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Sara D. Mars

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THE CORPORATE PRACTICE OF MEDICINE: A CALL FOR ACTION

Sara Mars†

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† B.S., Business Administration, University of Southern California, 1992; J.D. Candidate, Case Western Reserve University School of Law, 1997. The author will be an Associate in the Health Law Department of Foley, Lardner, Weissburg & Aronson, Los Angeles, beginning October, 1997.
I. INTRODUCTION

THE DOCTRINE PROHIBITING THE CORPORATE practice of medicine evolved as a state law restriction in the early 1900s. Although this prohibition cannot be traced to one direct source of law, it has emerged through a combination of states' medical practice acts and public policy arguments espoused by several courts.1 Some legitimate fears associated
with allowing corporations to engage in the practice of medicine can be attributed to interests in preserving the sanctity of independent physician-patient relationships. Those who are wary about allowing corporations to practice medicine fear that the disjointed interests of physicians (presumably concerned with the well-being of patients) and corporations (presumably concerned with shareholder satisfaction) will jeopardize the quality and delivery of health care. "[C]ommercialization of [medicine], exploitation of the public, and quackery" were perceived to be evils that would ensue if corporations were authorized to practice medicine.

Despite these legitimate concerns associated with allowing corporations the freedom to practice medicine, state and judicial enforcement since the 1950s has remained almost nonexistent. This lack of enforcement, however, does not mitigate the chilling effect that the doctrine imposes on practitioners and other medical providers.

Notwithstanding the lack of enforcement, the justification behind barring corporations from practicing medicine appears to overlook the realities of the current health care market place. The justification is eroding as a result of the myriad statutory

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1. 1994) (discussing public policy concerns such as divided loyalties and loss of physician autonomy); Cal. Ass'n of Dispensing Opticians v. Pearle Vision Ctr., 191 Cal. Rptr. 762, 768-69 (Cal. Ct. App. 1983) (discussing public policy against lay control over optometrists); Parker v. Bd. of Dental Exam'rs, 14 P.2d 67, 72 (Cal. 1932) (raising the concern of divided loyalties among licensed dentists and a dental corporation).

2. The use of the term "practicing medicine" throughout this Note includes such acts as corporations hiring licensed medical practitioners to provide needed medical services.

3. Alanson W. Willcox, Hospitals and the Corporate Practice of Medicine, 45 CORNELL L.Q. 432, 434 (1960).

4. See Patricia F. Jacobson, Prohibition Against Corporate Practice of Medicine: Dinosaur or Dynamic Doctrine? in 1993 HEALTH LAW HANDBOOK 67, 67 (Alice G. Gosfield ed., 1993) (commenting that the doctrine is a "hibernating bear waiting to wake up and assert itself"). See also J. Anthony Manger & Linda J. Cowell, The Corporate Practice Doctrine: Is it Still Viable?, HEALTHSPAN, Apr. 1989, at 3, 8 (1989) (cautioning practitioners that even if health care providers have devised ways to side-step the corporate practice doctrine, the need to reevaluate the doctrine is still alive). See also Mark A. Hall, Institutional Control Of Physician Behavior: Legal Barriers to Health Care Cost Containment, 137 U. PA. L. REV. 431, 509-11 (1988) (stating that even if the corporate practice of medicine doctrine exists nominally, the prohibition will still influence corporations' willingness to innovate changes in organization).

5. The corporate practice of medicine prohibition is a "potential legal landmine for an industry seeking to develop new structures and relationships in response to market pressures." James F. Blumenstein, Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation, 79 CORNELL L. REV. 1459, 1471 (1994).

and common law exceptions. Medical practitioners and providers must not ignore the corporate practice prohibition since it is hard to predict when it will be enforced. It can hardly be denied that in some respects the landscape within which physicians practice medicine in the 1990s can be distinguished from that of the early 1900s when the doctrine came into vogue. Therefore, it is difficult to rationalize why the doctrine should remain unmodified. State legislatures must review the prohibition and eliminate vestiges of its strictness if the strictness no longer fits within the modern delivery of health care.

State legislatures cannot maintain the doctrine as it existed in the early 1900s without considering the changes in the structure and delivery of health care today. There has been a trend toward moving away from traditional indemnity health insurance plans (fee-for-service) toward managed care plans (capitation). The number of Americans enrolled in health maintenance organizations (HMOs) increased from nine million in 1980 to forty million in 1992. With a greater emphasis toward cost-containment in health care, several physicians predict that the health care industry will rely primarily on corporate physicians working as salaried employees of managed care plans, medical groups, medical foundations, and hospitals. Medical groups, hospitals, and management service organizations (MSOs) are also aggressively purchasing physician practices to achieve greater economies of scale. Furthermore, attitudes of practicing physicians appear to be more accepting of direct employment relationships with institutional health care providers. In fact, many physicians today prefer employment by medical corporations over the traditional solo-practitioner arrangement.

7. The image of the gray-haired sole-practitioner family practice physician no longer depicts the way in which health care is administered today.
11. More and more physicians are opting into employment relationships to ease the admin-
Considering these developments in the health care industry and looking forward to the twenty-first century, it is difficult to perceive how state legislatures can allow the corporate practice of medicine doctrine to remain exactly as it stands today. As corporations around the nation attempt to respond to the problem of high health care expenditures by controlling costs through integrated delivery systems, "[the doctrine's] sweep becomes oppressive . . . as it threatens desirable experimentation." Therefore, state legislatures must review the existence of the doctrine in light of the dramatically integrated health care delivery system that exists today.

There are some abuses that the corporate practice of medicine doctrine was developed to protect against which still must be discouraged. Legitimate concerns include physician autonomy over medical judgments, divided loyalties between a medical corporation, its physician employees and its patients, and allowing unlicensed or lay persons to make medical treatment decisions or diagnoses. However, imposing a complete ban on

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istriative burdens within their practices. See Mike Mitka, Doctor Pay Shrinks for the First Time in '94, AM. MED. NEWS, Jan. 22, 1996, at 1 (discussing a survey performed by the American Medical Association's Center for Health Policy Research indicating that although self-employed physicians are paid more than employee physicians, their presence in the market is decreasing—58% in 1993 as opposed to 55% in 1994, while employee physicians have increased their presence in the market from 36% to 39%, respectively). See also Jeffrey F. Chase-Lubitz, The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry, 40 VAND. L. REV. 445, 446 n.8 (quoting Wessell, More Young Doctors Shun Private Practice, Work as Employees, WALL ST. J., Jan. 13, 1986, at A1, which referenced a 1983 study conducted by the American Medical Association that found that 39% of patient-care doctors younger than age 36 were employees of corporate entities or large group practices. The study also stated that the percentage of doctors who were employees decreases in older age groups as follows: 23% of those between the ages of 36 and 45, 20% of those between the ages of 46 and 55, and 19% of those over age 56).

12. National health care expenditures are estimated to have reached $938 billion in 1994, an increase of 6.1% over 1993. As a percent of the total United States economy (GDP), these estimates are high. However, national health care expenditures are estimated to remain constant at 13.9% of GDP. Leveled growth in national health care expenditures predicted for 1994 can be attributed to moderate growth in national health care expenditures coupled with relatively strong growth in GDP. 1995 national health care expenditures were predicted to reach $1 trillion (14.2% of GDP). In 2000, national health care expenditures are predicted to reach $1.5 trillion (15.9% of GDP) and in 2005, national health care expenditures are predicted to reach $2.2 trillion (17.9% of GDP). See Sally T. Burner & Daniel R. Waldo, National Health Expenditure Projections, 1994-2005, 16 HEALTH CARE FIN. REV., Summer 1995, at 221 (projecting national health care expenditures for 1994-2005 using 1993 as a baseline year and assuming current practices and laws remain constant).

13. See Hall, supra note 4 (quoting Joseph Laufer, Ethical and Legal Restrictions on Contract and Corporate Practice of Medicine, 6 LAW & CONTEMP. PROBS. 516, 527 (1939)).
medical corporations' abilities to employ physicians remains too strict and creates a chilling effect on health care providers and practitioners who would like to enter into employment arrangements with medical corporations.

This Note will focus on why mitigating the strictness of the corporate practice doctrine in relation to its prohibition against allowing corporations to enter into employment agreements with licensed medical practitioners should be encouraged and implemented through amendments to existing state legislation. Although the corporate practice of medicine doctrine includes a prohibition against fee-splitting, that topic is beyond the scope of this Note. This Note will develop a unique analysis of the corporate practice of medicine prohibition by examining its weakening rationale as it is being whittled away by numerous exceptions. Also, this Note will offer a unique way of modifying the doctrine, considering the numerous safeguards already in place, through a proposed Uniform Physicians Employment Act. Although the corporate practice doctrine has been previously criticized, there have been no works that have recommended solutions to its strictness.

Section II of this Note will briefly outline the origins and development of the venerable corporate practice of medicine doctrine. Section III will describe the legal and policy flaws and inconsistencies with the doctrine vis-à-vis the current health care system. Section IV will discuss numerous legal safeguards available to aid in protecting against those evils which the corporate practice of medicine doctrine set out to prevent. Section V will illustrate the potential threat of the doctrine's staying power in light of recent federal and state legislation. Finally, Section VI of this Note proposes to eliminate the strictness of the doctrine by creating an alternative Uniform Physicians Employment Act. This uniform act will serve as a means for states to reconsider their current laws pertaining to the corporate employment of physicians by advocating a unified approach for practitioners and providers. The Uniform Physicians Employment Act will encourage greater

consistency for practitioners and providers throughout the nation. As long as specific conditions are met by corporate health care providers, these corporations should be able to directly employ physicians to administer health care services under the Uniform Act.

