquestionably influences physician behavior, particularly if the physician's practice is at risk if they do not comply with guidelines or policies. Several participants made the point that there remains an irreconcilable conflict between a physician practicing medicine, taking care of a patient and being controlled by a corporation, whether it is through employment or some other means.

Great concern exists among the medical profession over who owns and controls medical delivery and payment systems. Some participants argued there are different ways to draw the line so that physician decision making is not affected. For example, there could be bars on corporations telling doctors how many patients to see in an hour and what medications to prescribe.

Others noted that even when the lines are drawn, employment by a corporation or lay entity has very different consequences than by someone with the same license. If the owners have the same medical license, they can be held accountable similarly to employees for professional liability. Another person agreed that there is a difference between being

employed in a corporation wholly owned by those who hold the same license then being employed by a non-licensed group. There was much agreement that it was hard to structure a relationship in which professional autonomy is assured when you are reporting to people who do not understand or have the direct responsibilities that a physician does.

Most cases involving the Corporate Practice of Medicine Doctrine are now being litigated on the basis of employment. The few states that enforce the Doctrine claim a physician can only be employed in a professional corporation format in which the doctor is the sole shareholder or sole director to avoid exerting external influence on medical judgment. In states where there is no statutory framework, there is no enforcement of the Doctrine.

One of the concerns about the employment relationship, however, is that the entities that employ physicians seem to always have market share as their goal. It was noted by participants that one of the main faults with corporate employment is that it unavoidably pressures a physician not to deviate from corporate policy or be ousted if that looming threat is ignored.

One participant noted that surveys consistently show that doctors who are part of the plans in which they are employed by other doctors are the most satisfied. The example offered was the Kaiser Permanente Medical Group in California. Under that plan, management demands only licensed physicians can serve in management and they must maintain at least some level of active practice.

One of the unanswered questions was the Doctrine's effect on the quality of care. Currently, there is a dearth of solid evidence indicating whether states that have enforced the Doctrine have better health outcomes than states that do not. Some participants argued that the employment structure in which a physician is in is not as important as the impact on quality of care and how to measure that impact and make person's accountable.

Another participant agreed that there was an implicit message in the Doctrine that only physicians are capable of functioning on behalf of patients in a healthcare system. He said there seemed to be an inherent bias in the Corporate Practice of Medicine laws that physicians are noble and non-physicians are amoral when it comes to caring for the sick.

Another participant said he was not sure a ban on employment necessarily safeguards patients and that employment relationships can be structured in a way in which the hospital does not have the ability to exercise control over the direction or manner in which physicians render medical judgment. Banning employment may be harmful to patients in





certain cases. For example, in underserved parts of the U.S., employment is a way to allow physicians to practice, he added.

Participants stated that there are ways to permit employment and safeguard the physician and patient relationship. Tennessee, for example, just lifted a ban against the Corporate Practice of Medicine. The law, enacted in 1995, states that the independent judgment of physicians may not be restricted in any employment agreement.

In the Illinois *Berlin v. Sarah Bush Lincoln Health Center* case in which a lower court ruled that that a hospital cannot contract directly to employ physicians, a similar clause was offered, added one participant. The hospital vowed not to have or exercise control or direction over physician medical judgment, skill and practice. A participant who favored the employment relationship said the court's finding reflected a good faith effort by an employing hospital to recognize that physician clinical decisions should not be interfered with.

Although contractual relationships with hospitals are acceptable, another participant said the Doctrine is not banning employment but rather banning employment of physicians by non-physicians or by institutions that are nonlicensed practitioners. The debate over the pros and cons of managed care depends on how care is managed, according to this participant. The ban does not say that doctors cannot be managed and should not practice in groups that are accountable; the ban just says if doctors are going to be managed, then they should be managed by doctors.

This participant also said he was wary of having the whole quality movement held out as reassurance that the Doctrine is not necessary. The evidence on quality, in his view, just is not there. Many held the view that no matter how well-informed a patient is, there is an essential difference between the dependence a sick patient has on the services a doctor can deliver and what happens when an individual goes into the market to buy a car or appliance.

Should the employment focused corporate practice statutes be eliminated and replaced with something else?

When asked whether the Doctrine should be allowed to wither, one participant said it was hard to view it in an isolated way because the structure is reinforced by a bevy of other laws, including a bar on fee-splitting, all of which were oriented toward keeping physician judgment independent from corporate interests. One participant characterized it as one piece of a mosaic aimed at protecting patient quality and physician control over assuring that quality.

