

AT DEATH'S DOOR—IDAHO'S CORPORATE PRACTICE OF MEDICINE DOCTRINE

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I. INTRODUCTION

The corporate practice of medicine doctrine, generally stated, is the principle that medicine should only be practiced by licensed individuals and corporations should be prohibited from employing or otherwise contracting with licensed individuals to practice medicine on their behalf.¹ The doctrine is rooted in early state medical practice acts adopted in the late nineteenth century, which by their language only permitted natural persons to be licensed to practice medicine.² The rationale behind the doctrine is that only human beings can be licensed to practice medicine and, therefore, corporations, themselves, cannot practice medicine.

The American Medical Association (AMA), a group comprised of physicians for the purpose of advocating on their behalf, was the driving force behind the early state licensing statutes. In promoting the doctrine, the AMA sought to legitimize the medical profession, establish

1. The term "corporations" in this article either refers to corporations, specifically, or broadly refers to corporations, partnerships, and limited liability companies, where applicable.

2. Nicole Huberfeld, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX 243, 249–50 (2004).

physicians as the sole source for professional health care services, and otherwise control the health care market.³ In the twentieth century, the doctrine was further fueled by state judicial decisions and attorney general opinions, heavily influenced by the AMA's lobbying efforts, which interpreted state medical practice acts as prohibiting the practice of medicine by corporations, and invoked public policy concerns regarding corporate influence over a physician's professional medical judgment and corporate interference with the physician-patient relationship.

But the tides have turned against the corporate practice of medicine doctrine. Many states, although not always expressly rejecting the corporate practice of medicine doctrine, have adopted, or otherwise chosen not to enforce the doctrine against, the bevy of health care forms that necessarily involve corporations. The simple fact today is that corporations do practice medicine. The physician is the personification of the modern corporate health care system. And public policy concerns over the corporate influence on health care are addressed by the regulation and enforcement of licensed individuals, employment and independent contractor agreements that preserve the physician's independent medical judgment over health care decisions, and tort laws that hold corporations liable for the medical malpractice of their employees or independent contractors.

Idaho has never expressly adopted or rejected the corporate practice of medicine doctrine. The Idaho State Board of Medicine (Board) has historically taken the position that there is sufficient implied authority for the existence of the doctrine in Idaho.⁴ In making its case, the Board cites to the Idaho Medical Practice Act and accompanying regulations and the reasoning *Worlton v. Davis*,⁵ a decision by the Idaho Supreme Court. A thorough examination of the authority arguing for or against the doctrine's existence in Idaho reveals there are plenty of reasons to question the Board's position. There is no express language in the Idaho Medical Practice Act or its accompanying regulations prohibiting the corporate practice of medicine. Rather, the Idaho legislature has enacted legislation endorsing health care forms that involve corporate entities employing or contracting with licensed individuals to practice medicine on their behalf.⁶ Further, the Board has seemingly not enforced the doctrine against various health care forms involving corporations effectively practicing medicine through arrangements with licensed individuals. Moreover, public policy concerns expressed by the Board and the court in *Worlton* have been eradicated by regulation, contract, and tort law.

3. *See id.*

4. *See* Memorandum from Jean Uranga to the Idaho State Bd. of Med. Regarding Corporate Practice of Med. 11 (Feb. 26, 2007) (on file with author) [hereinafter Memorandum to Idaho State Board of Medicine].

5. 73 Idaho 217, 249 P.2d 810 (1952).

6. *See* IDAHO CODE ANN. §§ 54-1801 to -1841 (2010).