II. ORIGIN AND DEVELOPMENT OF THE CORPORATE PRACTICE OF MEDICINE DOCTRINE

The corporate practice of medicine doctrine originated in the early 1900s "as an ethical restriction on physicians’ economic relations." Medical practice in the nineteenth century was regarded as an inferior occupation. Physicians faced competition with several "‘irregulars’ — quacks and healing sectarians" who were not formally schooled in traditional medicine. Patients were "[d]isenchanted with the often ineffective and sometimes fatal results of ... [popular] treatments," and turned to the irregulars and their promises for speedy cures. Therefore, in 1846, the American Medical Association (AMA) was established in part to curb the dissatisfaction within the medical profession between physicians and "irregulars."

Notwithstanding the competition physicians faced from irregulars in the late nineteenth century, independent physicians were competing against contract practices. Contract practices were arrangements where corporations employed physicians to treat employees working in isolated industries such as mining and industry. This practice was the only way that employees of remote industries such as these could obtain health care. Independent physicians faced competition with other forms of corporate practices as well.

The sentiment among physicians regarding contract and other corporate practices was mixed. Some physicians opposed

16. Chase-Lubitz, supra note 11, at 446.
17. Id. at 448.
18. Id. at 449 (describing popular treatments administered by physicians such as "bloodletting, purging, and administering heavy dosages of mercury or quinine").
19. Id. at 456 (defining contract practices as corporations employing physicians to treat their employees in isolated industries such as "railroad, mining, and lumbering" as well as non-isolated corporations for a "predetermined salary" dictated by the corporation).
these practices because they created a bidding war among physicians vying for work, which drove the levels of reimbursement down to unthinkable levels. Physicians were no longer protected by the “monopolistic designs” of the medical profession. Other physicians, however, welcomed contract and corporate practices because of the stability of income these practices provided.

In the end, those physicians opposed to the contract and corporate practices influenced the AMA to enact provisions to prohibit them. The AMA responded by creating a set of ethical provisions to prohibit these types of practices. However, the decision in American Medical Association v. Federal Trade Commission eviscerated physicians’ efforts to prohibit the corporate practice of medicine through the AMA’s Principles of Medical Ethics. As a result, the prohibition against the corporate practice of medicine can no longer be enforced as an ethical restriction on physicians. Instead, it must be read through state statutes, medical practice acts, licensure requirements, as well as public policy arguments espoused through common law.

Only a small number of state statutes explicitly prohibit the corporate practice of medicine. More typically, the prohibition against corporations practicing medicine is implied by interpretation of state medical practice acts or state licensure requirements coupled with public policy concerns. Courts that have perceived the prohibition as stemming from statutory medical practice acts or licensure requirements hold that non-natural persons, like corporations, are not able to meet the requirements for practicing medicine. It is common for state licensure requirements to call for licensees to possess “consciousness, learning, skill, and good moral character.”

20. Id. at 457-58.
21. But see AMA v. FTC, 638 F.2d 443, 453 (2nd Cir. 1980) (holding that the AMA’s ethical principles which forbid physicians from entering into arrangements with any non-physician entity are anti-competitive).
22. Id.
23. See also infra Appendix-A for a state by state comparison of statutory prohibitions against the doctrine as well as carve-outs.
artificial entity, like a corporation, cannot possess those qualities and is not able to sit for medical board examinations, which is another requirement of some state statutes. Furthermore, the doctrine also prohibits fee-splitting arrangements between medical corporations and physicians.25

Public policy concerns provide an additional line of judicial attack against the corporate practice of medicine. First, physician employment by corporations controlled by lay persons arguably may reduce physician autonomy over medical judgments.26 Second, employed physicians may experience a sense of divided loyalty between their profit-seeking employer and their treatment-seeking patients.27 Finally, public policy arguments have been raised to attack the commercialization of the medical profession. Critics of commercialization within the health care arena are concerned that investors in for-profit medical entities that employ physicians will exert too much pressure on their physician-employees to promote the sale of professional services in order to obtain large profits.28 This may create pressure on employed physicians to place a greater emphasis on profitability over quality of patient care.29

25. See Hall, supra note 4, at 488-504.
27. For cases discussing divided loyalty, refer to Pacific Health Corp., 82 P.2d at 430 (discussing divided loyalties as a problem whether the physician receives benefits as salary or fees from a corporation); People v. United Med. Serv., Inc., 200 N.E. 157 (Ill. 1936) (discussing the corporate effect on the physician-patient relationship).
28. See Bartron v. Codington County, 2 N.W.2d 337, 346 (S.D. 1942) (discussing the for-profit influence upon the medical profession and finding it against public policy).
29. See Mark A. Hall & Justin G. Vaughn, The Corporate Practice of Medicine, in FOUNDATION AND REGULATION 3-3, 3-11 (Mark A. Hall ed. 1993). For cases discussing commercial exploitation, refer to State v. Boren, 219 P.2d 566, 567 (Wash. 1950) (allowing the state legislature to prohibit a corporation from owning or maintaining a dentistry practice in order to combat its commercial exploitation); Bartron v. Codington County, 2 N.W.2d 337, 338 (S.D. 1942) (discussing the for-profit influence upon the medical profession and finding it against public policy); Silver v. Landsburgh Bros., 111 F.2d 518, 519 (D.C. Cir. 1940) (differentiating the practice of medicine from the practice of optometry); Parker v. Bd. of Dental Exam'rs, 14 P.2d. 67, 71 (Cal. 1932) (describing the state's rejection of the commercial exploitation of dentistry).
III. PROBLEMS WITH THE CORPORATE PRACTICE OF MEDICINE DOCTRINE

A. State Licensure Requirements

State legislatures are given the power to regulate the practice of medicine since treating patients affects public health and safety. Concerns for protecting "public morals" also provide a justification for state legislatures to enact laws which regulate the practice of medicine. A real need exists for states to regulate medical practice through licensure and medical practice act requirements given the reliance and trust patients place in their physicians to render adequate health care. As a result, state legislatures have used their authority to limit the practice of medicine to natural persons. Obviously, since corporate medical entities do not possess the human qualities necessary to perform medical procedures, diagnose an ailment, or treat a sick patient, corporations are not entitled to obtain licenses to practice medicine. However, the problem with state licensure laws and medical practice acts stems from courts' wide interpretation and application of these laws. This wide interpretation serves as the basis for prohibiting medical corporations from employing licensed physicians to render health care.

Some courts have adopted the reasoning that since a medical corporation is physically unable to obtain a medical license because they are not natural persons, they cannot practice medicine. This line of reasoning overlooks the fact that corporations do not want to practice medicine in the strict sense of the meaning of medical practice. Rather, medical corporations are interested in entering into employment contracts with physicians, dentists, and other health practitioners who are licensed and can render medical care to the corporation's patients. For the most part, medical corporations are not seeking to employ unlicensed medical practitioners. On the contrary, a medical

30. See Parker, 12 P.2d at 71. See also Garcia v. Tex. Bd. Med. Exam'rs, 384 F. Supp. at 437 (commenting that states have an "unchallenged" right to regulate health services).

31. Id. at 438.

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corporation relies on the licensed physicians who serve it in order to function.

The more logical interpretation of state licensure and medical practice acts which form the basis of the corporate practice of medicine doctrine should be to allow employment relationships to exist between medical corporations and the physicians who serve them. Entering into employment contracts should be distinguished from diagnosing or treating a patient for an ailment. "Making contracts is not practicing medicine... [n]o professional qualifications are requisite for doing these things." Therefore, prohibiting medical corporations from entering into employment contracts with licensed physicians stretches the purpose of state medical practice acts and licensure requirements to an illogical breaking point.

Courts should not base their determination of whether a medical corporation violates the corporate practice of medicine doctrine on the argument that because corporations are not natural persons they cannot obtain medical licenses, and therefore, will violate the doctrine if they enter into employment contracts with physicians. A better test to determine whether one is practicing medicine should be "whether or not he holds himself out as being able to 'diagnose, treat, operate or prescribe for any human disease... or who shall offer... to diagnose, treat, operate or prescribe for any human disease.'" Unless a corporation is truly interfering with its employed physicians' medical judgments, there seems to be no sound basis for the continued blanket and unconditional prohi-

33. See Parker, 14 P.2d at 76 (differentiating between corporations making contracts or collecting payment for services and corporations making professional medical judgments). See also People v. Woodbury Dermatological Inst., 85 N.E. 697, 698 (N.Y. 1908) (holding that registration requirements were not intended to apply to corporations (hospitals, dispensaries...) which were authorized under an alternative statute to carry on the practice of medicine upon compliance with those statutes' requirements without registration).
34. Parker, 14 P.2nd at 76 (arguing that the California legislature did not intend the practice of dentistry to include a corporation which did nothing more than conduct the business affairs of the office) (emphasis added).
bitions on contractual employment arrangements which courts have interpreted as violative of the corporate practice of medicine doctrine.\textsuperscript{36}

\section*{B. Public Policy Concerns Being Ignored with Several Exceptions to the Doctrine\textsuperscript{37}}

State legislatures as well as courts have created several exceptions to the corporate practice doctrine. Some of the exceptions to the corporate practice doctrine allow professional corporations, not-for-profit hospitals, HMOs, teaching hospitals, and industrial organizations to enter into employment contracts with physicians.\textsuperscript{38} Although the entities that fall under the corporate practice exceptions do not violate the doctrine per se, the public policy concerns are just as alive in these arrangements as in non-exempt corporate entities.

