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## The Corporate Practice of Medicine Doctrine

*By Allegra Kim  
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*Requested by  
The Assembly Committee on Health*

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*By Allegra Kim  
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## EXECUTIVE SUMMARY

The Assembly Committee on Health requested this report to elucidate the ban on hospital employment of physicians in California. The committee wished to learn the history of the Corporate Practice of Medicine (CPM) prohibition, whether California's practice is typical, and the effects of the prohibition. This report describes the corporate practice of medicine doctrine, its evolution and current status in California and other states, and implications for California.

The CPM prohibition has been applied in different ways over time, but currently it most commonly refers to a ban on the employment of physicians by hospitals. In California, the CPM prohibition is interpreted from two sections in the *Medical Practice Act*: Business and Professions Code Section 2052, requiring a medical license to practice medicine, and Section 2400, declaring that corporations have no professional rights, privileges, or powers. However, court decisions and Attorney General Opinions have defined most of the prohibitions that are now collectively called the CPM doctrine as it is applied in California.

The involvement of corporations in medical practice gained attention in the early part of the 20<sup>th</sup> Century, when mining companies needed to hire physicians to provide care for employees in remote areas.<sup>1</sup> Problems arose when physicians' loyalties to their employers conflicted with patients' medical needs. With the aid of state legislatures and the courts, physicians seeking to promote and protect their profession and autonomy succeeded in prohibiting the CPM. In many states, however, the CPM prohibition was not explicitly codified in statutes. Instead, the application of the doctrine developed over time through interpretations of medical licensing statutes and other laws, and in courts as a matter of public policy. The policy concerns cited were the incongruity of a profit motive in medicine, division of physician loyalty between employer and patient, and lay control over physicians.

Concerns about physician autonomy, lay control, and patients/consumers' ability to choose their physicians returned to the fore with the expansion of health insurance plans in the 1930s. Prepaid health care service plans were recommended in order to control costs, but were vigorously opposed by physician groups because they typically employed or contracted with physicians. The CPM doctrine was invoked to block even non-profit health care service plans. As a result, health care service plans were quite limited across the states.

By the 1950s, hospitals had come to depend increasingly on physicians, thus raising the question of hospital employment of physicians. The CPM prohibition was applied to for-profit and non-profit hospitals as corporate entities, resulting in bans on hospital employment of physicians, albeit unevenly across the nation.

By the early 1970s, rising health care costs caused federal and state policymakers to promote managed care, including prepaid health care service plans, with legislation authorizing health maintenance organizations (HMOs). To circumvent the CPM

doctrine, which had been a barrier for decades, the new federal and state legislation, including California's, preempted state laws that inhibited HMOs.

Today most states, including California, allow an exemption for professional medical corporations to employ physicians, and some no longer enforce the CPM doctrine at all. California also allows physician employment by teaching hospitals, certain community clinics, narcotic treatment programs, and some non-profit organizations. Yet in other respects, California maintains the prohibition more rigorously than most states and is one of only a few that still prohibit most hospital employment of physicians. Even the American Medical Association, historically the driving force behind the CPM prohibition, no longer views physician employment per se as a violation of medical ethics and has removed the doctrine from its ethical code.

There is limited research on the effects of the CPM prohibition. Hospital administrators believe the CPM doctrine complicates their ability to ensure adequate staffing, but the doctrine does not appear to be determinative. The CPM prohibition may restrict opportunities for physicians and innovation in physician compensation and health care delivery.

Although the CPM doctrine is generally not believed to be extremely detrimental, its present utility seems limited. The evolution and erosion of the CPM prohibition over many decades has resulted in a doctrine that is far removed from its origin and lacks coherence and relevance in today's health care landscape. Because the policy concerns that the CPM prohibition was meant to address are still important and have been raised in other contexts, California's statutes and regulations now address these concerns more directly. The existence of these more focused safeguards, and the ability to enact others if needed, raise the question of whether maintaining the CPM doctrine still makes sense.

## WHAT IS THE CORPORATE PRACTICE OF MEDICINE DOCTRINE?

The “corporate practice of medicine” (CPM) has multiple meanings which reflect different origins and changes in health care over time. It sometimes refers to the aggregation of medical groups into larger health care systems, or the coordination of physicians in more efficient, effective, or profitable ways by adopting organizational practices from the larger corporate sector.

Corporatism may also be applied to health care organizational practices including privatization, conversion of non-profits to for-profit entities, and the emergence of multi-state, multi-product insurance plans.<sup>2</sup> CPM may denote any involvement of corporations in medicine. CPM may also be defined more narrowly, for example, as the employment of a physician by a lay-controlled corporation that sells the services of the physician for a profit<sup>3</sup> or provides the physician’s services to its employees free of charge. *CPM now most commonly refers to the employment of physicians by hospitals, but is also still used to refer to employment of physicians by for-profit and non-profit corporate entities and government.*

Because this report traces the history of the CPM prohibition, and because a variety of denotations of CPM are still relevant to health care, various definitions of CPM are necessarily used.

### LEGAL BASIS

The prohibition on CPM is also known as the CPM bar, CPM ban, or CPM doctrine, and is a proscription of the employment of physicians. Typically, this doctrine is based on state medical practice acts, which are statutes that list the qualifications needed to obtain a license to practice medicine, and prohibit anyone without a valid license from practicing medicine. In California, the Medical Board of California interprets the doctrine in two sections of the *Medical Practice Act*:

- Business and Professions Code, Section 2052 states that practicing medicine without a valid license is unlawful.<sup>4</sup>
- Section 2400 states that “[c]orporations and other artificial entities shall have no professional rights, privileges, or powers.”<sup>5 6 7</sup> These statutes together are interpreted as a ban on corporations practicing medicine by employing physicians because corporations and other artificial entities are not granted licenses and therefore have no professional rights, privileges, and powers. Courts, California Attorneys General, and the legislature have since determined how this statute would apply to the practice of medicine.

According to the Medical Board of California, limitations on the rights, privileges, and powers of corporate and other artificial entities are intended to prevent unlicensed persons from interfering with or influencing the physician’s professional judgment.<sup>8</sup> The reasoning behind this intention is that corporations cannot have the training, education,

and personal characteristics that are needed to receive a medical license.<sup>9</sup> In addition, corporations are unable to develop the relationship of trust and confidence that is necessary for the relationship between a professional and patient or client.<sup>10</sup> Similarly, a corporation must not employ physicians because the physician's acts would then be attributable to the unlicensed employer.<sup>11</sup>

## **POLICY RATIONALE**

Even before the states passed their medical practice acts, however, the prohibition of CPM was considered a matter of sound public policy and was recognized by courts before 1900 (as is described below in the chapter on the evolution of the CPM doctrine). California Attorney General's Opinions have also helped define the doctrine in California. The policy rationale for the CPM Doctrine can be summarized as follows:

- A profit motive will lead to commercial exploitation of physicians and lower professional standards.
- An employed physician's loyalty will be divided between his/her patient and employer.
- Lay persons should not have control over professionals.<sup>12 13</sup>

## **THE CPM DOCTRINE IN CALIFORNIA**

States that prohibit CPM do so in different ways. California prohibits most physician employment, with several notable exceptions in statutes, and the Medical Board of California provides guidance on the interpretation and application of the prohibition.

### ***Restrictions***

In California, hospitals may not employ physicians to provide professional services. Although this prohibition is not explicitly stated in statute, a 1971 California Attorney General's Opinion, written in response to a request from the Medical Board of California, clearly stated that hospitals could not practice medicine and therefore could not employ physicians, even for emergency rooms.<sup>14 15</sup>

Locum tenens agencies, which arrange temporary placements for physicians, may contract with physicians but may not employ physicians or determine the physicians' pay or hours of work.<sup>16 17</sup>

Some revenue-sharing agreements between physicians and hospitals are permissible. For example, gross income sharing is generally considered acceptable where the hospital's portion of fees is proportional to the expenses it incurs in furnishing facilities for the physician. Net-revenue sharing agreements, however, are generally not permissible, as they are seen as more prone to fraud and abuse.<sup>18</sup>

According to the Medical Board of California, each of the following activities is defined as practicing medicine and is therefore restricted to licensed physicians:

- Decisions concerning diagnostic tests for a particular condition
- Determining whether to refer to or consult with another physician/specialist
- Assuming responsibility for the overall care of the patient, including available treatment options
- Determining how many patients a physician must see or how many hours a physician must work in a given period.<sup>19</sup>

In addition, only licensed physicians may make business or management decisions and engage in activities that result in control over a physician's practice of medicine.