Others agreed that the Doctrine has accomplished important things, particularly promoting a commitment to professionalism in caring for patients. But it remains unclear as to whether the Doctrine has contributed to compelling physicians to put a patient's welfare ahead of their own economic interest. If there is no difference in quality, professionalism or continuity of care—things that patients value—then it has not done its job and ought to be changed or replaced, said one participant. Another issue raised by Colloquium participants was whether in areas where the Doctrine has been enforced it has addressed concerns physicians are worried about today, such as losing a large patient base if they are deselected from a health plan network with no cause.

Another participant countered that just having it on the legal books has dampened the commercial exploitation of medical practice, preventing corporations with no medical background from opening a medical clinic and employing physicians. Many participants agreed there is a self-enforcing aspect of the Doctrine that has cut down the number of arrangements that could be potentially abusive and harmful to consumers. One participant said that experience shows that the further away from straight employment relationships, the less control that is exercised over the doctors professional decision making.





Issue Area #2: Economic and Business Issues

Core Questions

- *Is the Doctrine appropriate and helpful in today's managed care marketplace in which there is:*
 - *Significant market pressure to control healthcare costs;*
 - *Managed care contracting with various provider payment methodologies;*
 - *Organizations with internal utilization review/quality assurance programs;*
 - *Organizations that have outcomes management systems; and/or*
 - *Significant competition among local providers, requiring them to access capital, coordinate services and jointly seek payor contracts.*
- *Can and should the practice of medicine be distinguished from the management of medical practices and the management of the delivery of healthcare services in applying the Doctrine? Should the payment of a "percentage management fee" be recognized as unlawful fee-splitting and a violation of the Doctrine?*
- *Is there a distinction between the operations of nonprofit and for-profit providers in the existing marketplace that justifies an exemption from the Doctrine for nonprofit corporations? Should HMOs be exempt from the Doctrine?*
- *Should the Doctrine and professional corporation statutes be modified to permit joint professional corporation ownership and the integration and coordination of care by healthcare professionals holding different licenses?*
- *Is the Doctrine consistent with economic and public policy concerns that underlie state and federal anti-kickback, physician anti-referral, antitrust, reimbursement, tax-exemption and other laws and policies?*

Major Areas of Consensus, Points of Tension and Unresolved Issues

Consensus

- There should be a line between business/administrative decisions and medical decisions.
- Physicians should be the principal architect of treatment protocols and clinical pathways. Clinical decision making that is appropriate for the patient should not be impeded by a business rationale.
- The business enterprise has to function in today's marketplace and that requires hundreds of millions of dollars in capital. Entities that clearly delineate business decisions from medical decisions are preferable to what is in the market today. Corporations that let the investors and business experts have final say over things that are clearly business oriented—such as what markets to enter, how to price products, and what the array of products are—and leave clinical matters and best practice issues in the hands of physicians would be a the best model.
- There is legitimate societal need to control costs and effectively administer healthcare.





Points of Tension

- Whether a doctor-owned and controlled company was sufficiently capitalized to compete for premium dollars, it would be the preferred model to oversee care and develop treatment protocols.
- The Corporate Practice of Medicine Doctrine is a “bump in the road” and has little to do with the inappropriate influence of money on clinical decision making. There was no consensus on whether the Doctrine is a hindrance or a help to achieving the goal of physician control of medical practice.
- Doctor-owned health plans that are competitive would be a preferred model but it should not be the only model on the market; investor owned alternatives spur competition and afford consumer choice.
- Whether there is something intrinsically superior to having physicians control the entire process of developing treatment protocols and practice criteria. Some fear favoring one model over another because alternatives are what are helping the market function.
- Whether physician-owned and controlled entities can raise the necessary capital for infrastructure to measure quality and advance technology of patient care to compete and operate efficiently. Some argued that these entities have heretofore lost money or compromised physician income for return to investors.
- How the Doctrine functions to spur downstream of risk, which puts risk as well as limited financial resources into the hands of medical practitioners who then have to make decisions.

Unresolved

- Whether medical boards or the National Committee for Quality Assurance (“NCQA”) or other accrediting organizations should confidentially survey doctors in health plans to see how their practices are being affected by corporate priorities and use the information gathered from those surveys to target problems.

Does the Corporate Practice of Medicine Doctrine help? Is it appropriate?

Colloquium participants struggled with the question of whether the Doctrine was helpful in addressing the effect economic and business interests are having on healthcare delivery and practice. Participants held mixed views on whether the Doctrine adequately addresses core contemporary health practice issues and whether it was a help or hindrance to competition.

It was noted that in states such as California or Texas—where the Doctrine is more vigorously enforced—HMOs and other managed care arrangements are flourishing. Although the Doctrine may influence the way contracts with physicians and corporate entities are structured, a majority of participants agreed that it has not thwarted the ability of managed care plans to exercise control—for better or worse—on medical decisions.