The public policy concerns behind the doctrine appear to be ignored as so many arrangements are being excepted from the rule. State legislatures and courts alike are applying the doctrine inconsistently by carving out numerous exceptions which comprise a large sector of the health care industry. Meanwhile, several corporate entities with similar structures and characteristics as exempt arrangements are being required to comply with the corporate practice doctrine. If state legislatures believe that the public policy concerns behind the corporate practice doctrine are not as strong as they were at the time of inception, the state legislatures should clarify or amend their laws to that effect.\textsuperscript{39} Otherwise, corporations operating within

\textsuperscript{36} Some states have carved out exceptions to the corporate practice doctrine to mitigate the extreme effects of the rule. However, the doctrine still creates problems for corporate entities engaged on the business side of medicine. See infra Appendix-A, “Statutory Compilation,” for a state by state comparison of exceptions.

\textsuperscript{37} With respect to state licensure requirements, it is a non-sequitur that corporations are incapable of possessing the human qualities necessary to obtain a license to practice medicine. Therefore, it is more useful to analyze corporations’ activities in relation to the public policy concerns of lay control, divided loyalty, and commercialism than simply whether a corporation possessed a license.

\textsuperscript{38} See infra Appendix-A, “Statutory Compilation,” for a state by state comparison.

\textsuperscript{39} See discussion infra Part VI regarding proposal for action and clarity.
the health care industry will have to take their chances as a non-exempt corporate entity.

Section III-B of this Note will analyze common statutory exceptions to the corporate practice doctrine through the lens of the public policy concerns raised by the doctrine — lay control, divided loyalties, and commercialization.\(^4\) By analyzing the statutory exceptions to the corporate practice of medicine in this light, this section will illustrate how the doctrine is being eroded as its public policy concerns are given arbitrary weight depending on the situation. This problem provides further support for the proposition that the corporate practice of medicine doctrine cannot exist as is. State legislators should be convinced that the time has come to remove the strictness of the doctrine in response to the reality that the strictness is being whittled away in practice. Maintaining the facade that the corporate practice of medicine prohibition remains a complete bar to corporations employing licensed physicians causes confusion as it distorts the realities of modern medical practices.

1. Professional Corporations Exception
   a. Lay Control

   A professional corporation is, by definition, "organized by those rendering personal services to [the] public of a type which requires a license . . . which prior to such . . . [licensure] could not be performed by a corporation."\(^4\) In interpreting this definition of a professional corporation, the public policy concern over lay person control does not appear to be relevant in a professional corporation structure. Since all members of a professional corporation are required to be professionals, or properly licensed, the risks associated with lay control do not exist.\(^4\) Furthermore, the very purpose behind professional

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\(^4\) See supra footnotes 26-29 and accompanying text for an explanation of the public policy concerns.


\(^4\) See Hall & Vaughn, supra note 29, at 3-18 (stating that many states require shareholders of a professional corporation to also be active in the practice). But see MODEL PROF. CORP. SUPP. § 30 (1984) (allowing professional corporation membership to consist of up to 50%
corporations is to minimize the risks of diluting professional norms by requiring members to have the requisite professional qualifications.\textsuperscript{43} This precept of maintaining professional norms through an organization of licensed physicians, not lay persons, is exactly what the corporate practice doctrine was designed to encourage.

However, in those states which have adopted the Revised Model Act,\textsuperscript{44} the requirements for professional corporation membership may no longer be limited to licensed professionals. Because of the fresh viewpoints, objectivity, and outside expertise lay members may bring to a professional corporation, only fifty percent of the directors and fifty percent of principal officers are required to be licensed professionals under the Revised Model Act.\textsuperscript{45} Although the public policy concern over having lay persons participate in the control of medical corporations has merit, those states that allow lay membership within professional corporations are still susceptible to the dangers of lay influence. Therefore, the professional corporation scenario provides a good illustration of the arbitrariness of the corporate practice prohibition's scope, despite the presence of the public policy concern about lay corporate control.

b. Divided Loyalty

Another public policy concern behind the corporate practice doctrine is the fear of physicians' divided loyalties between a corporate employer and their patients.\textsuperscript{46} The argument behind creating an exception for professional corporations rests on the premise that physician members of a professional corporation will remain autonomous in their health care decision making. If member physicians within a professional corporation maintain their autonomy, patient welfare should not be

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\textsuperscript{43} See BARRY R. FURROW ET AL., HEALTH LAW § 5-23 (1995).

\textsuperscript{44} See MODEL PROF. CORP. SUPP. § 30 (1984) (allowing professional corporation membership to consist of up to 50% lay members).

\textsuperscript{45} Id.

placed at risk. This public policy argument in favor of exempting professional corporations is valid only if states have not adopted a provision mirrored after the Revised Model Act.\textsuperscript{47} Otherwise, the potential problem of lay members' interference with physician-members' autonomous medical judgment remains.

c. Commercialization

Public policy concerning commercialization of the medical profession may be violated, notwithstanding the fact that licensed professionals comprise the membership of professional corporations. Even assuming that a professional health care corporation does not have any lay membership, the public policy concern for protecting against commercialization is still very much alive. After all, physician members of a professional corporation are "owners" of that professional corporation.

Physician members will contemplate their return on investment when making a decision that will affect the professional corporation. If they did not, they would not bear the financial risks of incorporating as a professional corporation. The physician members' profit motives and concern for creating market power seem no different in this type of arrangement than in general corporations where shareholders are interested in the financial performance and future of the company. Furthermore, professional corporation members are afforded limited liability status for "ordinary business obligations of the corporation (i.e. business debts, negligence unassociated with professional services, bankruptcy)"\textsuperscript{48} similar to that of owners of general corporations. Though each individual physician member is liable for rendering professional services within a professional corporation, there are no incentives as a collective group to be any more cautious over decisions than members of a general corporation since limited liability applies to the entire professional corporation. It is difficult to rationalize, therefore, how medical

\textsuperscript{47} See MODEL PROF. CORP. SUPP. § 30 (1984) (allowing membership to consist of up to 50% lay members).

\textsuperscript{48} See FURROW ET AL., supra note 43, at § 5-26.
credentials of physician members will automatically buffer the professional corporation against commercialization and market abuse just by virtue of member physicians’ medical licenses.

2. Not-For-Profit Hospital Exception

Some state legislatures and courts have recognized not-for-profit hospitals as an exception to the corporate practice of medicine doctrine. Since not-for-profit hospitals must meet both the organizational and operational tests of Section 501(c)(3) of the Internal Revenue Code in order to qualify for tax-exempt status, it is reasonable to allow these corporations to employ physicians and engage in the corporate practice of medicine. In order to receive tax-exempt status under §501(c)(3), corporations must be "organized and operated for religious, charitable, scientific . . . or educational purposes." Not-for-profit health care institutions can serve an important function in society by providing charitable health care to the indigent and to under-served communities. However, today’s not-for-profit hospitals are being heavily scrutinized and criticized for their lack of commitment to charitable purposes. If today’s not-for-profit hospitals are tending to approximate for-profit hospitals in their structure and behavior, then the exception for these entities appears to be an arbitrary application of the doctrine.

Because many not-for-profit health care providers are being forced to compete with fully integrated and cost-conscious for-profit entities, not-for-profit institutions are beginning to pay less attention to charitable purposes and more attention to competition and commercialization. In light of

52. See GENERAL ACCOUNTING OFFICE, NON-PROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR THE EXEMPTION HRD-90-84 (May 1990) (concluding that Congress should consider revising the criteria for tax exemption if it believes that providing charity care should be a fundamental basis for such an exemption).
53. See Regina E. Herzlinger & William S. Krasker, Who Profits from Nonprofits?, HARV. BUS. REV., Jan.-Feb. 1987, at 94, 104-05 (illustrating that nonprofit hospitals tend to act to serve the self-interests of the professionals within the organization at the expense of societal interests in better access to health care services). But see Jan P. Clement et al., What Do We Want and What
this movement away from charitable giving, the distinctions between for-profit and not-for-profit entities become blurred. The statutory exceptions to the corporate practice of medicine doctrine which apply to not-for-profit hospitals and foundations must be reconsidered against this current trend away from charitable purposes.

a. Lay Control

Not-for-profit entities may only allocate earnings toward their tax-exempt activities in conformity with the private inurement clause of the Internal Revenue Code. Earnings, therefore, may not be distributed to management, private shareholders, or other institutional decision makers. These private inurement prohibitions may appear to be a safeguard against affording lay hospital administrators the opportunity to take advantage of a not-for-profit hospital by rewarding themselves with unreasonable monetary rewards for the entity's profits.

However, board membership within not-for-profit hospitals must include lay members of the community. Although lay members of a not-for-profit hospital board do serve important roles to ensure that the tax relief given to not-for-profit hospitals is paid back through community benefits, such as care for the indigent, lay membership on the board flies in the face of the corporate practice of medicine doctrine. Because the potential for lay influence on boards is alive in not-for-profit entities, the distinctions between not-for-profit and for-profit

Do We Get from Not-for-Profit Hospitals?, 39 HOSP. & HEALTH SERV. ADMIN. 159, 174-75 (1994) (suggesting that not-for-profit hospitals should provide benefit reports to members of the community to approve and illustrating that 75% of California not-for-profit hospitals meet one of the five suggested community benefits: uncompensated care, education and research, below-cost services, price discounts, and retained earnings). See also Barbara Arlington & Cynthia Carter Haddock, Who Really Profits from Not-for Profits?, 25 HEALTH SERV. RESOURCES 291, 291-301 (1990) (commenting on the Herslinger and Krasker article which is also cited in this footnote).