As echoed by national commentators, the corporate practice of medicine doctrine is an anachronism in today's health care environment.⁷

Health care professionals and corporations doing business in Idaho need to be able to rely on the existence or non-existence of the corporate practice of medicine doctrine in Idaho, as opposed to its selective enforcement. This article encourages the Idaho legislature to amend the Idaho Medical Practice Act to expressly authorize corporations to employ or contract with licensed individuals to provide medical services and, therefore, eliminate any doubt as to whether the corporate practice of medicine doctrine exists in Idaho. Parts II, III and IV of this article provide a thorough overview of the history of the doctrine, focusing on its anti-competitive origins, as later revealed by the Federal Trade Commission (FTC),⁸ and following the erosion of its existence in the modern health care landscape. Part V analyzes the Board's grounds for asserting that there is sufficient implied authority for the existence of the doctrine in Idaho and the flaws in the Board's reasoning. Parts VI and VII argue that any implied authority in favor of the doctrine's existence is defeated by the multiple statutory enactments endorsing corporate forms of health care and the measures taken to immunize professional medical judgment from corporate influence. Finally, Part VIII proposes a statutory amendment to the Idaho Medical Practice Act to provide certainty that the doctrine does not exist in Idaho by expressly allowing corporations to employ or contract with licensed individuals to provide medical services on their behalf.

II. THE HISTORY OF THE CORPORATE PRACTICE OF MEDICINE DOCTRINE

A. The Establishment of Medicine as a Profession and the Creation of the AMA

In order to understand the origins of the corporate practice of medicine doctrine, one must assume the perspective of physicians struggling to define the professional practice of medicine during the late nineteenth century.⁹ Well-educated and well-trained physicians seeking to establish their abilities to provide professional, effective, and quality medical care were locked in competition with lesser-educated and lesser-trained physicians, quacks, faith healers, and other so-called "irregulars"¹⁰ promising miracle and speedy cures to the desperate and the

7. See generally Huberfeld, *supra* note 2; Adam M. Freiman, Comment, *The Abandonment of the Antiquated Corporate Practice of Medicine Doctrine: Injecting a Dose of Efficiency into the Modern Health Care Environment*, 47 EMORY L.J. 697 (1998); Jeffrey F. Chase-Lubitz, Note, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445 (1987).

8. See generally *In re Am. Med. Ass'n*, 94 F.T.C. 701 (1979).

9. Chase-Lubitz, *supra* note 7, at 448.

10. The term "irregulars" encompasses those whose "practice is based on an exclusive dogma to the rejection of the accumulated experience of the profession, and of the aids

sick.¹¹ Thus, the practice of medicine during this time was tainted by a blurred line between science and salesmanship, and a confused public often chose false promises over actual deliverables.¹² Physicians and patients alike were frustrated by the inability to discern between effective and ineffective medical care.¹³

Competition within the medical profession was also devastating to physicians' livelihood. Physicians during this time were far from the esteemed, well-to-do, class of professionals they are today.¹⁴ The choice of medicine was a distant third behind the practice of law and the clergy.¹⁵ Those who did choose to practice medicine found the profession to be far from lucrative, with most earning an income somewhere between the working-class and the middle-class family incomes of the time.¹⁶

In response to economic threats, physicians fought to implement policies designed to guild the medical profession and control competition within the industry.¹⁷ In 1847, a group of physicians led by Nathan Smith Davis banded together to establish a national organization known as the AMA.¹⁸ The AMA's initial goals reflected physicians' struggle to advance their livelihood, improve the preeminence of the medical pro-

actually furnished by anatomy, physiology, pathology, and organic chemistry." CARLETON B. CHAPMAN, PHYSICIANS, LAW, AND ETHICS 109 (1984) (quoting PROCEEDINGS OF THE NATIONAL MEDICAL CONVENTIONS HELD IN NEW YORK, MAY 1846, AND IN PHILADELPHIA, MAY 1847, at 100 (1847)). For more information on the historical efforts of physicians to establish the medical profession, see DONALD E. KONOLD, A HISTORY OF AMERICAN MEDICAL ETHICS 1847–1912 (1962); Chase-Lubitz, *supra* note 7, at 448–55; and Freiman, *supra* note 7, at 699–700.

11. Chase-Lubitz, *supra* note 7, at 448–49.

12. KONOLD, *supra* note 10, at 19.

13. *Id.*

14. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 82–83 (1982) (citing 1851 Report of the Committee of the American Medical Association).