Examples of these restricted activities include, but are not limited to:

- Ownership and control over patient medical records and their contents
- Making clinical competency or proficiency determinations for selecting, hiring, and firing physicians, allied health staff, and medical assistants
- Setting the parameters under which physicians contract with third-party payers
- Decisions regarding coding and billing procedures
- Selecting medical equipment and medical supplies.

These types of decisions and activities may not be delegated to an unlicensed person, including management service organizations.<sup>20 21</sup> Although a physician may consult with unlicensed persons in making such business or management decisions, the physician must retain the ultimate responsibility for those decisions.<sup>22</sup>

Thus, the following examples of medical practice ownership and operating structures are prohibited in California:

- Non-physicians operating a business advertising, offering, and/or providing patient evaluation, diagnosis, care, and/or treatment. Only licensed physicians may offer or provide these services.
- Physician(s) operating a medical practice as a limited liability company, a limited liability partnership, or a general corporation.
- Management Service Organizations (MSOs) arranging for, advertising, or providing medical services, even where physicians own and operate the business (MSOs may only provide administrative staff and services for a physician's medical office).
- A physician acting as "medical director" when the physician does not own the practice. An example is a business offering spa treatments that include medical procedures such as Botox injections, laser hair removal, and medical microdermabrasion, that contracts with or hires a physician as its "medical director."<sup>23</sup>

## *Exceptions*

California allows exceptions to the corporate practice of medicine bar through professional medical corporations and allowances for employment of physicians by specific entities (mainly medical schools and non-profit hospitals), and for health maintenance organizations.

### *Medical Corporations*

The 1968 *Moscone-Knox Professional Corporation Act* in California's Corporations Code allows the formation of professional medical corporations. A professional corporation is defined as a corporation that is "engaged in rendering professional services in a single profession..." Under this statute, medical corporations are not required to get a certificate of registration from the Medical Board of California if their services are rendered through employees who are licensed by the Medical Board of California.<sup>24</sup>

A medical corporation must be owned and governed by a physician majority, with any non-physician minority including only specified types of health professionals. At least 51 percent of a medical corporation's shares must be issued to physicians licensed to practice in the same jurisdiction, and these shareholders may not vest others (unless shareholders) with voting rights.<sup>25</sup> A medical corporation may also have the following types of non-physician licensed professionals as shareholders, officers, directors, or professional employees, if they do not exceed the number of licensed physicians and their shares do not exceed 49 percent of the total number of shares: podiatrists, psychologists, registered nurses, optometrists, marriage and family therapists, clinical social workers, physician assistants, chiropractors, acupuncturists, and naturopathic doctors. Unlicensed employees are not permitted to render any professional services.<sup>26</sup>

### *Teaching hospitals*

Section 2401 of California's *Medical Practice Act* allows approved medical and osteopathic school clinics to charge for physician services if the charges are approved by the physicians.<sup>27</sup> A California District Court found that the CPM bar should not apply to the University of California medical schools and hospitals because "[t]he university's ability to generate income to cover some expenses does no more than reduce the burden on the state's taxpayers. Concerns about for-profit corporations have nothing to do with non-profit teaching hospitals."<sup>28</sup>

### *Narcotic Treatment Programs and Non-profit Research Clinics*

Non-profit narcotic treatment programs approved by the State Department of Alcohol and Drug Programs and specified non-profit research clinics and may also employ physicians and charge for professional services as long as they do not interfere with the physician's professional judgment.<sup>29 30 31</sup>

### *Non-profit community clinics*

Although not specified in statute, there is judicial and legislative recognition that the CPM bar may be relaxed for philanthropic associations. The California Attorney General found that community clinics (defined in Health and Safety Code Section 1204(a)) may lawfully employ physicians if they meet certain conditions. The clinics must be licensed, serve a defined population (such as low-income), be operated as a non-profit corporation, and charge based on ability to pay, if at all.<sup>32 33</sup>

### *Pilot Program for County Hospitals in Underserved Areas*

The *Medical Practice Act* allowed an exemption under SB 376 (Chapter 411, Statutes of 2003), a small pilot project to allow direct employment of physicians by qualified district hospitals in underserved communities. The rationale for SB 376 was that physicians have a disincentive to practice in rural or remote areas because opening a practice in small or disadvantaged communities comes with significant economic risk. To address the physician scarcity in such areas, SB 376 allowed qualified public hospitals to shoulder the economic risks by hiring physicians as full-time paid staff with employment benefits. As employees, physicians would not have to hire staff or obtain worker's compensation or malpractice insurance. Qualified hospitals:

- provided more than 50 percent of patient care days to Medicare, Medi-Cal, and uninsured patients,
- had net losses in Fiscal Year in 2000-01, and
- were located in counties with populations under 750,000.

The participating hospitals were allowed to employ no more than two physicians at any one time, for a term not exceeding four years. The hospitals were also required to enter into contracts before December 31, 2006.<sup>34</sup> Despite interest expressed before the legislature, only five hospitals participated, hiring a total of six physicians.\*

### *Other physician employment*

The *Medical Practice Act* allows a constrained opening for exemptions from its declaration that corporations have no professional rights, privileges, or powers. Section 2400 states:

...the Division of Licensing [of the Medical Board of California] may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic.<sup>35</sup>

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\* Kevin Schunke, SB 376 Administrator for the Medical Board of California, e-mail communication March 6, 2007.

As a result of the 1973 Federal *Health Maintenance Organization Act*, health maintenance organizations are exempt from California's ban on physician employment.<sup>36</sup>

Another exception is that Medi-Cal managed mental health plans may contract with hospitals for per diem reimbursement for psychiatric inpatient services, including a mental health professional's daily visit fee.<sup>37 38</sup>

## **EVOLUTION OF THE CORPORATE PRACTICE OF MEDICINE DOCTRINE**

The CPM doctrine may be traced to several disparate origins, including physician licensure, protection of the medical profession from price competition, the need for medical care for workers in dangerous industries and remote areas, and the changing role of hospitals in medical care.

Physician licensure evolved in the 1800s as physicians struggled to gain professional autonomy and the respect of the public. In the early 1900s, corporations began to employ physicians on a salary or contractual basis to treat employees. Businesses that hired doctors for profit also emerged. Hospitals' role in health care also changed and began to require the services of more physicians. The medical profession objected to the involvement of corporations in medicine, citing concerns about excessive caseloads, divided loyalty and lay interference in health care decisions, patients' freedom to choose a doctor, and third parties making profits from physicians' work. Courts and other government entities shared these public policy concerns and argued that corporations could not be licensed to practice medicine.<sup>39</sup>

The history of the CPM ban involves at least two kinds of corporate practice of medicine; the first is the corporate physician, explicitly employed (or contracted) by a corporation to serve its employees. This is also known as contract practice. The second might be described as the business of medicine, whereby non-physician entities, including hospitals, profit from the work of physicians. This chapter describes the rise of, and subsequent challenges to, these two types of corporate medicine in the U.S.

## **PHYSICIAN LICENSING AND THE ESTABLISHMENT OF MEDICINE AS A PROFESSION**

The corporate practice of medicine doctrine is often traced to the establishment of medicine as a profession. Nineteenth Century physicians faced significant competition from “irregulars” who had not received traditional medical training. The public regarded physicians with skepticism, so they turned to “irregular” healers. The fact that some physicians aggressively promoted their treatments made it harder to distinguish them from the irregulars. As a result, physicians sought to establish medicine as a profession and to distinguish themselves from the irregular healers.<sup>40</sup>

The struggle to establish the profession of medicine gave rise to the AMA in 1847. The AMA immediately set out to establish the preeminence of the “regular” medical profession by imposing higher standards, licensing requirements, raising standards for medical education, and instituting a code of ethics. Included in the code of ethics was a prohibition on advertising, which was intended at least in part to distinguish physicians from irregulars.<sup>41</sup>

In the 1870s some physicians pushed for more and succeeded in getting some minimal state licensing statutes enacted. State licensing boards were established soon afterwards. The AMA also continued to work to raise standards for medical education and licensing,

thus further limiting the field of competition and raising the expertise and quality of practitioners.<sup>42</sup> These changes, along with advances in medicine, resulted in greater public respect and better physician pay.