54. See Treas. Reg. § 1.501(c)(3)-(2)(c)(2) (1986) (stating that an organization is not tax-exempt if its net earnings inure in whole or in part to the benefit of private shareholders or individuals).

55. See Boisture, supra note 8, at 11 (discussing the Internal Revenue Service's insistence that the Board of Directors for foundation model integrated delivery systems (IDS) limit physician representation to 20% and that the rest of the Board be comprised of community members).

56. See Clement et al., supra note 53, at 176.
organizations that some states have made in interpreting the corporate practice doctrine is no longer as sharp.

b. Divided Loyalty

The public policy concern over division of loyalty takes on a different shape within a not-for-profit hospital. Conflicts that physicians may have between patient care and corporation profits are mitigated by the very nature of the not-for-profit structure since profits must be used for exempt activities and may not inure to private individuals, shareholders, et cetera. However, the division of loyalty that exists is an indirect one. Since not-for-profit managers have weak market controls gauging or checking their management over profits, it is likely that they may keep profits away from charitable purposes by awarding large salaries to hospital administrators and may also employ excessively large staffs.\textsuperscript{57} Indirectly, therefore, the not-for-profit structure provides opportunities for division of loyalty because the administrators who have no real economic stakes tied into the performance of their not-for-profit hospitals. Earnings that may be funneled away to pay excessive salaries instead of providing for charitable patient needs may lead to problems of divided loyalties by shifting resources away from charitable purposes toward wasteful ones.

c. Commercialization

Not-for-profit hospitals exhibit a strong market force in the U.S. health care system. The largest sector of hospital beds is organized as not-for-profit entities.\textsuperscript{58} Also, tax-exempt status may create an additional incentive for not-for-profit hospitals to commercialize since this tax benefit provides an advan-
tage over for-profit corporations who incur federal tax liability. Although not-for-profit hospitals retain a larger market presence than for-profit hospitals, the market base for these two types of arrangements is identical. As a result, trying to remain competitive with for-profit hospitals may conflict with the charitable purposes and community benefits required of the tax-exempt provider. Not-for-profit hospitals may obtain a competitive advantage over for-profit hospitals because of the tax subsidy unique to not-for-profit entities. It is difficult to discern whether tax-exempt status is being commercially exploited in today's integrated health care delivery system, although the issue has been the subject of much debate. However, because of their market presence and the potential to exert a competitive tax advantage over for-profit hospitals, public policy concerns over not-for-profit hospitals' commercialization are valid.

3. Health Maintenance Organizations (HMOs)

Health Maintenance Organizations evolved as a means of improving upon the excesses of traditional cost-based reimbursement schemes through capitated reimbursement schemes. Congressional enactment of a federal HMO enabling statute paved the way for their proliferation among the states. Prohibiting HMOs from contracting with physicians could arguably fall under activity which inhibits HMOs' abilities to organize (state activities that can be construed as inhibiting the operation of HMOs are prohibited). Enacting a state law or enforcing an already existing state law which limits the freedom of HMOs would violate the federal HMO enabling

60. See Herzlinger & Krasker, supra note 53, at 105 (cautioning that not-for-profit hospitals must not ignore the important social benefits that they were organized to provide).
62. See 42 U.S.C.A. § 300e-10 (West 1996) (prohibiting state laws which support requirements that inhibit HMOs' existence).
63. See 42 U.S.C.A. § 300e - 10(a)(1)(E) (West 1996) (prohibiting state laws which contain requirements that inhibit HMOs' compliance with federal law).
statute. As a result, almost all of the states have exempted HMOs from the corporate practice prohibition.\textsuperscript{64} Notwithstanding an HMOs' lofty goals of preventing over-utilization through capitation and other cost-containment mechanisms, the HMO structure embodies characteristics which the corporate practice of medicine was designed to avoid. Lay control, divided loyalty, and commercialism are all palpable concerns within an HMO structure.

\textbf{a. Lay Control}

The decision to approve medical procedures or lengths of hospital stays for HMO subscribers is often made by lay persons, although some approvals are made by physicians employed by an HMO to approve medical treatments. To alleviate the potential for abuses of lay power within HMOs, provider-operated HMOs are becoming increasingly popular. Provider-operated HMOs afford physicians a higher level of autonomy since they would be able to control both the financing and delivery of health care.\textsuperscript{65} Although this may seem like the best method to eliminate the problem of lay control within a health care system, this model tends to approximate that of a professional corporation. Like the professional corporation, provider-operated HMOs will still exhibit problems of divided loyalties and commercialism. Physicians practicing within provider-operated HMOs have no less incentive to consider their financial interests in the organization than in professional corporations.

\textbf{b. Divided Loyalty}

The issue of who actually controls health care decisions

\textsuperscript{64} See infra Appendix-A, "Statutory Compilation," for examples.

within HMOs has become a popular topic of debate.66 Having the HMO dictate a capitation payment schedule at the outset of a physician's contract with that HMO imposes severe constraints within which the physician must provide care.67 Although capitation may appear to be the solution to high health care costs, this system of reimbursement may create an incentive for physicians to underutilize care. Capitation, therefore, creates a dilemma for the HMO physician. First, should the physician withhold care because the HMO will not pay for it? If so, the physician could face medical malpractice charges. Second, the only alternative for that physician to provide care in excess of the capitated level is to bear personally the burden of the extra costs of care.68 Because of this dilemma, it is difficult to see how HMO physicians can ensure that their primary concern will be for the patients' welfare.

Similarly, HMOs impose gag orders within their contracts which in essence prohibit the physician from discussing the details of the capitation payment schemes within which they must provide care. Gag orders prevent a physician from discussing alternate treatments not offered by the patient's plan. Additionally, gag orders prohibit the HMO physicians from recommending specialists who do not participate in the plan.69 Violation of these gag provisions may lead the HMO to deselect the responsible physician from the HMO plan.70 Many of the HMO contracts allow for deselection without cause.71 With the constant threat of loss of employment, or deselection from an HMO, it is not hard to see that division of loyalty between the HMO physician and the patient are real concerns within

66. See, e.g., Ellyn E. Spragins, Beware your HMO, NEWSWEEK, Oct. 23, 1995, at 54 (discussing problems of divided loyalties between physicians and HMOs which have resulted in adverse health results in HMO patients).

67. A capitated rate is a fixed, predetermined payment for provisions of health service per HMO patient.


69. For a detailed discussion of gag orders and their effect on physician activity, refer to Jennifer L. D'Isidori, Stop Gagging Physicians! 7 HEALTH MATRIX 189 (1997).

70. Deselection is the process by which an HMO may terminate its relationship with a plan physician, usually without cause.

this type of organization.

c. Commercialization

Enrollment in HMOs is growing\textsuperscript{72} while more physicians are opting to choose employment relationships with HMOs because of the competitive advantages HMOs offer within the health care market.\textsuperscript{73} As HMOs gain market power, they are able to exert a significant presence in the health care industry. Whether physicians choose to become HMO employees or choose to organize as provider-owned HMOs similar to professional corporations, HMOs definitely exert the market power which the corporate practice doctrine was designed to discourage. Protecting the market power of the sole-practitioners from abuses was an important precept of the original corporate practice prohibition. However, with the changing landscape of the delivery of health care towards managed care, the commercial aspects of HMOs may no longer be considered as great an evil.

Despite these problems of lay control, divided loyalty, and commercialism inherent in HMOs, several states have enacted laws which exempt HMOs from the corporate practice prohibition.\textsuperscript{74} Given the underlying rationale that HMOs are designed to contain health care costs, the HMO exception to the corporate practice prohibition is at least understandable if not justified. However, the problem with exempting HMOs is not with encouraging cost-containment under these arrangements, rather it is the arbitrariness of creating exceptions to the corporate practice doctrine when its tenets are being violated. The arbitrariness of outlining exceptions to the corporate practice prohibition will undermine the doctrine's staying power. Therefore, state legislatures should re-analyze other non-HMO medical corporations in this same manner and alleviate some of the doctrine's strictness.

\textsuperscript{72} See Boisture, supra note 8, at 14 (requiring even Medicare and Medicaid recipients to join approved HMOs to receive care under these programs).

\textsuperscript{73} See Mitka, supra note 11, at 7 (describing the decline in the percentage of self-employed physicians and the rise in the percentage of employee-physicians).

\textsuperscript{74} See Appendix-A, "Statutory Compilation," for examples.
4. Independent Contractors

By definition, independent contractors do not engage in the corporate practice of medicine. Since they are not employed by the hospital and retain individual medical licenses to practice, they do not create the same threat of lay control and divided loyalties as do other arrangements. Commercialism is not at issue with independent contractors since each contractor can not possess enough market power to influence the delivery of health care.

C. Alternative Methods of Examining the Doctrine

Although teaching hospitals and MSOs have no structural similarities, their characteristics provide a basis for sound arguments as to why the corporate practice of medicine doctrine should be revamped or reexamined. Using both teaching hospitals and MSOs as examples of how the interpretation of the meaning of the doctrine should be modified will illustrate the weaknesses in the doctrine's rationale. These two examples provide a better method of analysis for courts to use when faced with a potential violation of the corporate practice doctrine.