15. *Id.* at 82. An 1851 study polled approximately 12,500 men who had graduated from eight of the nation's largest colleges between 1800 and 1850. Of those polled, roughly two-thirds entered either the practice of law or the clergy and less than eight percent became physicians. *Id.*

16. *Id.* at 84. An 1850 Massachusetts public health report showed that the average physician had annual billings of \$800 and an annual income of \$600. *Id.* In comparison, it is estimated that around the same time a working-class family's annual income ranged from \$200 to \$800; a middle-class family's annual income ranged from \$800 to \$5,000; and a wealthy family's annual income ranged from \$5,000 to \$10,000. *Id.*

17. Huberfeld, *supra* note 2, at 243, 245–46.

18. CHAPMAN, *supra* note 10, at 105–06. A year after he was elected to serve in the New York Medical Society, Davis introduced a proposal for the establishment of a national medical association to "elevate the standard of medical education in the United States." *Our Founder, Nathan Smith Davis*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/about-ama/our-history/the-founding-of-ama/our-founder-nathan-smith-davis.shtml> (last visited Apr. 19, 2011). Though his ideas were considered "impractical, if not utopian" to some of his contemporaries, Davis' efforts culminated in the establishment of the AMA in 1847. *Id.* For more on the history of the AMA, see AM. MED. ASS'N, <http://www.ama-assn.org> (last visited Apr. 19, 2011).

fession, and protect themselves from market competition.¹⁹ To accomplish these goals, the AMA, led by its House of Delegates (the legislative body) and the Judicial Council (the judicial body),²⁰ immediately set out to (i) reform medical education, (ii) establish uniform ethical standards, and (iii) implement mandatory licensing requirements. These mandatory licensing requirements are the origins of the corporate practice of medicine doctrine.

B. Educational Reform

In the late nineteenth century, medical colleges were not accredited and were not held to any standardized, national curricula requirements.²¹ Instead, medical education was dominated by so-called “diploma mills” that produced future physicians as a for-profit, commercial enterprise.²² Soon after its establishment, the AMA exerted pressure on medical colleges to increase their admission requirements and strengthen their curricula.²³ The AMA also sought to standardize the duration of medical study to no less than four years.²⁴ The larger medical colleges (either independent, for-profit institutions or schools within already-established state universities), implemented these educational reforms, in cooperation with the AMA’s efforts,²⁵ and in return increased the

19. For example, in an 1846 resolution calling for the establishment of the AMA, it was demanded that a national association of physicians be created “for the protection of [physicians’] interests, for the maintenance of their honour and respectability, for the advancement of their knowledge, and the extension of their usefulness.” CHAPMAN, *supra* note 10, at 105 (quoting PROCEEDINGS OF THE NATIONAL MEDICAL CONVENTIONS HELD IN NEW YORK, MAY 1846, AND IN PHILADELPHIA, MAY 1847, at 17 (1847)).

20. Freiman, *supra* note 7, at 711 n.83. In essence, the House of Delegates legislates the AMA’s official policies and the Judicial Council has the power to interpret such legislation. *Id.* (citing *Am. Med. Ass’n v. Fed. Trade Comm’n*, 638 F.2d 443, 449 (2d. Cir. 1980)).

21. Huberfeld, *supra* note 2, at 249–50.

22. *Id.* For example, in 1894, at least 21 “diploma mills” were actively selling medical degrees, one of which is said to have “matriculated” 60,000 students over a 40-year period. JOHN HALLER, *AMERICAN MEDICINE IN TRANSITION, 1840-1910*, at 224 (1981).

23. Freiman, *supra* note 7, at 700–01. The AMA established the Council on Medical Education in 1904, which was tasked with developing standardized education and training requirements, including at least four years of high school education, four years of medical education and training, and passage of a licensing test. STARR, *supra* note 14, at 117–18. The council also developed a national grading system for medical colleges, which in turn put economical and reputational pressures on those medical colleges with lower standards and weaker curricula. *Id.* at 118. For more information on the history of the AMA’s early efforts to reform medical education, see JOHN BURROW, *ORGANIZED MEDICINE IN THE PROGRESSIVE ERA* 33–37 (1977).

24. See BURROW, *supra* note 23, at 34–35; STARR, *supra* note 14, at 117–18. See generally Chase-Lubitz, *supra* note 7, at 450–54, nn.39–45.