Establishing medicine as a profession is central to the prohibition on the corporate practice of medicine because of the requirements for physician licensure. States' medical practice acts require physicians to meet high standards of training and character in order to obtain licenses to practice medicine. Corporations cannot receive medical training and do not possess human qualities such as character and judgment, and therefore may not be licensed to practice medicine.

## **CONTRACT PRACTICE**

The earliest form of prepaid health care in the U.S. was industrial contract practice. Contract practice was initially a way to pay for medical care for some working class populations, including workers in remote and dangerous industries, members of lodges in urban areas and immigrant communities, and members of shop organizations.

### ***Industrial Contract Practice in Remote and Dangerous Industries***

Isolated conditions for railroad, mining, and lumber operations necessitated extensive corporate involvement in medical care. Railroad and mining companies began to employ physicians to treat injuries in 1860. As industrialization and injury rates increased after the Civil War, these physician employment arrangements became more popular and were adopted by steelmakers and other manufacturers. At this point, industrial medicine involved treatment of occupational injuries, rather than diseases.<sup>43</sup>

Railroads were leaders in developing extensive employee medical programs. With extremely high injury and mortality rates among more than a million workers—in 1900 one of every 399 workers was killed on the job—railroads employed more than 6,000 surgeons to treat workers, as well as passengers and pedestrians. Railroad companies promised physicians a salary in order to induce them to move to the often poor, remote, and sparsely settled regions where railroads were being built and run. In addition to concern about the hazards of railroad work, railroad companies were interested in protecting themselves from lawsuits. The surgeons employed by the railroad companies often also served as expert witnesses, representing the companies in damage suits.<sup>44</sup> Most firms contracted for treatment through independent physicians and hospitals for a flat rate per worker, per month.<sup>45 46</sup>

In the early 1900s, industrial physicians also began to conduct pre-employment and periodic health exams in other industries. Workmen's compensation laws around 1910 led to the increasing involvement of physicians in the preventive medical engineering of the workplace. However, only a few industries became heavily involved in financing and sometimes managing medical care in the manner of the railroads. In most industries, even when a physician was employed by the company, the medical services offered were limited, typically to what was needed to keep people working.<sup>47</sup>

### *Consumer Clubs*

Fraternal orders and mutual benefit societies provided important benefits, including life insurance and aid to sick and disabled members. By the early 1900s, at least a quarter of American families probably had access to benefits through these clubs. Clubs needed physicians to conduct examinations for life insurance, and especially after the 1890s, to provide care for their members, and sometimes members' dependents. Clubs paid physicians a fixed rate per member to provide care. Medical care through these clubs was more common in immigrant communities and urban areas. Among national fraternal organizations that provided medical benefits, the branches in wealthier areas tended to not employ lodge doctors because their members could afford to choose their own private physicians. The physicians who contracted with these organizations were often relatively inexperienced and accepted these contracts as a way to build a practice.<sup>48</sup>

In addition to fraternal orders and mutual benefit societies, work and shop organizations also contracted with physicians to provide medical services to their members.<sup>49</sup>

### *Challenges to Contract Practice in Medicine*

Although contract practice in the form of prepaid health care rose to meet a need for health care, it engendered distrust in both physicians and workers.

#### *Workers*

When a company employed or contracted with physicians, it usually controlled the choice of physicians, while also deducting from employee wages for the cost of physician salaries and hospital access. Many workers objected to this lack of choice and saw it as part of a "web of class domination."<sup>50</sup> Moreover, when medical evaluations determined compensation awards, employees naturally distrusted the company doctors.<sup>51</sup>

A Department of the Interior investigation of mining operations illustrates why workers objected to contract physicians. The 1947 report revealed not only appalling conditions, but also a system of medical care in which physicians were chosen on the basis of personal friendships and "financial tie-ups" rather than professional ability. Company doctors submitted workmen's compensation claims on 21 percent of industrial injuries, compared with 89 percent by non-company physicians. Coal mining operators were able to deny workers verification for workmen's compensation claims as well as knowledge of industrial diseases by limiting medical care to doctors that they had chosen.<sup>52</sup> Unions therefore pressed for cash benefits and control over welfare funds in place of these company-controlled medical services.<sup>53</sup>

During the Great Depression, companies cut back on employee welfare programs, including the provision of health care. In the 1940s, collective bargaining gained strength in heavy industry and companies further relinquished control over services as a strategy for control over workers. Group health insurance took a different form and workers were allowed to choose their health care.<sup>54</sup>

## *Physicians*

Although some physicians appreciated the stable income obtained through contract practice,<sup>55</sup> those who worked for companies were often regarded with suspicion or even contempt by other physicians.<sup>56 57</sup> The AMA opposed contract and corporate practice from as early as 1890.<sup>58</sup> The 1912 Principles of Medical Ethics stated that the AMA opposed contracts in which physicians could not render adequate service or that interfered with reasonable competition among the physicians in a community.<sup>59 60</sup> The AMA and other critics argued that contract practice:

- was ‘destructive of the personal responsibility and relationship which is essential to the best interest of the patient’<sup>61</sup>
- compromised the physician’s allegiance to the patient<sup>62</sup>
- denied the patient’s freedom to choose a physician<sup>63</sup>
- forced physicians to maintain a high patient load and thus compromise the quality of services<sup>64</sup>
- abolished fee-for-service payment and a way for physicians to value their own services and income levels
- threatened physician autonomy<sup>65</sup>
- forced doctors to bid against each other for contracts, thus driving down income.<sup>66 67 68</sup>

However, the AMA did not go as far as branding all of contract practice as unethical; in fact, the AMA conceded that there were some settings in which contract practice was necessary and ethical, such as when many workers were employed remote from urban centers, in some industrial settings, or when a community was “too small to offer sufficient inducements to a competent physician to locate therein.” The AMA also allowed exceptions for charitable institutions and the armed forces in employing physicians,<sup>69 70</sup> though working for lodges was objectionable.<sup>71</sup> Judgment about a contract’s adherence to the AMA’s *Principles of Medical Ethics* depended on the specific terms of each contract.<sup>72</sup>

## **THE BUSINESS OF MEDICINE**

Another form of business involvement in medical care was the sale of medical services to the public by a third party, or “corporate practice.” The emergence of profit-making medical institutions was effectively limited by a series of legal decisions in most jurisdictions. Between 1905 and 1917, courts in several states ruled that corporations could not engage in the commercial practice of medicine, even if they employed licensed physicians, because a corporation could not be licensed to practice medicine and commercialism in medicine was contrary to “sound public policy.”\* By the 1920s and

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\* However, Starr observes that these decisions illogically did not apply to employment of company doctors, or to for-profit hospitals (Starr, 1982).

1930s, courts across the nation indicated that the prohibition on the corporate practice of medicine was firmly established. This does not, however, mean that it was clearly defined.

A number of important cases concerning the corporate practice of medicine were heard in California. In the 1927 *Pilger v. City of Paris Dry Goods* decision, the California Court of Appeal wrote: "...authorities seem to be uniform that a corporation can neither practice nor hire lawyers, doctors, or dentists to practice for it."<sup>73</sup> Yet the same decision also indicated approval of employing or contracting with physicians: "There can be no doubt that a corporation may undertake to furnish the services of a competent physician...and that it may under certain circumstances be liable in damages—as, for instance, the person employed was not authorized to practice."<sup>74</sup>

In 1932 the Supreme Court of California noted that the prohibition on professional corporate practice was "a settled question in this state." Deciding a case concerning a commercial dental enterprise, the court asserted that the law could not be interpreted as separating the "business side" of dentistry from the professional practice itself and that by forming corporations, and employing licensed dentists, Painless Parker was unlawfully engaged in the corporate practice of dentistry.<sup>75 76</sup> Although this case was cited widely, some other courts actually accepted a distinction between professional and management activities of a corporation.<sup>77 78</sup>

The AMA declared in its 1934 code of ethics that making a profit from medical work was 'beneath the dignity of professional practice, unfair competition with the profession at large, harmful to the profession and the welfare of the people, and contrary to sound public policy.'<sup>79</sup> The code of ethics further stated that it is "unprofessional" for a physician to permit a "direct profit" to be made for anyone else, such as an investor, from a physicians' labor,<sup>80</sup> although the AMA did not object to physicians making profits from other physicians' labor.<sup>81</sup> The AMA also argued that commercialism might lead to lay involvement in a physician's decision making and interfere in the relationship with the patient.<sup>82</sup>

## **INSURANCE AND PREPAID HEALTH PLANS**

As the health care landscape continued to change, the concept of the CPM, and thus the nature of the ban, also changed. While commercialism in medicine was being banned, another type of corporate entity became increasingly involved in medicine. Blue Cross Hospital Insurance was born in the Great Depression, when few people could pay for hospital care.<sup>83</sup> The expansion of hospital insurance in the 1930s confounded early definitions of the CPM.<sup>84</sup> Again, the concerns were physician employment and autonomy, patient's choice of physicians, and commercial exploitation.