1. Teaching Hospitals

There have been a few cases which have addressed the corporate practice of medicine prohibition in relation to teaching hospitals. Specifically, the arguments espoused in Los

75. See Hitchner et al., supra note 65, at 285 n.50 (cautioning that there is no uniformly accepted meaning of the term MSO because MSO is not a legally defined term and may stand for a "management service organization, a managed services organization, or a medical service organization").

76. See, e.g., Albany Med. College v. McShane, 489 N.E.2d 1278, 1278 (N.Y. 1985) (holding that a state-chartered medical college did not violate the corporate practice of medicine doctrine when it shared fees generated by physician faculty members because the college's corporate charter empowered it to promote medical instruction); San Diego v. Gibson, 284 P.2d 501, 504 (Cal. Ct. App. 1955) (holding contract between county board of supervisors and charitable corporation that provided medical and teaching services did not constitute the corporate practice of medicine); Los Angeles County v. Ford, 263 P.2d 638, 642-43 (Cal. Ct. App. 1953) (compelling the Chairman of the Board of Supervisors to execute contracts to allow two medical schools to render medical and teaching services to the county hospital and finding no violation of the corporate practice prohibition).
Angeles County v. Ford are good examples of how the corporate practice of medicine doctrine should be applied in all contexts, not just teaching hospitals. In Ford, two accredited medical schools were seeking to enter into a contract with the Los Angeles County Board of Supervisors to receive fair compensation for providing their licensed medical teaching staffs’ services to indigents treated within the county hospitals. A separate contract for each school’s services was entered into by the County Board of Supervisor’s chief administrative officer. These contracts were approved by the Board, but were rejected by the chairman of the Board of Supervisors. The chairman refused to execute these contracts on the basis that they violated the corporate practice of medicine prohibition. The court held that the not-for-profit medical schools could enter into contracts to provide health care to the indigent, via the county hospitals, without violating the corporate practice doctrine.

Although Ford involved a situation where charity care was being administered in a not-for-profit context, the application of the Ford court’s rationale in favor of the medical schools should be extended to for-profit arrangements as well. The Ford court recognized that the contracts to provide indigent care did not call for the entire medical school’s administration to render care. On the contrary, the actual provision of medical services was to be made exclusively through licensed physician faculty members. Since the medical schools themselves do not influence the physician’s medical decision, they play no part in the physician-patient relationship. Therefore, the risks of lay control and divided loyalties are minimized.

The rationale set forth in Ford should be extended to apply to for-profit medical corporations who enter into employment contracts with licensed physicians to provide health care services. So long as the medical corporations do not interfere with the medical decisions of their employee-physicians, they should not be considered to have engaged in the practice of

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78. Id. at 638-39.
79. Id. at 643.
80. Id. at 642-43.
medicine. Unless a medical corporation's administrators are involved in the actual treatment and diagnoses of patients' ailments, medical corporations should be able to employ licensed physicians to render those services to patients.

It is difficult, therefore, to reconcile cases which hold that the doctrine is being violated simply because a corporation is employing physicians with what appears to be the more logical interpretation of the corporate practice of medicine doctrine. The more logical position should be to allow corporations to employ physicians so long as the employee physicians retain their freedom of action where lay control, divided loyalty, and commercialism would have little effect on the physician-patient relationship. However, it may be difficult to develop exacting criteria defining what constitutes freedom of action and what should be excluded since each situation will be fact-specific. It is equally difficult to condemn employment arrangements between hospitals and licensed physicians solely on the basis that the hospital, as a corporate structure, is unable to obtain a medical license. The line of demarcation that courts have drawn, based on structure, should be reanalyzed in terms of

81. Courts should, however, find those corporations who render treatment and diagnoses through unlicensed employees in violation of the corporate practice doctrine.

82. Cf. People ex rel. Bd. of Med. Exam'rs v. Pacific Health Corp., 82 P.2d 429, 430 (Cal. 1938) (stating that the fact that a corporation itself did not take part in rendering actual treatment and diagnostic services did not absolve the corporation from violating the corporate practice of medicine doctrine).

83. See Parker v. Bd. of Dental Exam'rs, 14 P.2d 67, 71-72 (Cal. 1932) (rejecting medical corporation's argument that there was a distinction between the practice of dentistry and the business aspects of the corporation and, therefore, finding that the corporation violated the corporate practice doctrine). See also Cal. Ass'n of Dispensing Opticians v. Pearle Vision Ctr., 191 Cal. Rptr. 762, 769 (Cal. Ct. App. 1983) (holding that Pearle Vision held itself out as an optometrist by exerting control over the financial aspects and practices of its franchisees in violation of the corporate practice doctrine). But cf. St. Francis Reg'l Med. Ctr. v. Weiss, 869 P.2d 606, 618 (Kan. 1994) (holding that a licensed hospital's employment contracts for services of physicians did not violate the corporate practice of medicine doctrine where the test to determine a violation of the doctrine should be whether the corporation was holding itself out as being able to diagnose, treat, operate, or prescribe for any human disease, pain, or injury); State Bd. Exam'rs of Optometry v. Pearle Vision Ctr., 767 P.2d 969, 978 (Wyo. 1989) (holding that an optical dispensing franchisor did not violate the corporate practice doctrine since it had little control over the decisions of the licensed optometrist); Blank v. Palo Alto-Stanford Med. Ctr., 44 Cal. Rptr. 572, 580 (Cal. Ct. App. 1965) (discussing that even though the corporate practice doctrine was not at issue in the case, the fact that the doctors retained their freedom of action relieved the hospital from liability).

84. See St. Francis Reg'l Med. Ctr., 869 P.2d at 618 (holding that without medical providers, a hospital cannot achieve that for which it is created and licensed to treat the sick and injured).
whether the form of the arrangement is truly interfering with a physician’s freedom of action, not on an abstract basis of corporate form.

2. MSOs

Another example of a corporate practice exception is the MSO arrangement. MSOs will typically acquire the tangible assets of physicians’ practices as well as provide administrative management services for the practices, or other medical groups. These arrangements are typically made under contract whereby lay management organizations take control over administrative services within a hospital or hospital-physician group joint venture. MSOs can take on several organizational forms such as a simple hospital service, or becoming a wholly-owned subsidiary of a hospital, or a corporation owned by shareholders. MSOs offer efficiency and economies of scale for independently practicing physicians through the use of “common administrative personnel and information systems, volume purchasing, and consolidate[d] services and equipment.” Therefore, the benefit to physicians would be that they could have more time to devote to delivering health care services to their patients.

Since MSOs are not making medical decisions per se, but are merely serving as an administrative arm for independent physicians, it is easy to see how this type of arrangement falls outside of the reach of the corporate practice doctrine. Administrative services differ from medical services. Administrative services involve little direct contact with patients and require no license to perform. Such services include practices like billing health insurance companies, purchasing supplies, and monitoring the maintenance of patient records. Conversely, medical services involve direct patient contact, where the medical treatments and diagnoses require special medical training and licensure.

In the MSO arrangement, medical decisions are still made

85. See Hitchner et al., supra note 65, at 285-87 (explaining the MSO model of integration).
86. See id. at 285.
87. Id. at 285-86.
88. Id. at 286.
by the licensed physicians contracting with the MSOs. Therefore, if states are willing to recognize exceptions to the corporate practice doctrine for MSOs because of their purely administrative functions, other non-MSO medical corporations providing only administrative services should also be exempted. That is, corporate entities which provide merely general administrative, financial support, or arrange for employment of licensed physicians or medical practitioners should not be considered to be violating the doctrine as long as they do not interfere with physicians' medical determinations.

D. Federal Trade Commission (FTC) Supports Contracts with Non-Physicians

The FTC supports the notion of providing physicians and other medical practitioners the opportunity to enter into employment or proprietary contracts with hospitals or other lay institutions. In American Medical Association v. Federal Trade Commission, the FTC argued that the ethical provisions set forth in the AMA Code of Medical Ethics discouraged physicians from entering into potentially efficient business formats and restricted physicians' ability to develop business structures in a manner they desired. The AMA was ordered to modify its Code of Medical Ethics to rid it of its anti-competitive language.

89. See id.
90. The proper test should be based on whether the level of control a corporation has over licensed physicians or medical practitioners in the arrangement intrudes on the practitioners' ability to practice medicine. See Bd. of Exam'rs of Optometry v. Pearle Vision Ctr., 767 P.2d 969 (Wyo. 1989) (applying a test based on franchisor's control over franchisee's medical decision and concluding that franchisor did not exhibit control over the franchisee's medical domain). But cf. Cal. Ass'n of Dispensing Opticians v. Pearle Vision Ctr, 191 Cal. Rptr. 762, 769 (Cal. Ct. App. 1983) (overlooking the control test and finding that the franchisor did violate the corporate practice doctrine because of its controls on the financial aspects of franchisees' practices).
91. See AMA v. FTC, 94 FTC 701, 701 (1979) (holding that certain provisions of the AMA's code of medical ethics which prohibited physicians from working for or entering into business relationships with non-physicians unreasonably restrained competition), aff'd, 638 F.2d 443 (2nd Cir. 1980), aff'd, 455 U.S. 676 (1982).
92. AMA v. FTC, 94 FTC at 701.
93. The AMA CODE OF MEDICAL ETHICS, Preamble §VI, at xiv (1994) reads: "[a] physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services" (emphasis added). But cf. the 1957 version of the AMA CODE OF MEDICAL ETHICS at §III (1957) which was at issue in AMA v. FTC, 638 F.2d 443, 447 (1980): "[a] physician should
The FTC has also been active in commenting about the benefits of commercial practice within several medical disciplines. Specifically, the FTC has analyzed whether there are benefits derived from limiting certain professions, such as medicine, to its licensed members. Although the FTC acknowledges that licenses have been required in order to "maintain quality of service and protect the professional's independent judgment," it takes the position that "such restrictions in the licensed businesses [such as medicine] are usually [maintained] to reduce competition and increase prices." Since this activity has the effect of harming consumers, the FTC has concluded that these practices should be carefully weighed.