If the Doctrine were enforced more uniformly by states, it is unclear what effect it would have. A 1991 study by the OIG showed that in states with clear prohibitions on the corporate employment of physicians, hospitals could still build their medical staffs to service their emergency rooms and other essential departments through contracting. Most participants agreed that it was hard to detect that the Doctrine as currently structured by states has much of an economic effect on corporate practice.

One market proponent said that the Doctrine does have the effect of limiting ownership of medical delivery practices and thus restricts the availability of alternatives. He stated that the mere existence of the Doctrine does have consequences for patients in the same way that certificate-of-need laws (also driven by states) do. He admitted that it is hard to study empirically the effect of the Doctrine on cost and quality.

In addition, some argued that by excluding other forms of competition or alternatives for consumers, the Doctrine facilitates provider self-interest more than patient welfare. Some participants maintained that physician controlled plans would address some of the tensions in the market today. Others said that would limit opportunity for competition and the emergence of other healthcare entities that would create more choices and lower costs for patients and purchasers.

Another participant said that by breathing life back into the Doctrine and applying it to address the current and future health systems may have merit. Today, many payors rely on formulas or standards to deter-





mine whether medical care is needed or to evaluate the performance of providers. Many of the goals of the formulas are to scale back care. Historically, bars on the Corporate Practice of Medicine have prevented corporate managers from directly treating medical patients. As those bars are eliminated by virtue of state complacency, there is no legal or ethical set of principles to guide the behavior of corporate health plan managers.

Many participants held the view that deciding whether the Doctrine has helped or hurt the current economic climate in healthcare is misguided. In their view, its relevance has become more salient as costs become the overarching issue in health delivery. Many employment deals are being crafted around the Doctrine today and some participants warned that there could be future economic and quality costs if there is not a doctrine similar to the Corporate Practice of Medicine in place.

One participant said the Doctrine provides a sort of check and balance between the providers and the payors of care. As healthcare entities increasingly consolidate, there also will be a combining of control of relationships and the relationships will be left in the hands of a relatively small number of very large entities, which may be provider controlled or shareholder controlled. The Doctrine, he maintained, provides some protection against excessive corporate control.

Another participant said the Doctrine does not really have much influence on the way the medical system operates. It just requires structuring systems in different ways in different states. Some said that the best way to address problems with health plans and managed care in the future is not to rely on an absolute Doctrine that is out of touch with today's world of healthcare but to deal with abuses directly that are eroding the patient/physician relationship.

There was discussion that the Doctrine could lead to harm by becoming a shield behind which corporations and other lay entities could shirk responsibilities. Said one participant: "In other words, health plans could say it's the doctor who makes medical decisions. Because we can't employ him, we can't control him."

Those who favored more regulation of healthcare delivery disagreed. They argued that when patients go to a physician and put their care in that physician's hands, they should not have to worry that the physician's recommendations are accountable to standards or guidelines in the corporate interest and that opinions will be steered according to the employer's decree. Some argued in favor of national standards and accountable managed care arrangements that would ensure that individual doctors are responsible to each other as well as their patients for professional standards—without unwarranted interference by lay people.

The participants wrestled with how the Doctrine could solve those kinds of problems but the discussion veered into the difference between the regulatory and legislative route.

Another participant said that the rash of the state and federal laws enacted in the past year attempting to curb “drive-through” pregnancy deliveries and outpatient mastectomies are treating symptoms of a fundamental problem in healthcare today. The Doctrine can be a tool to emphasize the conflict between the economic drivers of organizations designed to be accountable to stockholders and the desire to have doctors make decisions in the best interests of patients. A revived Doctrine, he said, can address a lot of the new healthcare providers in the market and ensure that the doctor/patient relationship does not fall subservient to CEOs and stockholders.

Another physician participant said that he was troubled by the paternalistic theme being espoused by many physicians in the Colloquium, who wanted to cede to physicians the primary ability of running health plans. If physicians take control of these plans, they would also be responsible for controlling costs and utilization—something they do not have a great track record on. Competition has forced doctors to change their practice patterns, this participant said.

Others said there are plenty of examples of doctor-run managed care organizations competing with each other to keep prices down and ensure high quality. In California, there is Kaiser Permanente; in Massachusetts, the vast majority of managed care plans competing are nonprofit doctor-managed, according to one Colloquium participant.

Still others countered that the argument that the payor is not part of the doctor/patient relationship is ignoring reality. One Colloquium member argued that there is no reason for physicians to control costs until the payor enters the equation. Concern was also raised about the implication of claiming that doctor-managed organizations are superior to other forms of healthcare management. The implication is that there is something inherent in a physician’s character that makes their style of management more friendly to patients and more conducive to good medical outcomes.