In 1932, the Committee on the Costs of Medical Care, a national commission funded through private philanthropies, recommended the expansion of contract-style practice through group prepaid medical practice. Some physician members of the committee issued a minority report that criticized group prepaid practice contracts for leading to the solicitation of patients, creating competition among physicians, and demoralizing the

profession. This minority report was endorsed by the AMA's House of Delegates. In 1934 the AMA also stated that allowing a lay entity to profit directly from a physician's compensation for providing medical services was unethical.<sup>85</sup> The AMA also opposed prepaid direct service plans controlled by physicians.<sup>\* 86</sup>

In 1935, the California Court of Appeal decided a case against an insurance company regarding its power to "appoint" physicians to provide services. The court held that allowing a "middleman" to intervene for profit in the relationships between the professions and the public is unlawful "commercial exploitation," and that a corporation cannot evade rules by hiring others. The court also noted that in the same year the California Legislature had decided not to change the prohibition on the corporate practice of medicine and dentistry.<sup>87</sup> Other California court decisions also held that when an insurance company maintains the right to select a doctor, it is practicing medicine.<sup>88</sup>

The AMA also strenuously opposed non-profits' employing or contracting with physicians. The AMA threatened physicians who participated in the Group Health Cooperative of Washington D.C., a non-profit cooperative controlled by an elected board, with reprisals, and persuaded all D.C. hospitals to deny them privileges, among other activities. The AMA called the cooperative unlicensed, unregulated health insurance, and CPM.

However, in 1938, the AMA and local medical organizations were indicted by the U.S. Department of Justice on antitrust charges for their efforts to suppress the Group Health Cooperative.<sup>89</sup> This ruling is credited with keeping alive "...the possibility of creating alternative delivery systems, thus preserving the possibility of effective price competition in health care."<sup>90</sup>

Despite this victory for cooperatives, the profession continued to block cooperatives elsewhere, often with the help of state court decisions that included non-profits in the CPM ban. Between 1939 and 1949, 26 states passed laws that effectively barred

Kaiser Foundation Health Plan was successful among prepaid group practices largely because it was a partnership between one insurance plan and several medical groups tied together by exclusive contractual relationships, instead of a vertically-integrated firm. Physicians were not Kaiser employees, but rather partners and employees in one of the regional Permanente Medical Groups. The insurance plan took care of enrollment and revenues, while physicians retained control over the administrative and clinical dimensions of medicine. The Permanente Medical Groups had complete control over affairs within the constraints of the prepaid budget. They decided how many and which types of physicians to hire, how much to pay, and how they would be evaluated. (Robinson, James C. *The Corporate Practice of Medicine: Competition and Innovation in Health Care*. Berkeley, CA: University of California Press, 1999.)

\* Prepaid plans are health care service plans, which promise to *provide or arrange for services* and are thus distinct from traditional health insurance plans, which promise to *pay* for medical services the patient obtains from physicians. (Debra L. Roth and Deborah Reidy Kelch, "Making Sense of Managed Care Regulation in California." Prepared for the California HealthCare Foundation, November 2001.) In prepaid medical practice, the physicians assume more risk because they are obligated to provide care at a predetermined cost, and cannot simply charge for additional services that a patient might need.

consumer-run medical service plans. Some of these states permitted medical service plans if the incorporators or a majority of directors were physicians, or if the plan was approved by the state medical society. Some states required all plans to allow patients to choose their physician.<sup>91</sup> Pre-paid plans such as Kaiser Permanente and Group Health Cooperative of Puget Sound, where physicians controlled the plans and built their own clinics and hospitals, survived only on the West Coast.<sup>92</sup>

## **HOSPITAL EMPLOYMENT OF PHYSICIANS**

In the 1950s, more health care was being provided by salaried physicians in prepaid group practices and physicians employed by hospitals, especially teaching hospitals. Medical faculty and residents tripled in this decade. Many AMA delegates opposed employment by hospitals, whether corporate hospitals or state-owned, tax-supported hospitals, arguing that hospital employment threatened physician allegiance to patients.<sup>93</sup>

Previously, courts had held that only a “natural person” could be licensed to practice medicine and that corporations, as “artificial persons,” could neither be licensed nor sell the services of a licensee.<sup>94</sup> Over time, however, many courts found that employment of physicians at not-for-profit hospitals was not illegal CPM, but rather an independent contractor arrangement as long as hospitals did not attempt to control medical policy.<sup>95</sup>

By the end of the decade, the AMA had also softened its stance, leaving open the possibility of physician employment as long as there were no restrictions on their medical decisions. The AMA also continued to strongly support the rights of individuals to choose their physicians and health care delivery systems.<sup>96</sup>

In *Darling v. Charleston Memorial Hospital* (1965), the Supreme Court of Illinois decided an important case concerning hospital employment of physicians. The court found that hospitals do have direct legal responsibilities for quality of medical care provided by physician contractors to patients. Thus it recognized that hospitals, in addition to individual professionals, could “...have direct obligations to patients and thus the right to oversee the work of affiliated physicians...”<sup>97</sup>

## **MANAGED CARE**

### ***Federal Health Maintenance Organization (HMO) Act of 1973***

By 1970, health costs had increased so sharply that health care was widely considered to be in crisis.<sup>98</sup> By this time, solo practice and fee-for-service medicine were losing ground to new health care organizations with corporate characteristics, known collectively as managed care.<sup>99</sup> After the CPM doctrine had been used to block the prepaid health plans proposed in the 1930s, federal and state laws were needed to carve out exceptions to the CPM doctrine to accommodate the managed care model.<sup>100</sup>

The Nixon administration welcomed profit-making corporations into health care. In 1973, Congress enacted the *Health Maintenance Organization Act of 1973*. The *HMO Act* did not expressly preempt or eliminate the CPM doctrine, but it did preempt state

laws that could inhibit HMOs, including the prohibition on employing physicians.<sup>101</sup> This Act is seen as a definitive policy statement in favor of a corporate-based, competitive health care market.<sup>102 103</sup>

Governor Reagan also welcomed HMOs as a matter of state policy to reduce Medi-Cal costs.<sup>104 105 106</sup> In 1971, the California legislature enacted AB 949, legislation that encouraged enrollment in prepaid health plans for Medi-Cal beneficiaries.<sup>107 108</sup> However, the result of the 1971 legislation was severely problematic. Some of the new prepaid health plans served as non-profit shells that funneled money to for-profit corporations, some plans sold “shares” to providers who hoped to reap profits from provider payments, and some providers were not paid for services provided. The media reported poor quality care, misrepresentations by health plan enrollers, physicians being unavailable, and failures to provide promised transportation for medical care. The legislature responded with regulatory standards and California Department of Health Services (CDHS) oversight, but problems continued.<sup>109</sup>

The California legislature passed additional legislation to remedy the problems, leading to Governor Jerry Brown’s Prepaid Health Plan Advisory Committee and the *Knox-Keene Health Care Service Plan Act of 1975*. The *Knox-Keene Act* established the basic regulatory framework for health care service plans and assigned regulatory authority to the Department of Corporations. In many ways, it paralleled the federal *HMO Act*.<sup>110</sup> In passing the *Knox-Keene Act*, the legislature clearly stated its intent and purpose to uphold the role of the physician as the determiner of the patient’s health needs, to foster the relationship of trust and confidence between the physician and patient, and to ensure the receipt of available and accessible medical services.<sup>111</sup> In other words, the legislature intended to address the concerns that were the basis of the CPM bar, given the authorization of health care service plans, or HMOs.