Another criticism the FTC has set forth about restricting affiliations between licensed medical practitioners and lay corporations is that it restricts professional groups from taking advantage of the capital resources of those corporate entities. Having the ability to take advantage of a strong capital position can allow medical entities to develop large-scale practices that can benefit from economies of scale and stronger purchasing power. Therefore, the FTC encourages the removal of prohibitions which restrict lay entities and professional practitioners from entering into employment arrangements and other business relationships; otherwise, innovation and efficiency will be stifled. The FTC's favorable acceptance of allowing lay practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle" (emphasis added).
corporate entities to contract with licensed medical professionals provides strong support for streamlining the corporate practice doctrine. Although FTC rulings do not have the effect of invalidating state laws which authorize such activities, its position is definitely persuasive authority for action.

E. Lack of Enforcement

Case law interpreting the corporate practice doctrine has been sparse. Many of the courts still rely on corporate practice doctrine precedents set in the 1930s. The doctrine can be invoked as a sword or a shield to a breach of contract claim or violation of a covenant not to compete clause brought by a hospital or other health care corporation. Despite the doctrine's lack of enforcement, the prohibition can have a chilling effect on medical corporations' transactions. The uncertainty of whether the doctrine will be enforced is a matter of great concern. The penalties for violating the corporate practice doctrine include injunctive relief and loss of license so that both the corporation and its physicians would have valid reasons not to ignore the doctrine altogether. If state legislatures would take the time to reexamine the corporate practice doctrine in relation to the modern health care context and make the necessary amendments to clarify its scope, this chilling effect will be minimized.

100. See Cal. Bd. of Optometry v. FTC, 910 F.2d 976, 978 (D.C. Cir. 1990) (vacating an FTC rule to prohibit state-imposed restrictions on the practice of optometry on the grounds that the FTC did not have the statutory authority to invalidate state law).

101. See generally Berlin v. Sarah Bush Lincoln Health Ctr., 664 N.E.2d 337, 338 (Ill. App. Ct. 1996) (granting summary judgment to a physician in an action to have a restrictive covenant declared unenforceable since allowing corporations to enter into employment contracts with physicians was a violation of Illinois public policy regarding the corporate practice of medicine), aff'd on appeal, No. 4-95-0569 (Ill. App. Ct. April 12, 1996); Early Detection Ctr., Inc. v. Wilson, 811 F.2d 860, 861 (Kan. 1991) (invoking the corporate practice doctrine as a defense to a breach of contract and breach of a covenant not to compete claim and finding that the corporation violated the doctrine since both the physician and the professional corporation were required to be licensed). But see St. Francis Reg'l Med. Ctr. v. Weiss, 869 F.2d 606, 618 (Kan. 1994) (rejecting physician's argument that his employment contract with the hospital was void because it violated the corporate practice prohibition).
IV. SAFEGUARDS

Despite the inherent concerns over corporate involvement in medical practices vis-à-vis lay control, divided loyalties, and commercialism, there are several legal safeguards available to discourage abuses within corporate practices. These safeguards include hospital licensure requirements, threat of medical malpractice, Medicare fraud and abuse sanctions, Stark physician anti-referral sanctions, state disciplinary board action, and insurance regulations. These safeguards should instill confidence in state legislators who are hesitant about reexamining the corporate practice doctrine and limiting its chilling effect on the practice of medicine in the context of today's health care delivery system. The quality of care rendered should not be determined by relaxing some of the strictness of the doctrine given the safeguards that exist to protect against corporate overreaching and abuse.

A. Hospitals' Independent Duty - The Corporate Negligence Liability Theory

Hospital licensure statutes set forth the purposes for which a hospital is organized. Many states require that hospitals are responsible for "provid[ing] quality medical care." Having an additional regulatory scheme via hospital licensure requirements as a safeguard should "eliminate[s] the concerns which the corporate practice of medicine prohibition was devised to quell."102 "Lay interposition in the doctor-patient relationship would be as repugnant to hospital management as it would be to the profession."103 Furthermore, "[i]t would be incongruous to conclude that the legislature intended a hospital to accomplish what it is licensed to do without utilizing physicians as independent contractors or employees."104 Since most hospital administrators are not medically qualified to make treating and

103. Willcox, supra note 3, at 446.
104. St. Francis Reg'l Med. Ctr., 869 P.2d at 618 (indicating that hospitals employed physicians at the time the corporate practice doctrine evolved and that if the doctrine serves to prohibit this type of relationship, it would disrupt the provision of health care).
diagnosis decisions on their own, hospitals have to be able to employ qualified medical practitioners to render care for their patients.

In addition to the hospital licensure protection, hospitals may be held liable for the negligent treatment of a patient in its care under the corporate negligence theory of liability. *Darling v. Charleston Community Hospital*¹⁰⁵ serves as an example of this proposition. The *Darling* court held a hospital liable for the failure of its staff to properly monitor the patient; "[t]he [s]tandards for [h]ospital [a]ccreditation, the state licensing regulations and . . . by-laws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient."¹⁰⁶ Therefore, the fear of lay hospital administrative control or division of loyalty between the physician, the hospital, and patient can be minimized by imposing direct corporate liability on hospitals. Unfortunately, not all states have accepted the notion of direct corporate liability in this context.¹⁰⁷ In order to protect against the abuses of the corporate practice of medicine such as divided loyalties and lay control of medical corporations and hospitals, more states should embrace the *Darling* court's imposition of direct corporate liability.¹⁰⁸

¹⁰⁵. 211 N.E.2d 253, 257 (Ill. 1965).
¹⁰⁶. Id. ¹⁰⁷. See, e.g., Petriello v. Kalman, 576 A.2d 474, 475 (Conn. 1990) (holding that the hospital did not have a duty to obtain informed consent by a patient being treated by a non-employee physician).
B. Physicians’ Independent Duty

1. Medical Malpractice

Should a physician choose to prioritize the corporation’s interests above that of his patients, the risk is run of being held liable on a malpractice claim. When a medical expert defines what the standard of care would be for a given procedure, and the physician’s level of care falls below that level, the physician could be held liable for malpractice. Essentially, it is the individual physician’s balancing of interest between the patient and employer which will determine how far she will go in treating a particular patient. A physician must balance corporate policies regarding administration of care with the independent responsibility to her patient. However, the fear of malpractice liability will probably outweigh reprisal from an employer. If a physician risks mere reprisal from an employer, she can always find other employment. But, if a physician is found liable under a malpractice claim, she risks losing her license to practice and her professional record will be forever marred by the malpractice action.

2. Utilization Review and the Wickline Scenario

Physicians have a duty to appeal utilization review determinations which prevent a patient from receiving full and adequate medical treatment as deemed necessary by the physician. Therefore, if a corporate entity is denying coverage for a particular procedure or length of hospital stay, the physician must challenge the corporation’s determination if she believes that the patient is in need of more medical care. “[T]he physician who complies without protest with the limitations imposed by a third-party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient’s care.”


110. Wickline, 239 Cal. Rptr. at 819 (emphasis added).
The implication from *Wickline* is that if a physician, against his better medical judgment, discharges a patient when reimbursement is denied by a third-party payor, he may face medical malpractice liability. In addition, the *Wickline* court noted in dicta that third-party payors may also be held accountable for patient injury resulting from denial of care.″ Wilson v. Blue Cross of Southern California″ limited *Wickline* by holding that physicians and utilization review bodies could be held jointly and severally liable for patient injury. This line of cases provides a safeguard to limit the potential abuses of divided loyalties which the corporate practice doctrine set out to protect against. Neither the physician nor the utilization review body will be able to escape liability if the physician's medical determination dictates that better health care should have been administered or made available to the patient.

3. State Disciplinary Boards

State judicial bodies afford state medical boards wide discretion to engage in disciplinary review of physician practices as well as imposing sanctions. Disciplinary review arises in cases where physicians engage in practices beyond the scope of what the board has deemed appropriate within the practice. In addition, state medical boards will impose sanctions on those persons holding themselves out to practice medicine without a license. With the threat of disciplinary sanctions, physicians should be deterred from siding with his corporate employer should a conflict arise where he is faced with a potential divided loyalty dilemma. Adverse actions by a state medical board's disciplinary division may be reported to the National Practitioner Data Bank.″ This may impose adverse effects on the physician's long-term career plans in medicine and act to encourage physicians, whether employed by corporations or not, to refrain from giving into divided loyalties.

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111. *Id.* (stating that third-party payors may be held liable for defects in the design of their cost containment schemes).
112. 271 Cal. Rptr. at 876.
C. Medicare-Medicaid Fraud and Abuse Statute

The public policy concern over divided loyalties and commercialization can be protected through the Medicare-Medicaid fraud and abuse statute. Violation of this statute imposes severe penalties. A situation involving a physician's divided loyalties between a hospital and patient could arise if the physician was receiving remuneration by a hospital or other health care facility (clinic, diagnostic center) for sending his patient to that facility. This is a valid concern embedded within the corporate practice doctrine; however, the fraud and abuse statute invalidates this activity provided that Medicare or Medicaid funds were in any way associated.