25. See *infra* note 48 (regarding the collaboration between the AMA, larger medical colleges, and state licensing boards to marginalize the competition posed by smaller medical colleges and their graduates). In 1910, the AMA asked an independent group to evaluate medical colleges in an effort to drive the lesser medical colleges out of business. STARR, *supra* note 14, at 118–20. Not surprisingly, the report criticized the poor medical education provided by these lesser medical colleges and recommended eliminating them. *Id.* at 120.

costs of medical education, training and tuition and marginalized the smaller medical colleges and so-called “diploma mills.”²⁶ While these educational reforms undoubtedly succeeded in improving the quality of the medical education and training received by physicians,²⁷ the overall effect of the AMA’s efforts was to reduce competition among both medical colleges²⁸ and practicing physicians.²⁹

Specifically, out of 161 schools evaluated, 82 were deemed acceptable; 47 were deemed imperfect, but redeemable; and 32 were deemed unsatisfactory. HALLER, *supra* note 22, at 225. It is believed that this report is responsible in part for the closing of 29 schools by 1910. *See id.*

26. *See* Huberfeld, *supra* note 2, at 249–50; *see also* Freiman, *supra* note 7, at 700–01. As Freiman explains, “The costs of attending medical school rose as tuition increased due to mandated higher standards, reducing the number of medical students and driving many for-profit schools out of the medical education business.” Freiman, *supra* note 7, at 701.

27. *See* Freiman, *supra* note 7, at 701; *see also* STARR, *supra* note 14, at 120–21. Burrow offers anecdotal evidence of the quality of medical education during the AMA’s early reform efforts:

At the Tulane University School of Medicine, George Dock testified to the virtual illiteracy of his third-year students whose assaults on orthography included ‘inflamed,’ ‘bowwalls,’ ‘simptom,’ ‘tetnas,’ ‘puss,’ and ‘irruption.’ Lincoln Cothran, as a member of the California State Board of Medical Examiners, found graduates in their ‘untutored earnestness’ offering such approximations as ‘tung,’ ‘bludvescles,’ ‘dyafram,’ ‘uren,’ and ‘rectum.’ Henry Beates, Jr., President of the Medical Council of Pennsylvania, declared that of the papers he graded on licensing examinations some 30 to 40 percent represented appalling examples of illiteracy. George M. Gould, a prominent medical editor, complained that three-fourths of the four-thousand annual graduates of medical institutions could not practice medicine intelligently. Laying much of the blame for degraded standards on commercial medical colleges, Charles H. Wallace, while president of the Missouri Medical Association observed, “These student hunters entice the barber from his chair, the mechanic from his bench, and the huckster from his wagon, all with imperfect education, and push them by roseate pictures into the field of medicine. What can such conditions bring forth [he asked] but imperfectly-feathered fledglings who flutter along the marshes and never rise to the dignified heights of the real physician.

BURROW, *supra* note 23, at 31.

28. *See supra* note 25 (regarding the AMA’s contracted-for 1910 report on the state of medical colleges and its responsibility for closing several schools).

29. *See* STARR, *supra* note 14, at 118–26. Starr explains that as a result of the AMA’s educational reform efforts, the academic year went from an average of six months to no less than eight years of post-high school education. *See id.* at 118. Additionally, the AMA’s education reforms resulted in a dramatic decrease of the number of physicians entering the medical profession and competing for a share of the marketplace, presumably as the AMA intended. In 1900, there were 173 physicians for every 100,000 people. *Id.* at 126. In 1920, the ratio was reduced to 137 physicians for every 100,000 people. *Id.* In 1930, the ratio again was reduced to 125 physicians for every 100,000 people, where it remained until the 1960s. *Id.* “Under the emerging system, young doctors could scarcely hope to be making a living on their own before age thirty.” *Id.* at 118.