Meanwhile, other states also adopted legislation explicitly recognizing that the CPM doctrine would not apply to HMO-provider relationships.<sup>112</sup>

### ***Anticompetitive Practice Ruling against the American Medical Association***

Although the AMA’s *Principles of Medical Ethics* did not have the force of law, its opposition to physician employment served as the main impetus for the corporate practice doctrine. In 1979, the Federal Trade Commission (FTC) asserted that the AMA’s ethical guidelines were anticompetitive as they illegally restricted members’ ability to advertise and solicit patients, as well as their ability to engage in contractual relationships. The FTC had found that the AMA’s guidelines concerning corporate practice “had the purpose and effect of restraining competition by group health plans, hospitals, and similar organizations, and restricting physicians from developing business structures of their own choice.”<sup>113</sup> The FTC therefore issued a Final Order requiring the AMA to eliminate the ethical restrictions published in its *Principles of Medical Ethics*, thus severely weakening the foundation on which the CPM Doctrine was built.<sup>114</sup>

## STATUS OF THE CPM DOCTRINE

Today the corporate practice of medicine usually denotes employment of physicians. Like California, most states' statutes do not *explicitly* prohibit physician employment. This chapter provides a broad overview of the status of the CPM doctrine in different states.

### FEW STATES PROHIBIT HOSPITAL EMPLOYMENT OF PHYSICIANS

A 1991 study by the U.S. Department of Health and Human Services Office of the Inspector General (OIG) found that only five states clearly prohibited hospital employment of physicians: California, Colorado, Iowa, Ohio, and Texas. Among these states, there are exceptions, such as California's exception for teaching hospitals, Iowa's exception for pathologists and radiologists, and public hospitals in Texas. Laws defining the practice of medicine did not clearly prohibit hospitals from employing physicians in other states.<sup>115</sup>

In some states, general provisions forbidding unlicensed persons from practicing medicine have not been applied to hospitals recently. However, rulings in a couple of other states have strengthened the CPM prohibition by prohibiting unlicensed persons from being partners in medical practices. These rulings have caused concern that the decisions could threaten arrangements through which hospitals provide medical staff.<sup>116</sup>

The five states that generally prohibit hospital employment of physicians, and another three states—Illinois, New York, and New Jersey—also preclude hospitals from employing physicians for services in outpatient clinics. These states require that corporations employing physicians in outpatient clinics be incorporated as professional service corporations.<sup>117</sup>

### OTHER PHYSICIAN EMPLOYMENT

As of 2004, 37 states, including California, bar non-physicians from owning businesses in which physicians treat patients.<sup>118</sup> The AMA also interprets statutes and cases in 37 states as barring physician employment by non-physician organizations.<sup>119</sup> In contrast, the authors of *Corporate Practice of Medicine Doctrine: 50 State Survey Summary* examined state laws and regulations that prohibit business corporations from practicing medicine or employing physicians, and found that as of September 2006, 36 states do *not* have statutes or regulations prohibiting corporations from practicing medicine or employing physicians. However, many of these states *do* have case law or Attorney General Opinions that place restrictions on the CPM. The authors also note that even states that do have statutory CPM restrictions may not enforce them.<sup>120</sup>

In 1993, the California Medical Association (CMA) Legal Counsel produced a report that considered the full spectrum of the CPM. The report, *Summary of State Positions on the Corporate Practice of Medicine Bar*, demonstrates the many types of statutes, decisions, and opinions that the CMA interprets as supporting the CPM bar.

For some states, including Alabama, Alaska, Louisiana, Mississippi, Missouri, Nebraska, and New York, the CMA report cites statutes that prohibit the unlicensed practice of medicine, with no proscription of physician employment or corporate practice. These statutes have often been interpreted as not constituting a CPM bar. For example, Mississippi's Board of Medical Licensure was not concerned with the business arrangements licensees enter, as long as they met specified criteria, including physician control over patient treatment.<sup>121 122 123</sup> In contrast, New York, Wisconsin, and Pennsylvania courts supported the CPM doctrine without more explicit statutes<sup>124</sup> (although New York clearly allows hospitals to employ physicians<sup>125</sup>).

Other state statutes explicitly exclude corporations from practicing medicine. These statutes might deny corporations professional rights and privileges (as in California) or other involvement in medicine, or restrict licenses to individuals. Examples of these states in addition to California are Colorado, Ohio, South Carolina, South Dakota, Texas, and Utah. As with California, allowances might be made for non-profit entities, professional corporations, HMOs, and so forth. Ohio restricts licenses to individuals, and its set of statutes and interpretation are fairly comparable to California's.<sup>126</sup>

In some states, the statutes are less explicit but the courts interpret a bar on corporate practice of a profession. Illinois' CPM-related statutes only prohibit practicing without a license, aiding and abetting unlicensed practice of medicine, and allowing another person to use one's license. Yet Illinois courts held that the conduct of a dentistry school and, in a separate case, that a dentistry school advising students on specific problems of patients, were both unlawful practice of dentistry by a corporation.<sup>127</sup>

Some state statutes prohibit practicing under another name, fee splitting, or aiding and abetting an unlicensed person in practicing medicine. Observers have interpreted these statutes as prohibiting the corporate practice of medicine. On the other hand, New Mexico statutes prohibit permitting another to use a medical license and limit professional corporations to rendering professional services only through licensees, but a 1987 New Mexico Attorney General Opinion found no statutory prohibition of non-physician corporations employing physicians. The opinion further suggested that the corporate practice bar might no longer be appropriate.<sup>128</sup>

Like California, many states have statutes that explicitly permit physician employment in specific circumstances. In Indiana, for instance, the CPM bar (beyond the prohibition on unlicensed practice) is found in case law from 1937, while HMOs, professional corporations, hospitals, and mental health institutions are statutorily allowed to practice medicine or employ physicians. Iowa statutes allow hospitals to employ radiologists and pathologists, and HMOs and professional corporations to employ physicians, but case law prohibits physician employment if the corporation exerts control.<sup>129</sup>

## **THE AMERICAN MEDICAL ASSOCIATION (AMA)**

Since the FTC's Final Order requiring the AMA to remove its CPM guidelines from its *Principles of Medical Ethics* in 1979,<sup>130</sup> the contemporary *Principles* states that physicians should "...be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care."<sup>131</sup> The AMA officially approves of a

variety of physician-hospital contractual relations, including hospital employment of physicians, association with a hospital as a medical specialist, or independent practitioner with staff privileges. The AMA also officially approves of a variety of arrangements for paying physicians, including annual salary, hourly rate, or other arrangements related to the professional services, skill, education, expertise, or time involved.<sup>132</sup> However, the AMA insists on the caveat that employment relationships should not permit lay interference in medical matters. Also, in 2005 the AMA's Board of Trustees recommended that the AMA be available to provide guidance to medical societies considering model legislation prohibiting physician employment by non-professional corporations.<sup>133</sup>

The AMA does not discourage advertising except if it is deceptive or “[a]ggressive, high-pressure” advertising that might create unjust expectations or is accompanied by deceptive claims is unacceptable.<sup>134</sup>

### **THE CALIFORNIA MEDICAL ASSOCIATION (CMA)**

The CMA considers the CPM doctrine “a fundamental protection against the potential that the provision of medical care and treatment will be subject to commercial exploitation.” The CMA's Legal Counsel defines the CPM bar broadly, as a prohibition on lay entities hiring or employing physicians or other health care practitioners, or interfering with physicians or other health care practitioners' practice of medicine. Lay entities are also prohibited from contracting with health care professionals to render services. The CMA further notes that the CPM Bar “...is designed to protect the public from possible abuses stemming from the commercial exploitation of the practice of medicine,” and that California's courts and legislature have upheld the CPM Bar to protect physicians from the “pressures of the commercial marketplace.”<sup>135</sup>

### **HOSPITAL ASSOCIATIONS**

The American Hospital Association, in an Amicus Curiae Brief submitted to the Supreme Court of Illinois in 1996, clearly stated its position in favor of allowing employment of physicians. The brief argues that the CPM doctrine no longer serves the purpose of protecting physician autonomy, as employment does not mean relinquishing control over clinical decisions to employers. Restraints such as utilization review and reimbursement mechanisms such as capitation have a greater impact on how physicians practice than does employment status. The brief further cites marketplace trends and actions of the U.S. Congress and other federal entities that recognize the lawful employment of physicians.<sup>136</sup>

The California Hospital Association has no official position regarding the CPM doctrine.\*

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\* Barbara Glaser and Lois Richardson, California Hospital Association. Telephone communication, September 6, 2007.