One participant noted that most physicians, when they become managers, take on the characteristics of managers. When there is a bottom line to worry about, they behave comparably to corporations. If the intent is to preserve the doctor-run organization, it seems naïve to assume that doctors are exempt from corporate motivations. Another physician participant agreed that if all management of the system were handled by doctors, it is not clear whether doctors at the bedside would practice more effectively.





Another physician participant said it was possible to have medical decisions made under the exclusive domain of those trained and licensed to do so with appropriate protections for their ability to have independent judgment, and still have payors involved in deciding what they will pay for.

How could the Corporate Practice of Medicine Doctrine solve problems arising in the marketplace today?

There was no unanimity on the Doctrine's utility today. Many felt that the Doctrine is a relic of the past, causing unnecessary expenses, and hindering development of innovative delivery. Many participants who support it and want it revived acknowledged that it is easily circumvented. But most Colloquium participants accepted that until the tensions in the health system are eased and patient confidence in healthcare grows, the Doctrine's inconveniences are tolerable. Its existence does force people to consider its origins and initial goals, some participants conceded.

One Doctrine foe said the idea of blocking hospitals from employment seems gratuitous because these are highly regulated, licensed and accredited institutions with an independent medical staff and an independent legal obligation to the patient. There is not the same kind of conflict as with other corporate entities. Other participants disagreed, noting that corporate policies influence medical decisions when they are closely linked to financial incentives. A straw poll taken during this session reflected that a majority of Colloquium participants believed that management of physicians violates the Doctrine. But it depends on how a contract is structured and how tightly physicians are managed by a corporate entity. For example, a physician organization seeking management services to help with a capitation contract would be acceptable; it is a matter of where to draw the line.

Should there be an exception from the Doctrine for nonprofit entities?

There was a lengthy discussion about how the tax status of health systems affects control and patient care. One participant said there does not seem to be a difference because there are so many hybrids in healthcare today. The for-profits have nonprofit foundations and the nonprofit integrated systems have for-profit subsidiaries. One participant said it was difficult to make a distinction on social contribution anymore. Another agreed that it is becoming difficult to tell the difference between the behavior of a for-profit and nonprofit healthcare organization anymore.

Another participant said that there is an assumption that the non-profit tenet is adhered to and that its fundamental mission is public service. Consequently, he said the relationship it has with the public and the nature of the fiduciary obligations of its officers and directors are different than for a for-profit corporation. Another participant said there is a vast difference in management between for-profit plans such as the for-profit Aetna/U.S. Healthcare and Group Health of Puget Sound, a nonprofit plan. He said tax status is crucial.

Another participant said that the central issue vis-à-vis the Doctrine is the issue of control. She said she would be hardpressed to see how the tax status of an entity would affect a difference about the concerns surrounding control over clinical decision making.

In the end, there was no consensus about whether the Doctrine should be applied to for-profits rather than nonprofits. The majority of participants agreed that the ultimate for-profit/nonprofit nature of an organization that might employ a physician would not affect implementation of the Doctrine. One participant summed it up: "I don't see there's a difference of behavior or action between nonprofits and for-profits generally. They do have subsidiaries. They do have foundations. That's the reality." He raised an example of how a nonprofit hospital ousted a physician medical director for disagreeing with the facility's business plan. The final decision is always made by corporate leaders, whether in a nonprofit or for-profit, he added. Another participant said although he sees major differences in the way nonprofits and for-profits operate, he would not espouse enacting a law simply to protect nonprofits from corporate practice bans.

As policy makers consider alternatives to the Doctrine to accommodate contemporary practice, one participant said that safeguards for patient protection and physician/patient joint decision making should be applied equally to for-profits and nonprofits.

Some participants argued that if there were not for-profit entities such as physician practice management companies or HMOs willing to help doctors practice, the solo practitioner would not survive. Doctors today need capital and equipment to compete if they want to negotiate with health plans for business. The real question, this participant emphasized, was how to balance control over the physician and management provided to the physician within the bounds of corporate goals. This person argued that there is not anything inherently wrong with some measure of shared control. The issue is really how to help physicians exercise the right control over their patients and in what areas are physicians losing control.





There was a brief discussion about professional corporation statutes and whether providers of similar licenses such as optometrists and ophthalmologists should be prohibited from being co-shareholders in the same professional corporation. In California, this kind of activity is allowed and there have been no problems, according to one participant. Another participant said if this were barred, it would eliminate some of the innovation that is occurring now in multi-specialty groups. One participant said that the incentive to churn out patients would diminish if physicians were required to take a fixed fee or assume risk for patients.

If corporate practice is needed in today's healthcare environment, why should the Doctrine remain?

The discussion then shifted to why the Doctrine should remain if it is not necessarily having much of an impact on quality of care and physicians are not in control anymore. One participant said the reason is that there needs to be some active corporate practice of medicine attention. He noted that the market is heavily commercialized and price remains the dominant consideration and there is no adequate or comprehensive way of ensuring that sick patients are well taken care of. The only way is to hold doctors accountable to patients, to malpractice liability and to colleagues.