Additionally, the concerns over commercialization, or exploiting the growth of health care facilities for mere profit motives, are mitigated through the statute. The fraud and abuse statute imposes liability so long as it can be shown that a facility is remunerating cash or payments in-kind to physicians for patient referrals. Although the fraud and abuse statute provides a series of safe harbors for activities such as practitioner recruitment, sale of a practice, group purchasing activities, and certain employee-employer relations to name a few, it provides a deterrent from divided loyalties and over-commercialization because of the strict sanctions that may result. Therefore, the corporate practice of medicine doctrine can be relaxed in light of safeguards found under the Medicare-Medicaid fraud and abuse statute.

D. Stark Physician Anti-Referral Statute (Stark Bill)

This anti-self-referral statute may reduce the fear of commercialism which the corporate practice doctrine was established to protect. Under the Ethics in Patient Referrals Act, or the Stark Bill, a physician or an immediate family member is prohibited from referring Medicare and Medicaid patients to an entity to perform designated services in which the physician

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114. Violators of the Medicare-Medicaid fraud and abuse statute may face civil monetary penalties of up to $25,000, criminal sanctions of imprisonment up to five years and loss of Medicare and Medicaid provider status. See 42 U.S.C.A. § 1320a-1320(7)(a-b) (West 1996).
115. 42 U.S.C.A § 1395nn(a) (West 1996).
holds a financial interest. This prohibition has the effect of discouraging physicians from setting up clinics or affiliating with other medical facilities in order to exploit their patients for self-profit. This reduces the potential risk for commercial abuse.

Although the Stark Bill does not impose criminal sanctions as does the Medicare-Medicaid fraud and abuse statute, violating physicians risk losing their Medicare and Medicaid reimbursement eligibility and may not be able to bill any individual for those services related to the violative self-referral. Civil money penalties up to $15,000 for each violative service billed may be imposed.

V. LEGISLATIVE DEVELOPMENTS THREATEN THE STAYING POWER OF THE CORPORATE PRACTICE OF MEDICINE DOCTRINE

A. Federal Legislation

There have been several federal bills introduced during the 104th Congress which threaten the staying power of the corporate practice doctrine. Several of these bills are modeled after President Clinton's failed Health Security Act. State laws that discouraged the corporate practice of medicine would have been preempted by the Health Security Act. Through a review of recent legislation, it appears that Congress has been trying to effectuate what was put to rest after the failure of the Health Security Act. The common thread throughout the pending legislation seems to reiterate Congress' stance that state laws prohibiting the corporate practice of medicine should be preempted in the wake of modern integrated delivery health care systems.

Although all of these bills have been sent to various committees for review, none has been passed. The effect of a federal preemption on state laws prohibiting the corporate practice of medicine would be to completely eviscerate it from the control of the states. Federal preemption does provide a way to eliminate the inconsistencies and arcaneness of the corporate practice doctrine; however, Congress should use caution when considering a plan to completely eliminate the doctrine. 119 The corporate practice of medicine doctrine would still be an effective tool to discourage lay persons from trying to render health treatments and diagnoses without a license. However, a federal preemption could provide a benefit to the health care industry by standardizing the prohibition's scope by eliminating some of the arbitrariness of states' decisions to exempt certain practices over others.

B. State Legislation

Like Congress' attempts to soften the effects of the corporate practice doctrine, some states have recently modified existing state laws prohibiting the corporate practice of medicine. None of the states has adopted as aggressive an approach as Congress has with its proposals to preempt, or eliminate the doctrine; however, it appears that several states are beginning to chip away at the doctrine's strictness. Although many states still interpret the doctrine narrowly and do not allow corporations the ability to employ physicians, 120 there appears to be a slow-moving trend toward affording corporate health care providers greater freedom to lawfully engage in activities with licensed physicians and medical practitioners.

The Tennessee state legislature enacted a bill last year which frees licensed hospitals from the dictates of the corporate practice prohibition within physician employment contracts. 121 The legislation allowed licensed hospitals to contract for physicians' employment so long as the hospital does not

119. See infra Part VI for a discussion as to why the corporate doctrine should not be completely erased, but should be conditioned or modified.
120. See infra Appendix-A, "Statutory Compilation."
interfere with the physicians’ medical judgment. Although this bill did not completely eliminate the doctrine, as the federal preemptions propose to do, both the hospital and the employee must meet certain conditions in order to engage in employment arrangements.122 Furthermore, should a hospital terminate a physician’s employment because that physician failed to follow orders from the employer who dictated action against the physician’s will, the amended Tennessee law creates a cause of action for that physician.123

Colorado has also been active in reanalyzing its corporate practice of medicine prohibition. Last year, the Colorado legislature expanded an already existing law which was passed in 1993 to allow licensed hospitals in counties of less than 100,000 to employ physicians. The new law allows licensed hospitals and physicians to enter into contracts in counties where the population exceeds 100,000.124 This law defines parameters for the hospital to observe in order for the physician to retain autonomy in administering care to patients. Similar to the new Tennessee law, the Colorado law recognizes a physician’s cause of action against corporate employers that control the medical judgment of its employed physicians.

The common threads that are present in both the new Tennessee and Colorado laws illustrate an emerging trend towards eliminating the strictness of the corporate practice doctrine. Paramount is the idea that the physicians must retain their autonomous medical authority. Having statutes provide a cause of action for patients and/or physicians definitely offers a salient safeguard against the abuses that the corporate doctrine set forth to protect against. State legislators are finally beginning to heed the calls of their constituents’ complaints about the strictness of the doctrine in the wake of integrated delivery systems.125 As Tennessee and Colorado lead the way towards

122. See TENN. CODE ANN. § 63-6-204(c) (1996) (describing the employment relationship as one which does not restrict the physician from exercising independent medical judgment); TENN. CODE ANN. § 68-11-205 (1996) (describing exception to the independent medical judgment rule).
125. In fact many physicians may even prefer the employment arrangement because of the continuity and dependability in work hours, salary, etc.
cutting back on the corporate practice doctrine’s strictness, a
new message is being cast about the continued strictness of the
corporate prohibition.

VI. PROPOSAL FOR STATE LEGISLATIVE
ACTION: UNIFORM PHYSICIANS EMPLOYMENT
ACT (UPEA)

In light of the changing arena within which health care
services are administered today, the validity of the corporate
practice prohibition’s strictness should be challenged.\(^\text{126}\) Al-
though one solution would be to completely erase the doctrine
through a federal preemption or repeal of state law, the doc-
trine does merit a minimal level of existence. Without a mini-
mal existence, egregious corporate abuses with respect to phy-
sician autonomy would be possible.

The fact that the doctrine should still exist minimally does
not mean that it should be kept at status quo. The doctrine, as
it exists today, has been arbitrarily applied, if at all. This un-
certainty causes a problem for those parties who desire to enter
into employment relations. If public sentiment and current
practices are moving in the direction of reanalyzing the corpo-
rate practice doctrine in light of its strictness and arbitrariness,
then state legislatures have the responsibility of embodying
these sentiments through law.\(^\text{127}\)

The strictness of the doctrine with respect to the employ-
ment context needs to be altered. The new Tennessee and
Colorado laws serve as a good model for a solution; however,
other provisions are necessary to mitigate the problems that the
corporate doctrine sets out to protect against. An ideal statute
should include a compromise position where the law would
allow for the changing health care delivery system while taking
into account the current sentiment among physicians that being

\(^{126}\) Hitchner et al., *supra* note 65, at 276.

\(^{127}\) See generally Mitka, *supra* note 11, at 1 (commenting on the increasing trend in the
number of employed physicians and the desire for physicians to enter into employment
(raising the issue of “whether the time has come, as indicated by the movement for health
insurance and group medicine, to reverse the long settled policy against corporate medical
practice and declare it legal and proper;” but determining in this case that this was not the current
social viewpoint and therefore the legislature was not compelled to act).
an employee is no longer considered the great evil. These statutes must account for innovations, while at the same time offer physicians and patients protection against abuses of corporate control.

A Uniform Physicians Employment Act (UPEA) should be created to explicitly allow health care providers (hospitals, clinics, dental corporations, etc.) to employ physicians without insisting that the arrangement be in the form of one of the doctrine’s traditional exceptions such as an HMO, a not-for-profit corporation, or a professional corporation. By making this an explicit provision of the UPEA, it would protect all parties involved from the fear that the arrangement could be dismantled because of a corporate practice claim.

Like the Colorado statute, the UPEA must adopt a provision which explicitly allows physicians and patients to bring a cause of action against the medical corporation if that corporation interferes with the physician’s autonomous medical judgment. Defining what corporate activity constitutes action tending to adversely influence a physician’s autonomous medical judgment is something that will be developed as claims against corporations will be litigated. Perhaps a “corporate standard of care” could be used during litigation to determine what level of care a medical corporation should have demonstrated under like circumstances. This “corporate standard of care” would be based on what a reasonable corporation, similarly situated, would have done under a particular set of facts. Ultimately, the test for reasonableness will become an issue for the jury or judge to decide.