# POLICY ANALYSIS OF THE CPM DOCTRINE

## HOSPITAL EMPLOYMENT

Perhaps the most common application of the CPM doctrine is a prohibition on most hospital employment of physicians. The U.S. Department of Health and Human Services, Office of Inspector General (OIG) examined the effects of this proscription on hospital administration in a survey of hospital administrators, and compared results from the five states that clearly prohibited hospital employment of physicians—California, Colorado, Iowa, Ohio, and Texas—with other states.

The OIG reported that 38 percent of hospital administrators who responded to the survey in the five restrictive states, including 41 percent of California respondents, believed that the prohibition on employing physicians creates difficulties and imposes legal, recruitment, or administrative costs.<sup>137 138</sup> For example, the CPM bar can increase the difficulty of recruiting physicians by limiting medical staffing options. Hospitals cannot offer physicians financial guarantees, which could alleviate medical school debts or help establish a new practice. In rural areas, some believe, the CPM bar exacerbates the difficulty of recruiting physicians.<sup>139 \*</sup>

Hospital administrators also believe that being unable to employ physicians limits their ability to control the practice patterns and costs of individual physicians.<sup>140</sup> Also, because HMOs are permitted to offer physicians salaries, some hospital administrators believe that HMOs have a competitive advantage in recruiting physicians.<sup>141</sup>

Some respondents also reported that the CPM prohibition makes it more difficult to staff medical services (41 percent of respondents), basic emergency services (24 percent), and specialty emergency services (30 percent). However, hospitals in states that permit physician employment were as likely as those in prohibiting states to use on-call members of their active medical staff to provide specialty coverage in the emergency department, indicating that the CPM prohibition probably was not determinative. Significant barriers to providing specialty services also included shortages of specialists and low reimbursement rates; these were cited more frequently than physician employment laws.<sup>142</sup>

State prohibitions on the CPM can result in considerable legal complexity in the requirements governing hospital organizational arrangements. For example, in the five states that prohibit hospital employment of physicians, hospitals may not own medical practices. In these states, some hospitals will undertake complicated arrangements to

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\* California's 2003 pilot program (SB 376, Chapter 411, Statutes of 2003) to address the need for physicians in underserved areas by permitting hospitals to employ physicians, does not appear to have been very popular, but the program was very limited in scope and evaluation is still ongoing. (Kevin Schunke, SB 376 Program Administrator for the Medical Board of California, e-mail messages to author, March 6, 2007 and August 2, 2007.)

control a medical practice, such as establishing a medical foundation which can employ physicians in some settings.<sup>143</sup>

The OIG study concluded that although the physician employment laws were perceived as obstructive, they were actually relatively unimportant. Interviews with administrators supported this finding. In fact, one-third of respondents from the five restrictive states were actually unaware of the prohibition. In California, 20 percent of respondents were unaware.<sup>144</sup> A California respondent summarized the others' remarks well: "Most of us are able to accommodate through other mechanisms what repeal [of the CPM prohibition] would accomplish."<sup>145</sup>

## COMMERCIALISM IN PROFESSIONS

We found no research examining the effects of prohibiting commercialism in medicine on health care quality or costs. However, researchers have studied the effects of corporate practice restrictions on the cost and quality of optometric services.

The FTC Bureau of Economics sent trained data collectors posing as patients to optometrists in areas with and without restrictions on commercial practice. Restrictions on commercial practice included prohibitions on advertising, employment of optometrists, lay ownership, commercial locations, and branch outlets. The study found:

- Variation in quality among optometrists in cities both with and without commercial practice restrictions was wide and similar in both types of location.
- Workmanship of eyeglasses and unnecessary prescribing were also similar in both types of location.
- The existence of price advertising and commercial practice was associated with significantly lower prices, even among those who did not advertise, in nonrestrictive areas.
- In nonrestrictive areas, traditional optometrists who did not advertise gave more thorough exams and charged more than advertising and chain firm optometrists.
- There were no significant differences in the quality of eye exams between individual advertisers and optometrists employed by large chain optical firms.

In a separate study, a researcher specified four different kinds of governmental practice restrictions: location (usually that the office be solely for optometry and not shared with another commercial function), optometrist employment, the operation of multiple offices, and use of trade names. Her results were consistent with the previous observation that restrictions increase the price of ophthalmic goods and services, holding quality constant. The study showed that in restricted areas, the product cost five to 13 percent more than in non-restricted areas. Media advertising was also associated with 26 to 33 percent lower prices. The study revealed no statistically significant relationship between commercial practice restrictions and higher quality, or between prices and quality.

An unpublished FTC study found commercial dentistry practices (i.e., practices that employ at least one non-owner dentist, have at least three offices, and advertise) provided

higher quality for most common services but lower quality for complex services, such as surgery.<sup>146</sup>

## **THE CPM DOCTRINE AND INNOVATION**

Some health law practitioners argue that CPM prohibitions are increasingly ignored (California being one of a few exceptions), and even proponents of the doctrine have accepted the increased role of the corporation in medicine. Nevertheless, the existence of corporate practice laws—even if unenforced—in many states may pose a threat to innovation in health care delivery.<sup>147 148</sup>

The recent emergence of convenient care clinics, or retail clinics, is a timely example. One of the reasons cited for their limited growth in California is the strength of the CPM doctrine in this state. Even clinics staffed by nurse practitioners must have physician supervision, and the prohibition on physician employment in California appears to limit operation of these clinics to professional medical corporations, which must be owned and governed by a physician majority.<sup>149</sup> Thus, although convenient care clinics are not entirely prohibited by existing law, they are quite limited. While some would undoubtedly argue that preventing the expansion of retail clinics is a favorable application of the doctrine, a case can also be made that convenient care clinics could fill an important gap in access to health care.

The CPM doctrine has hindered innovation in ways to potentially control health care costs. Until the HMO movement of the early 1970s, including the federal *HMO Act of 1973* and related state legislation such as California's AB 949 in 1971, HMO advocates pointed to the CPM doctrine as an important legal barrier to HMO development.<sup>150</sup> Although the *HMO Act* and related state legislation made possible prepayment for managed care plans, other settings in which physicians might be employed are still subject to the CPM bar in some states, including California.

The CPM doctrine may also obstruct some efforts to provide access to care for specific populations. For example, in 1982 the California Attorney General deemed unlawful an arrangement in which a lay-controlled industrial medical corporation contracted with physicians on a fixed-fee basis to treat employees of another entity. The opinion cited divided loyalties (despite the physicians' independent contractor status) and the incongruity of a corporation's presence with the regulatory licensing scheme.<sup>151 152</sup>

## **PHYSICIAN EMPLOYMENT**

The CPM doctrine can also limit individual physicians' choices of how they may make their living. The FTC found that AMA's early guidelines concerning corporate practice "had the purpose and effect of restraining competition by group health plans, hospitals, and similar organizations, and restricting physicians from developing business structures of their own choice."<sup>153</sup> Although hospitals apparently work around the physician employment restrictions, it is possible that some physicians would appreciate and prefer

the security of employment.\* Indeed, national data reveal a trend of increasing physician employment, and observers suggest that the trend is being driven largely by physicians seeking more regular hours, relative security, and less responsibility for the business side of running a medical practice.<sup>154</sup>

One of the premises of the CPM doctrine is that a physician's employment status, in other words, who pays the doctor and how, can influence the practice of medicine. Paying physicians on a fee-for-service basis is said to be a cost driver, because it gives incentives for physicians to order expensive tests and perform procedures, and does not necessarily encourage the most appropriate care. For example, doctors are currently paid to check diabetic patients' eyes and feet, but not necessarily to ensure that they exercise. One alternative that has been suggested is to pay physicians fixed salaries, plus bonuses based on their patients' health outcomes.<sup>155</sup> Nationally, salary arrangements with bonuses (typically based on a group's total earnings) are now among the most common ways to compensate physicians<sup>156</sup> (though more restricted in California than in most states).