Even if it were not enforced and the limits in the various states were removed, others said it remains a blunt instrument aimed at using inappropriate controls over medical doctors. Even if it is enhanced, the person argued it would be easy to evade. Some argued that there needs to be a completely different solution other than the Doctrine.

The Doctrine's utility remains unclear. There was some question as to whether physicians can exercise independent judgment with or without it in place. Some argued that it has become the "scapegoat" enabling organized medicine and others to avoid focusing on professional judgment in a competitive world. There are also some societal goods and benefits that flow from an employer model that the Doctrine attempts to prohibit, some participants noted.

One participant called corporate practice bans a "slight irritant" that have little impact on preserving quality and just produce more work for lawyers. There was a split on the value of the law or whether it should be strengthened. Although there was no consensus, many argued that regulatory solutions with protections to thwart egregious actions in the market by non-licensed corporations seemed more appropriate.

Issue Area #3: Regulatory and Enforcement Issues

Core Questions

- *Should uniform national standards and enforcement of the Doctrine be required because of the multi-state nature of the healthcare marketplace?*
- *If the Doctrine is eliminated, should entities with economic control assume liability for medical decision making?*
- *Would licensing all entities providing medical treatment serve as a substitute for the outright prohibition on the corporate practice of medicine?*
- *Are the true beneficiaries of the Doctrine only the patient and his or her physician or do payors (business, government and their proxies) also have a legitimate interest in the use and enforcement of the Doctrine?*
- *If the Doctrine is to be enforced, what penalties for its violation are appropriate to impose on physicians, other healthcare professionals and the business entities with which they contract?*





Major Areas of Consensus, Points of Tension and Unresolved Issues

Consensus

- The Corporate Practice of Medicine bar has proven to be ineffectual in preventing inappropriate economic pressure on physician medical judgment but bans on employment by corporations are easily circumvented.
- There should be no national Corporate Practice of Medicine bar. The state laws should remain a state specific issue until they are replaced with regulation or legislation that resolves some of the control problems that rankle physicians and consumer advocates.
- National standards should include forcing plans to disclose what benefits are covered, the financial arrangements they have with physicians, medical loss ratios and the medical protocols that will be used and why. Also standards would not allow health plans to shift all risk to providers. They would limit a provider's risk assumption and require that plans have reinsurance policies. Plans also would have to meet solvency standards.
- The focus of standards should be on inappropriate control rather than imposing some new national licensing scheme.
- Standards developed should not impose inappropriate financial pressures on physicians that would lead them to underutilize and limit choices that patients have available in the marketplace.
- Because the goal is to protect patients, they need a venue for speedy remedy against a physician and a health plan. Patients will need to appeal and seek relief if they feel they are being dealt with unfairly or that the care they are getting is inappropriate.
- There should be more targeted standards to judge and regulate broadly defined healthcare delivery organization to get at the core of the physician/patient relationship. There needs to be more targeted standards that recognize the importance of physician control of medical decisions in the marketplace.
- Private accreditation may offer some solutions because of concern about government regulation.

Points of Tension

- There was disagreement as to whether the Doctrine should be abolished because, to some, it is crucial to a state's medical licensing process and interwoven with many other elements of professionalism. Abolishment, in the view of some participants, would accomplish little because it does not get at the root of today's problems over clinical control.
- There was no consensus on whether states should develop standards on their own or whether the federal government should. Some participants wanted states to develop standards on their own; others preferred uniform model acts for states to embrace or use as guides; others thought compliance could be tied to participation in the Medicare and Medicaid programs; one participant wanted national standards applied to all states; others favored a generic accrediting body such as the NCQA or the Utilization Review and Accreditation Committee ("URAC").

Unresolved

- Who would be responsible for enforcing compliance with the standards? Some thought enforcement should be handled at the state level by attorneys general or insurance commissioners, others thought the federal level via Medicare's regulatory apparatus or by the Labor Department, which regulates self-insured health plans under the 1974 Employee Retirement and Income Security Act ("ERISA").
- At what level would standards be imposed? Some thought they should be imposed at the plan level; others thought it should be at the physician level. Participants worried about the potential pitfall of tilting the playing field in one direction or another or favoring one type of entity over another, which could have the unintended consequence of limiting consumer choice.
- Also, there was no resolution on which standards should be linked to licensure and the ability to market a product and which ones should be tied to certification or accreditation. There is a major distinction between mandatory licensure and certification in terms of regulatory oversight.





Exactly who should be liable for medical decisions in a market in which business judgments routinely intersect with day-to-day healthcare practice?