One provision that should be included in the UPEA is not modeled after any existing state law. This provision would require that institutional health care providers appoint a medical director who would act as an arbiter in situations where the corporation’s breadth of power is at issue. The medical director must be a licensed physician or similar health care practitioner whose experience is consistent with what the medical corporation and health care practitioners are offering to provide to patients.128 Also, these medical directors should enter into

128. For example, the medical director of a medical corporation comprised of general practice physicians should also be a licensed physician who practices in general medicine.
independent contracting status with the institutional health care provider in order to avoid the problem of being biased in favor of the corporation. Medical directors would also be available to testify as expert witnesses and establish for the jury what a reasonable institutional health care corporation would do under similar circumstances.

VII. CONCLUSION

There is still a need for the corporate practice of medicine prohibition to protect against egregious abuses of corporate power. However, the prohibition must be modified to adapt to the present movement toward managed care and integrated health care delivery systems. State legislatures can not allow the doctrine to exist as it does today. The corporate practice of medicine vis-à-vis modern health care practices is too strict. Therefore, creating a Uniform Physicians Employment Act will serve to effectuate current practitioners' sentiments as well as provide a guide for states to eliminate some of the strictness of the doctrine, without completely eliminating the doctrine's protections. Since integrated health care delivery systems are becoming the preferred method of organizing in today's health care market, the Uniform Physician Employment Act will serve to provide national guidance on this issue. Having uniform laws would definitely eliminate the uncertainties many legal practitioners grapple with when faced with an opportunity to assist their health care clients in expanding into interstate markets.
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<thead>
<tr>
<th>GENERAL PROHIBITION AGAINST CORPORATE PRACTICE</th>
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<th>MSOS</th>
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<tr>
<td>ALASKA STAT. § 08.64.380(c) (Michie 1995) (defining the practice of medicine; however, no specific exemptions for corporations).</td>
<td>ALASKA STAT. § 21.86.250(c) (Michie 1995) (stating that HMOs with a valid certificate of authority are not considered to be practicing medicine and are exempt from laws regulating the practice of medicine).</td>
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<tr>
<td>1. CAL. BUS. &amp; PROF. CODE § 2082 (West 1995) (stating that those who practice, attempt to practice, or advertise without a certificate are guilty of a misdemeanor).</td>
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<td>2. CAL. BUS. &amp; PROF. CODE § 2400 (West 1995) (preventing most corporations and other artificial entities from having professional rights).</td>
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<td>2. CAL. BUS. &amp; PROF. CODE § 2400 (West 1995) (exempting from the prohibition charitable institutions, foundations or clinics by allowing them to employ licensees to render</td>
<td>2. CAL. CORP. CODE § 13402(b) (West 1995) (allowing professional corporations to render professional services).</td>
<td>1. CAL. HEALTH &amp; SAFETY CODE § 1209 (West 1995) (allowing professional corporations to furnish professional health services).</td>
<td>CAL. BUS. &amp; PROF. CODE § 2402 (West 1995) (stating that the not-for-profit exemption is not applicable to medical or podiatry corporations practicing pursuant to the Moscone-Knox Professional Corporation Act).</td>
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<td>2.</td>
<td>GA. CODE ANN. § 43-34-20(c) (1995) (defining the practice of medicine; however, providing no exemption for corporations).</td>
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<td>3.</td>
<td>HAW. REV. STAT. § 453-1 (defining the practice of medicine; however, providing no exemptions for corporations).</td>
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<td>4.</td>
<td>IDAHO CODE § 41-3913(2) (1996) (allowing HMOs to furnish health care services through providers that are under contract, or employed by, the HMO).</td>
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<tr>
<td>1. 225 ILL. COMP. STAT. ANN. 60/3 (West 1996) (prohibiting the practice of medicine by persons who do not obtain a valid license).</td>
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| IND. CODE ANN. § 25-22.5-1-1.1 (Michie 1995) (defining the practice of medicine; however, providing no exemptions for corporations). |

   | IND. CODE ANN. § 25-22.5-1-2 (a)(2)(D) & § 25-22.5-1-2(c) (Michie 1995) (exempting HMOs from the corporate practice prohibition as long as the HMO does not interfere with physicians' judgment or control; HMO's shareholders must be licensed to practice medicine). |

   | IND. CODE ANN. § 25-22.5-1-2(a)(20) & § 25-22.5-1-2(c) (Michie 1995) (exempting hospitals licensed under IND. CODE ANN. § 16-21 or § 12-25 from the corporate practice prohibition as long as they do not interfere with the judgment and control of the physicians employed). |

   805 ILL. COMP. STAT. ANN. 180/1-25 (West 1996) (allowing limited liability companies to engage in the practice of medicine as long as all members are licensed). |
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<td>1. IOWA CODE ANN. § 147.2 (West 1995) (prohibiting the unlicensed practice of medicine).</td>
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<td>2. IOWA CODE ANN. § 148.1 (West 1995) (defining the practice of medicine; however, providing no exemptions for corporations).</td>
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<tr>
<td>LA. REV. STAT. ANN. § 2006(3) (West 1995) (allowing HMOs to provide health care services through providers who are under contract, or employed by, an HMO).</td>
<td>LA. REV. STAT. ANN. § 904 (West 1995) (forbidding a professional medical corporation from engaging in any business other than the practice of medicine).</td>
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<tr>
<td>1. Me. REV. STAT. ANN. tit. 24-A, § 420511(C) (West 1995) (allowing HMOs to furnish health care services through providers under contract, or employed by an HMO).</td>
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<td>2. Me. REV. STAT. ANN. tit. 24-A, § 4222.3 (West 1995) (declaring that HMOs should not be deemed as practicing medicine).</td>
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<td>MASS. GEN. LAWS ANN. ch. 6A, § 72 (West 1996) (prohibiting unlicensed persons from practicing medicine).</td>
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<td>MICH. COMP. LAWS ANN. §333.17011(1) (West 1996) (prohibiting unlicensed individuals from engaging in the practice of medicine).</td>
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<td>MINN. STAT. ANN. § 62D.22.3 (West 1996) (providing that HMOs are not considered as practicing a healing art).</td>
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<td>N.M. STAT. ANN. § 61-6-20 (Michie 1995) (prohibiting persons from practicing medicine without a license).</td>
<td>N.M. STAT. ANN. § 59A-46-30(c) (Michie 1995) (not considering HMOs as engaged in the practice of medicine).</td>
<td>N.M. STAT. ANN. § 53-6-1 (Michie 1995) (allowing professional corporations to provide medical services to the general public through employed physicians).</td>
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<td>87 Op. Att'y Gen. 39 (finding that a corporation, not comprised of professionals, may provide medical services as long as it does not violate a statute or engage in lay exploitation or control of the medical profession).</td>
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<td>N.D. CENT. CODE § 43-17-34 (1995) (providing a penalty for practicing medicine without a license).</td>
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<td>N.D. CENT. CODE § 26.1-17-08 (1995) (prohibiting non-profit health service corporations from engaging in the practice of medicine).</td>
<td></td>
<td>1. N.D. CENT. CODE § 43-17-42 (1995) (allowing licensed hospitals to employ physicians directly, or indirectly, as long as there is a written contract and the hospital does not effect the physician’s independent judgment).</td>
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| **OHIO REV. CODE ANN. § 4731.41** (Baldwin 1996) (prohibiting persons from practicing medicine or surgery without first obtaining a state medical board certificate). | 1. **OHIO REV. CODE ANN. § 1742.01(G)(3)(a)** (Baldwin 1996) (deeming HMOs not to be practicing medicine).  
2. **OHIO REV. CODE ANN. § 1742.30** (Baldwin 1996) (allowing HMOs to employ physicians). | **OHIO REV. CODE ANN. § 1785.02** (Baldwin 1996) (allowing licensed professional individuals to organize and offer services as a corporation). | | |
| **OKLA. STAT. ANN. tit. 59, § 492(C)** (West 1996) (defining the practice of medicine; however, providing no exemptions for corporations).  
| **OR. REV. STAT. § 677.085** (1995) (defining the practice of medicine; however, providing no exemptions for corporations). | | | | |
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<tr>
<td>TEX. INS. CODE ANN. art. 20A.06(a)(3) (West 1995) (allowing HMOs to enter into employment contracts with providers to furnish health care services).</td>
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<td>TEX. REV. CIV. STAT. ANN. art. 1528(e) (West 1995) (allowing professional corporations to provide professional services through officers and employees who are licensed).</td>
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<tr>
<td>UTAH CODE ANN. § 31A-8-105(2) (1996) (allowing HMOs to furnish health care by contracting with providers).</td>
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<td>UTAH CODE ANN. § 16-11-4 (1996) (allowing professional corporations to practice medicine as long as their members are licensed to do so).</td>
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<td>VT. STAT. ANN. tit. 26, § 1314(a) (1995) (describing the penalty for one who does not have a license to practice medicine and does so anyway).</td>
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<td>VA. CODE ANN. § 34.1-2902 (Michie 1995) (prohibiting the practice of medicine without a license and making no exceptions for corporations).</td>
<td>VA. CODE ANN. § 38.2-4319(C) (Michie 1995) (prohibiting HMOs as not engaged in the unlawful practice of medicine).</td>
<td>VA. CODE ANN. § 13.1-546 (Michie 1995) (allowing professional corporations to render professional services through its officers, employees, and shareholders who are licensed).</td>
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<td>WIS. STAT. ANN. § 448.01(9) (West 1995) (defining the practice of medicine; however, providing no exemptions for corporations).</td>
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<td>WYO. STAT. ANN. § 33-26-102 (a)(xi) (Michie 1996) (defining the practice of medicine; however, providing no exemptions for corporations).</td>
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