Finally, even when an activity or arrangement is not clearly prohibited by the CPM doctrine, the doctrine can still affect health care services. Recently, for example, the court-appointed special receiver for California's prison medical care system cited the CPM prohibition as a reason for withholding payment to a company that arranged for inmates to receive care outside the prisons.<sup>157</sup> One observer argues that CPM laws are "'legal landmines,' remnants of an old and nearly forgotten war..."<sup>158</sup>

## **HAS THE CPM DOCTRINE OUTLIVED ITS USEFULNESS?**

The CPM doctrine has succeeded in preventing arrangements such as hospital employment of physicians and company physicians. But some 70 years after its inception, the doctrine has eroded and is perhaps outdated, as the organization and delivery of health care have evolved. However, the main policy concerns on which the doctrine was based are still relevant, and California has enacted legislation to more directly address these concerns, perhaps lessening the need to rely on the CPM doctrine.

### ***The CPM Doctrine and Evolving Health Care Organization***

Employers, through whom more than half of the U.S. population obtains health coverage, have shifted towards managed care in order to reduce health care costs.<sup>159</sup> Corporate managed care organizations now dominate the health care environment, and even physicians who are not employed by them are likely to contract to provide services for them.<sup>160</sup> Health care service providers have also integrated both vertically and horizontally, and increasingly contract with management service organizations, which perform administrative and oversight functions to increase the efficiency of practices.<sup>161</sup> These changes have effectively circumvented the CPM doctrine.

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\* Some physicians expressed appreciation for the benefits of employment. (Kevin Schunke, SB 376 Program Administrator for the Medical Board of California, telephone communication, March 6, 2007.)

### *Inconsistencies in the CPM Doctrine*

California's CPM doctrine has been defined largely through lawsuits and Attorney General opinions over decades, and then riddled by HMO and other legislation, its power and meaning are now inconsistent.

The employment status of physicians in California is affected inconsistently by the application of the CPM doctrine. Although some non-profit clinics may employ physicians, California applies the CPM doctrine to most other entities. Non-profit associations may employ physicians under specific circumstances<sup>162</sup> and non-profit corporations may employ physicians in clinics meeting specific requirements.<sup>163 164</sup> Teaching hospitals may employ physicians, but other hospitals, including most public and non-profit hospitals, may not employ physicians.<sup>165 166</sup>

Professional medical corporations are expressly permitted to engage in the practice of medicine, and may employ physicians. These medical corporations may operate on a for-profit basis, although the profit motive was one of the original rationales of the CPM prohibition.

### *California Law Addresses the Concerns of the CPM Doctrine Directly*

Statutory exceptions and permission for profit-seeking organizations such as HMOs and medical corporations to employ physicians may signal society's acceptance of the risks associated with a profit motive (commercial exploitation, lower professional standards), and physician employment (divided loyalty, lay control). The acceptance of these risks diminishes the force of the CPM doctrine as public policy. However, if these risks are allowed in order to achieve efficiencies of managed care, mechanisms to ensure that quality is not sacrificed for profits may be needed.<sup>167</sup>

States have responded to these risks by initiating more direct control mechanisms to address lay control, profit-motivated behavior, and divided loyalty in medical care. For instance, in response to problems with early HMO-enabling legislation, California enacted new regulations. The *Knox-Keene Health Care Service Plan Act of 1975* prohibits contracts between health plans and physicians or physician groups that contain any type of incentive plan which encourages the denial, limitation, or delay of specific medically necessary treatments.<sup>168 169</sup> Other pertinent provisions of the *Knox-Keene Act* include:

- Capitated payment agreements or shared-risk arrangements must not be tied to specific medical decisions.<sup>170</sup>
- Health plans must furnish medical services in a manner providing continuity of care.<sup>171</sup>
- Health plans must provide ready referral to other providers when good professional practice requires it.<sup>172</sup>
- All services must be readily available, and to the extent feasible, readily accessible, to all enrollees.<sup>173</sup>

- Health plans must assure that medical decisions are made by qualified medical providers, without influence of fiscal or administrative management.<sup>174 175</sup>

In addition, the California Code of Regulations requires that health care service plans separate medical services from administrative and financial management so that medical decisions are not “unduly influenced by fiscal and administrative management.”<sup>176</sup>

California also enacted legislation concerning hospital control over physicians. The *Medical Staff Self Governance Act* (SB 1325, Chapter 699, Statutes of 2004) establishes the independent status of hospitals’ medical staffs and their basic rights and responsibilities, including:

- Creating and amending medical staff bylaws (subject to approval by the hospital governing body, which cannot unreasonably withhold its approval);
- Establishing and enforcing criteria for medical staff membership and privileges;
- Establishing and enforcing quality of care and utilization review standards, and overseeing other medical staff activities, such as medical records review and meetings of the medical staff and its committees;
- Selecting and removing medical staff officers;
- Collecting and spending medical staff dues;
- Retaining and representation by legal counsel (at the expense of the medical staff).<sup>177 178</sup>

Proponents believed the legislation was necessary to prevent some hospital administrators and governing bodies from interfering with medical matters.<sup>179</sup> The CMA sponsored the *Medical Staff Self Governance Act*, and the AMA Board of Trustees recommended using it as a basis for model legislation to address circumstances in which hospitals might be seen as threatening independent medical decision-making.<sup>180</sup>

The *Medical Staff Self Governance Act* is remarkable for its legislative findings, which declare that medical care depends on the “...mutual accountability, interdependence, and responsibility of the medical staff and the hospital governing board...” The findings further state that “...the governing board must act to protect the quality of medical care provided and the competency of the medical staff...” and, “[t]he final authority of the hospital governing board may be exercised for the responsible governance of the hospital...,” but only “...with a reasonable and good faith belief that the medical staff has failed to fulfill a substantive duty or responsibility...” The bill also recognizes the “independent rights of the medical staff.”<sup>181</sup> Thus, in enacting this law, the legislature recognizes *both* the medical staff’s autonomy, and the responsibility of the hospital governing board and administration.<sup>182</sup>

#### *States That Allow Physician Employment Have Similar Requirements*

The importance of physician autonomy appears to be uniformly recognized in the U.S. However, some states have recently decided that physicians can be employed without

infringing this autonomy. Mississippi and Alabama revoked CPM prohibitions and explicitly allow corporations to employ physicians to practice medicine. They also implemented policies stating that physicians may enter into business arrangements provided certain prerequisites are met, such as that the “method and manner of patient treatment and the means by which patients are treated are left to the sole and absolute discretion of the licensed physician.”<sup>183</sup> In Alabama, the Commission on Medical Licensure ruled that a business employing licensed physicians to practice medicine did not violate any law against the unlicensed practice of medicine because physicians were specifically required to make decisions concerning medical services.<sup>184 185 186</sup> New York acknowledges the right of hospitals to employ physicians, and New Mexico and Louisiana also clearly allow employment of physicians.<sup>187</sup> Other states might also allow employment of physicians without the existence of statutes or court or other official decisions.

## POLICY OPTIONS

Courts in California and other states, while deciding on the legality of specific cases, have questioned the consistency of the CPM doctrine with health care as it has evolved, but have deferred to legislatures to make this determination. For example, in *People ex Rel. State Board of Medical Examiners v. Pacific Health Corporation*, the Supreme Court of California left open the possibility of abandoning the ban, should public opinion change, and stated that such a change should come from the state legislature.<sup>188</sup> The exceptions carved out of the CPM doctrine for HMOs, professional corporations, teaching hospitals, non-profit community clinics, and narcotic treatment programs seem to signal a change in public opinion. On the other hand, the legislature has clearly and repeatedly stated its intent that physicians, and not corporations, be responsible for patient care decisions.<sup>189 190 191 192</sup> Accordingly, observers argue that Congress<sup>193</sup> or state legislatures should clarify the doctrine’s scope to reflect current health care practices.<sup>194 195</sup> If the legislature decides to address the CPM doctrine, the following are options to consider:

- Determine and enumerate the types of entities that may (or may not) lawfully employ physicians.
- Decide whether hospitals (besides those already exempt from the CPM bar) should be allowed to employ physicians, on the condition that physicians remain in control of medical decisions.
- Decide whether convenient care clinics, or retail clinics, should be encouraged to expand in California, in which case the legislature could allow corporations other than professional medical corporations to operate these clinics and employ physicians. The legislature could also delineate the convenient care clinics’ scope and conditions of practice.
- Abandon the CPM doctrine and delineate lawful physician employment. The legislature has already enumerated some characteristics of acceptable and unacceptable physician employment practices for HMOs and in other statutes that allow physician employment or address physicians’ relationships with hospitals. These could be expanded and extended to physician employment in general.