Colloquium participants wrestled with a hypothetical case that exemplified the kinds of conflicts that arise regularly between payors and physicians today. The case also raised questions about how far liability responsibilities should extend when corporate entities are steering much of the healthcare decisions for patients, particularly when physicians are under their employ.

The hypothetical case involved a woman with a heart condition who was hit by a bus, brought to an acute care hospital, and suffered paralysis on her left side after a group of HMO employed physicians with staff privileges failed to diagnose a hematoma. Part of the reason for the faulty diagnosis stemmed from the decision by the medical director of the managed care plan to disallow payment for or transfer to a tertiary care hospital that would have been more equipped to handle such a complicated case.

In many parts of the U.S., these kinds of cases are now being debated in the courts. HMOs contend that because they do not “practice” medicine, they are not fiscally liable for the adverse consequences of a bad medical decision. Physicians, on the other hand, feel that HMOs through clinical guidelines or coverage policies are significantly influencing their judgment and thus should be culpable for poor medical outcomes if they are related to a claims payment decision. Most legal health experts will accede that there is a clear trend to make health plans more liable for their decisions in this area. The trend has already begun. In May, Texas passed the nation’s first law that lets consumers sue health plans for adverse medical outcomes stemming from plan policies. The law already has been challenged in court by a major insurer in that state.

Should there be corporate liability if a managed care organization employs a physician?

Some participants said it was very simple—that there should be a duty of care from the organization to the patient. One participant said that both the medical director of the health plan and the health plan that hired that physician should be liable for decisions that a hired physician makes. The rationale: the health plan has gotten into the business of making medical decisions by virtue of setting coverage policies and should therefore be held accountable.

Many physicians are feeling constrained because health plans are rendering medical decisions, but they are not sharing in the responsibility if those decisions yield negative consequences for the patient. One participant said doctors find it untenable and believe that they will not get quality medical decisions at the corporate level until there is accountability by the physicians in the plans as well as the plans themselves.

The other issue that was debated by Colloquium participants was the culpability of the employer who buys healthcare for an employee. A large proportion of employers offers only one plan or promotes one health plan option over another to keep their costs down. Participants discussed whether those employers should be held liable if a patient receives inadequate medical care from that health plan.

This issue of shifting liability onto employers who choose a plan or network but otherwise have no control over the so called “upstream liability” is a major one purchasers are grappling with today. Employers are examining the effects of plans making direct coverage and benefit decisions on treatments. In general, they take the position that treatment should be allowed regardless of what the coverage parameters are and whether payment will be allowed, according to one participant. Employers worry that if the corporate enterprise takes on liability, it could absolve physicians from responsibility to a certain extent.

In addition, the idea of transferring liability to a corporate entity or enterprise could exacerbate the concerns many Doctrine defenders have about the deleterious effects of the Corporate Practice of Medicine. One participant likened it to a slippery slope. Transferring liability responsibilities to employers and other commercial entities could encourage them to get more involved in treatment strategies and aggressively second-guess physician clinical decisions to protect themselves and their shareholder interest from lawsuits.

Many Colloquium participants agreed that when a physician’s recommendation is overruled by an HMO, the HMO should be liable because it is likely that the medical director’s coverage decision was dictated by the plan’s cost concerns. This would not take physicians off the hook if they failed to diagnose, as in the case example presented at the start of the session. Participants also considered the possibility that a health plan could turn around and shift liability to employers or purchasers, whose choice of a cheaper health plan left the HMO with little financial wiggle room when it came to deciding what it would or would not pay for.

The fact that physicians, patients and hospitals are left on the hook if the health plan does not pay is a contemporary practice that is breathing vibrancy into bars on the corporate practice of medicine, said one participant.





Is upstream liability a substitute for the Corporate Practice of Medicine Doctrine?

Other participants said focusing on tort liability is the wrong way to address gaps in the Corporate Practice of Medicine Doctrine. Some said it was a related but a side issue to the conflicts occurring in healthcare practice today. One participant said that the problems with corporate medicine are not going to evaporate by simply making it easier for patients to sue, noting that society already is overly litigious when it comes to medical services.

Another participant said there are a lot of parallels. He noted that there are many cases in which HMOs escape the Corporate Practice of Medicine ban and are sued for negligence. In California, parents sued an HMO for malpractice for refusing to give their child a CAT scan after she had fallen. The child had suffered a benign brain tumor several years before the incident but HMO protocols indicated that a CAT scan was not necessary based on the conditions surrounding the fall. The child suffered a cerebral access that left her blind and mentally retarded.

Another participant agreed that liability issues are a separate matter and have little to do with the relevance of the Doctrine. He maintained that if there is someone in the decision making stream that renders a negative judgment that injures a patient, that person should not be able to escape responsibility.

Another physician emphasized that the majority of HMO medical directors are not letting financial issues drive medical decisions when a patient's well-being is at stake. In many cases, the competence of the doctors conveying the patient's status can contribute to poor decisions. In the case example, it was unclear whether the physicians were providing the medical director with enough compelling evidence to justify a transfer. This raised questions about liability as well; if physicians are not sufficiently informing the health plan, then is the health plan liable for a decision based on inadequate information?

Although physicians are faced with having to quibble with health plans about whether a treatment is medically appropriate, they are still obligated to deliver the best care possible to a patient regardless of corporate pressures, argued one participant. Another participant agreed. Although the U.S. does not have a system of universal healthcare coverage, the medical system and the practitioners that work in it have a responsibility to treat people without regard to whether or not they can pay. A physician may be told that a treatment may not be covered but that does not mean a physician should not proceed and make the decision about what is appropriate.

Another participant noted that the malpractice restraints on physicians and hospitals is the backstop to patients being underserved. Despite the growing dominance of corporate decision makers in healthcare, there is not a comparable backstop. One member of the Colloquium said that it was unfair to assume that providers will pick up the slack if the health plan will not pay, noting that there is not any other sector of the economy in which that kind of response is expected.

One physician participant said for physicians to give the necessary care, regardless of whether that doctor gets paid or not, is not focusing on reality. Doctors in general are trained to treat patients regardless of their ability to pay. But he said if a doctor routinely admits patients to the hospital and there is no payment, the hospital is going to flounder and the doctor will suffer for failing to meet his fiduciary responsibilities.

Some health organizations are trying to find ways to protect physicians from liability, noted one Colloquium participant, including setting up clinical pathways and promising the medical staff that if they make a treatment decision based on those pathways then the hospital will protect the physician.

Another way to protect patients is to erect safeguards through the legislative process. One participant proposed a list of safeguards that would be needed to protect patients who are in risk arrangements in which the incentives are cost driven. There was a suggestion that these be legislated by Congress so that it would affect self-insured health plans, which under ERISA, are able to escape state regulation. About 60% of covered Americans are in such plans. Suggested legislative provisions included the following:

- Ensure that patients or plan enrollees understand what they are getting, with a clear explanation of benefits, including access to specialty care.
- Require disclosure of protocols and guidelines that are in place and the processes that are used in utilization management so patients will understand what kind of rules might govern decisions about hospital transfer.
- Mandate disclosure of the financial incentives put before physicians in the plan that could affect their treatment decisions.
- Maintain free access to information between physician and patient.
- Disclose medical loss ratios so patients would know how much plans are spending on medical care and how much is being plowed back into the plan for administrative costs and staff salaries.
- Require plans meet and publicize solvency requirements so patients know what they are before a plan flounders.





The preceding list contains several issues aimed at providing information to consumers to improve their ability to make choices and control their own medical care, principles at the heart of the Doctrine. Many of these safeguards are already being carried out by the NCQA and other accreditation groups such as the URAC. Colloquium participants agreed that these kinds of protections could be monitored by private accrediting groups that would see to it that they are carried forth by health plans.

The HMO industry also is responding to these kinds of concerns. The American Association of Health Plans, which represents 1,000 managed care organizations, is considering many of the components on the list. Health plans would have to have these kinds of policies in place to retain membership in the national trade association. Many plans have already adopted these informally and many of the proposals are either being required via state regulation and state licensing or through voluntary accreditation bodies. In addition, a national commission on quality—appointed by President Clinton—is now working on a national patient bill of rights that could become federal law.

There was relative agreement among participants that the more financial risk for healthcare that the doctors assume, the more control over decisions they will have as they try to manage those dollars. As risk is downloaded, Colloquium participants held the view that the decision making process would become more centrally provided by physicians.

Overall, participants did not feel that upstreaming liability was an effective substitute for addressing corporate practice tensions. One participant felt strongly that regulations or safeguards for consumers will not supplant the need for the Corporate Practice of Medicine Doctrine because ultimately the patient is still being treated in a system that owes it primary fiduciary responsibility to stockholders.

There was brief discussion about adding the ban on corporate practice to the list of safeguards, but the response was unenthusiastic. One participant said he would not put the Doctrine on the list because it is too blunt an instrument and too easily abated.

Another participant suggested that to get licensed or be approved by a private accrediting agency, HMOs should have to satisfy a stipulation that physicians have appropriate responsibility for medical decisions and there be a physician's committee or appeals mechanism for physicians. Another participant questioned who would enforce a list of practices that are declared illegal or likely to interfere with the decision making process of doctors. There was skepticism that these would be enforced any more vigorously than the Doctrine has been in recent years. At least the Doctrine exists, this person argued. If it is abolished and replaced with a list of prohibited practices, will those be enforced?