## **APPENDIX: CALIFORNIA STATUTES RELATED TO THE CORPORATE PRACTICE OF MEDICINE DOCTRINE**

This appendix includes summaries of statutes that are relevant to the corporate practice of medicine (CPM) doctrine. Although some statutes have broad implications, this appendix is limited to the statutes' application to the CPM doctrine and discussion in the report. This appendix is not intended to be an exhaustive compendium of CPM-related statutes.

### **BUSINESS AND PROFESSIONS CODE**

*Medical Practice Act*, Statutes of 1980, Chapter 1313, Section 2. Business and Professions Code, Chapter 5, Section 2000 et seq. (Former Business and Professions Code, Section 2000, Statutes of 1937, Chapter 414)

§ 2001 establishes the Medical Board of California.

§ 2001.1 charges the Medical Board with responsibility for protecting the public through its licensing, regulatory, and disciplinary functions concerning the practice of medicine.

§ 2052(a) defines the practice of medicine and declares that practicing medicine without a valid license is unlawful:

Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, or operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars (\$10,000), by imprisonment in the state prison, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.

§ 2052(b) declares that anyone who conspires with, aids, or abets another to practice medicine without a license is subject to the same punishment.

§ 2056 provides protection against retaliation for physicians who “advocate for medically appropriate health care.” (AB 1676, Statutes of 1993, Chapter 947)

§ 2056.1 ensures that health care service plans and contracting entities do not prevent physicians and surgeons from freely communicating with and advocating for their patients. (AB 3013, Statutes of 1996, Chapter 1089)

§ 2400 concerns corporations and the employment of licensees (physicians), and is interpreted as prohibiting corporations from practicing medicine by employing licensees:

Corporations and other artificial entities shall have no professional rights, privileges, or powers. However, the Division of Licensing [of the Medical Board of California] may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic.

§ 2401 of the *Medical Practice Act* allows for additional specific exemptions from the prohibition on physician employment as long as they do not interfere with clinical decisions:

§ 2401(a) allows approved nonprofit university medical schools to charge for professional services of faculty physicians in clinics operated for medical education, if the charges are approved by the physicians.

§ 2401(b) exempts “small, freestanding, nonprofit research institutes” specified under Health and Safety Code § 1206(p) to employ physicians and charge for their services, for the purpose of “transferring new health technology to the public.” (Statutes of 1997, Chapter 673)

§ 2401(c) allows specified narcotic treatment programs to employ physicians and charge for their services.

§ 2401(d) allows qualifying district hospitals to employ physicians, as described below under § 2401.1.

§ 2401.1 (SB 376, Statutes of 2003, Chapter 411) was a small pilot project to allow direct employment of physicians by qualified district hospitals with the following characteristics:

- located in a county with a population of less than 750,000
- provides a percentage of care to Medicare, Medi-Cal, and uninsured patients that exceeds 50 percent of patient days
- had net losses from operations in fiscal year 2000-01.

The participating hospitals were permitted to employ no more than two physicians at any one time, and had to enter contract before December 31, 2006, for four years or less. The statute is repealed January 1, 2011.

§ 2411 authorizes health care service plans that are licensed under the *Knox-Keene Health Care Service Plan Act of 1975* (Health and Safety Code, Division 2, Chapter 2.2, Section 1340), described below.

§ 2415 allows licensed physicians and podiatrists as individuals, groups, partnerships, or professional corporations, to obtain fictitious name permits. This is the only type of permit we could find for a chain of convenient care clinics that has sites in California. (Gary Qualset, Chief, Division of Licensing, Medical Board of California. Telephone Communication, May 24, 2007.)

§ 2416 defines conditions under which physicians and surgeons and podiatrists may practice in partnerships or groups.

§ 2418 defines locum tenens agencies as agencies that contract with clients to identify physicians to work for the clients on a temporary, independent contract basis. § 2418 also confirms that locum tenens agencies are prohibited from employing or determining pay for physicians, and that payments to the agencies are not to be related to the quantity or value of services provided by the physicians.

## **HEALTH AND SAFETY CODE**

In addition to the aforementioned exceptions defined in Business and Professions Code Section 2401, the California Attorney General found that community clinics, defined in Health and Safety Code Section 1204(a) (described below), may lawfully employ physicians if the clinics meet certain conditions. The clinics must serve a defined population (such as low-income) but not the general public. (Office of the Attorney General of the State of California. *Opinion No. CV 74-305*, May 20, 1975.)

§ 1204(a)(1) (A) and (B) define primary care clinics that are eligible for licensure: Community clinics and free clinics are operated by tax-exempt non-profit corporations that are supported by charity. Community clinics charge the patient based on the patient's ability to pay, using a sliding fee scale, qualify as tax-exempt under Internal Revenue Code Section 501(c)(3), and cannot be operated by a natural person(s). Free clinics are the same, except that they may not charge patients at all.

§ 1204(a)(2) affirms that primary care clinics described in § 1204(a)(1) may be reimbursed by third-party payors and enter into managed care contracts.

*Knox-Keene Health Care Service Plan Act of 1975*, Statutes of 1975, Chapter 941, Section 2. Health and Safety Code, Section 1340 et seq.

§ 1342 states the legislature's intent and purpose to promote the delivery of health and medical care to Californians who enroll in a health care service plan or specialized health care service plan by accomplishing the following:

§ 1342(a) Ensuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional.

§ 1342(g) Ensuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care.

§ 1348.6(a) prohibits contracts between a health plan and physician or physician's group that contain any type of incentive plan which encourages the denial, limitation or delay of specific medically necessary treatments.

§ 1348.6(b) clarifies that incentive plans involving general payments, such as capitated payment agreements, wherein doctors are paid a fixed budget for all patients they treat, are allowed as long as the payment agreements do not pertain to physicians making specific medical decisions.

§ 1367(d) requires health plans to provide medical services with continuity of care and ready referral to other providers when required by good professional practice.

§ 1367(g) requires health plans to assure that medical decisions are made by qualified medical providers, without influence of fiscal or administrative management.

§ 1367.01(c) requires plans' medical director to be a licensed physician who ensures that the process by which the plan reviews and approves, modifies, or denies requests by providers complies with the requirements of this section.

§ 1367.01(e) prohibits anyone other than a "licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues" from denying or modifying the requests for authorization of health care services for medical necessity.

Useful guides to the *Knox-Keene Health Care Service Plan Act of 1975* include:

[http://www.calpatientguide.org/appendix\\_e.html](http://www.calpatientguide.org/appendix_e.html)

<http://www.healthconsumer.org/cs016knoxkeene.pdf>

In addition, the California Code of Regulations § 1300.67.3 defines standards for health care service plan organizations, including paragraph (a)(1), which provides that plans must separate medical services from administrative and financial management so that the medical decisions will not be "unduly influenced by fiscal and administrative management."

## **CORPORATIONS CODE**

*Moscone-Knox Professional Corporation Act*, Statutes of 1968, Chapter 1375.

Corporations Code, Sections 13400-13410. Although this law concerns professional corporations generally, the following sections are described as they pertain specifically to professional medical corporations, which may lawfully employ physicians.

§ 13401(b) defines a professional corporation as a corporation that is organized under the General Corporation Law and is "engaged in rendering professional services in a single profession..." Medical corporations are not required to get a certificate of registration if their services are rendered by professionals licensed by the Medical Board of California.

§ 13401.5 enumerates the types of licensed non-physician professionals who may serve as shareholders, officers, directors, or professional employees of medical corporations:

podiatrists, psychologists, registered nurses, optometrists, marriage and family therapists, clinical social workers, physician assistants, chiropractors, acupuncturists, and naturopathic doctors. These licensed non-physicians as a group must not exceed the number of licensed physicians and their shares must not exceed 49 percent of the total number of shares.

§ 13405 allows medical corporations to provide medical services only through employees who are licensed. The corporation may employ unlicensed persons, but such persons shall not render any professional services.

§ 13406 restricts ownership of shares of capital stock in a professional corporation to licensed persons or to a person who is licensed to render the same professional services in the jurisdiction in which the person practices. Shareholders may not vest others who are not shareholders with voting rights.



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