Another participant countered that the ills that a corporate practice bar was intended to prevent have not evaporated. Consequently, it is important to find other solutions. Empowering consumers and getting them more involved in medical decisions is a very important goal that would preserve the principles of the Doctrine.

One participant said that a list of safeguards does not have to be mutually exclusive with Corporate Practice of Medicine statutes. But it is a more practical and realistic mechanism to deal with problems the system is creating for physicians and patients today.



IV. CONCLUSION

After a day-and-a-half of deliberations, several major themes emerged from the Colloquium:

- Despite significant problems with its historical definition and enforcement, it is too early to abolish the Corporate Practice of Medicine Doctrine. Nevertheless, there remains a clear split over whether the Doctrine is a relevant tool to address the tensions erupting in the marketplace today.
- The Doctrine's primary target of employment does not reach the core issue that concerns physicians and patients today, which is control over decision making in a market driven by payors and insurers.
- Healthcare delivery has to function in a competitive marketplace but there are ways to enhance the ability of physicians to control delivery decisions in this marketplace.
- There should be new, better, more targeted standards to judge or regulate delivery systems to ensure that the physician/patient relationship is preserved. Putting medical decisions in the hands of physicians and consumers will better protect the core values that the Doctrine was initially intent on promoting.

Although Colloquium participants began with a wide range of starting positions on the Doctrine's utility, discussion resulted in key areas of agreement that could help policy makers in the future.

There was strong consensus that the point of contact between physicians and patients should be physician oriented. All participants believed that physicians should be at the helm of clinical decisions and patients should be assured that those decisions are not driven by corporate motivations. But the group also felt that the Doctrine's focus on employment relationships is misguided and fails to address the anxieties that patients and physicians are feeling today.

Although there are legitimate concerns about the financial pressures that jeopardize physician decision making and control, most participants agreed that a ban on corporate employment does not influence the quality and choice issues that American patients value. The majority of participants felt that the sixty-year-old Doctrine is an insufficient response to the cost and practice pressures that exist in today's market setting. But in the absence of a better alternative, there was no consensus on whether a bar on corporate employment of physicians by non-licensed entities should remain or be lifted.





A majority of participants favored abolishing or replacing the Doctrine if better standards were developed and implemented to govern relationships between health plans, physicians and patients. Colloquium participants agreed that there should be development of targeted standards that recognize the importance of physician control of medical decisions and patient rights under managed care. Just abolishing the Doctrine without standards aimed at countering the tensions in contemporary healthcare delivery would accomplish little, the majority agreed, because it does not get at the root issues of autonomy, control and protection of patient care. There remained some tension, however, over how standards should be enforced and by whom. Colloquium participants agreed that in light of continued opposition to government intrusion, private accreditation agencies would be part of the solution to assuring that objective standards are carried out and data relating to quality outcomes are continually gathered and monitored.

Colloquium participants also agreed that there may be alternative models of delivery that would temper concerns. These models would have to balance the desires of the business side of healthcare with the medical practice side. The ultimate goal of these models would be to preserve the patient/physician relationship.

The Doctrine's utility as a preserver of physician independence in directing clinical decisions remained the greatest point of tension. Participants were clearly split on whether it is an adequate safeguard against inappropriate influence on medical judgment. There were many who said its current structure is a significant problem; a minority of participants wanted to keep it or enhance it. This was an issue that was not resolved by the Colloquium.

For now, the Doctrine serves as a life raft in a sea of realigning healthcare relationships. Even those participants who described it as absolutely ineffective in achieving its intended purpose and a potential hindrance to establishing cost-effective health delivery models were reluctant to advocate complete abolishment.

Some argued that addressing the Doctrine's structural and definitional shortfalls could be resolved by simply replacing it with another type of mechanism that would better address the core issues challenging the physician/patient relationship in today's healthcare arena. For many, proposing that it be repealed without replacing it with a set of laws or regulations or standards that accomplish important consumer protection goals would send a strong message that corporate control of medical practice is acceptable.

Many Colloquium participants also were torn by the prospect of complete abolishment because it is unclear what ills the Doctrine has caused. In the absence of something better that could be adequately enforced, the Doctrine serves a purpose. The majority of Colloquium participants seemed to agree that its historical lineage is irrelevant to the healthcare market of today and the future. Nevertheless, the intensity of the discussion made clear that the Doctrine serves as an important springboard for debating the challenge of balancing the modern control and quality concerns of patients and physicians with the legitimate business goals of cost containment—all of which are relevant to the future structure of the healthcare delivery system. Participants agreed that the goal is not to return to the unfettered healthcare era of the 1950s but to develop systems that can balance physician and patient autonomy with the need to keep the United States healthcare system from bankrupting society.



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