C. Ethical Standards

The AMA also sought early on to establish national ethical standards for the medical profession, and thereby elevate the public's perception of physicians and reduce the competition posed by "irregulars" within the industry.³⁰ Immediately after its inception in 1847, the AMA established a Code of Ethics (later renamed the Principles of Medical Ethics).³¹ The AMA Principles of Medical Ethics of 1847 provided as follows:

It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with *reasonable competition among the physicians* of a community. To do this is detrimental to the public and to the individual physician, and lowers the *dignity of the profession*.³²

This quoted passage, as well as the introductory statement to the AMA Principles of Medical Ethics of 1847,³³ evidence the AMA's primary focus, even in its establishment of national ethical standards, on improving the preeminence of the medical profession and reducing competition among physicians.

The AMA Principles of Medical Ethics of 1847 also proscribed various forms of commercialistic enterprises, including holding patents on medicines and instruments, promoting secret remedies, and advertising to enhance one's own medical practice, and restricted any consultation or professional relationship between "regulars" and "irregulars."³⁴ These prohibitions helped the AMA realize its goal of reducing the threat on physicians' livelihood posed by "irregulars" and their chief characteristic—the commercial exploitation of the medical profession.³⁵

30. Huberfeld, *supra* note 2, at 246. The introductory statement to the AMA Principles of Medical Ethics of 1847 explained that the law is "silent and, of course, inoperative in the cases of both fraud and poisoning so extensively carried on by the host of quacks who infest the land." CHAPMAN, *supra* note 10, at 106. The introductory statement was unequivocal in describing the AMA's purposes for its national ethical standards, describing the AMA's member physicians as the "trustees of science and almoners of benevolence and charity" and urging physicians to "use increasing vigilance to prevent the introduction into their body of those who have not been prepared by a suitably preparatory moral and intellectual training." *Id.* at 107.

31. See Freiman, *supra* note 7, at 709 n.79.

32. AMA, PRINCIPLES OF MEDICAL ETHICS, ch. 2, art. 6, sec. 2, *reprinted in* 5 J. IND. ST. MED. ASS'N 407, 409 (1912) (emphasis added).

33. See CHAPMAN, *supra* note 10, at 106.

34. Chase-Lubitz, *supra* note 7, at 448–50, nn.14 & 32; see also *supra* note 10 (discussing the dichotomy between "regulars" and "irregulars" within the nineteenth century's version of the practice of medicine).

35. Huberfeld, *supra* note 2, at 246. As one commentator explains, "[t]he [AMA Principles of Medical Ethics of 1847] served the AMA's need for a document that would demonstrate to the public the moral purposes of the profession, grant the AMA leadership control over its membership, and help establish a health care monopoly for regular practitioners." Chase-Lubitz, *supra* note 7, at 450.

1. Licensing Requirements

Yet, for many physicians, the AMA's efforts through educational reform and the establishment of national ethical standards were agonizingly slow to realize the AMA's goals.³⁶ Frustrated by the AMA's lack of progress, a group of member physicians within the AMA turned to state legal options and collaborated to lobby the individual states to (i) create state licensing boards, (ii) promulgate minimum licensing requirements, and (iii) enact corresponding state licensing legislation.³⁷ In theory, under the authority of state legal and regulatory controls, the AMA could better accomplish its goals for its member physicians.

The various states were receptive to the physicians' lobbying and soon enacted "medical practice acts,"³⁸ which at their common core,³⁹ (i) created a state medical board vested with regulatory powers over the medical profession, (ii) delineated the minimal qualifications for a license, and (iii) proscribed the practice of medicine without a license.⁴⁰ State licensing boards were given the power to review physician-candidates' diplomas, establish and review strict license examination requirements, and reject candidates deemed unfit to practice medicine.⁴¹ The state licensing boards also implemented mandatory licensing requirements⁴² (generally enacted as part of state medical practice acts),⁴³ which, at a minimum, required physicians seeking to lawfully practice medicine in a given state to (i) attend four years of high school, (ii) attend four years of medical education and training, and (iii) pass a licensing examination.⁴⁴ By the early nineteenth century, most states had enacted some version of a medical practice act and implemented some form

36. See GEORGE ROSEN, *THE STRUCTURE OF AMERICAN MEDICAL PRACTICE 1875-1941* 24-25 (1983).

37. Chase-Lubitz, *supra* note 7, at 451. State licensing legislation, together with other forms of legal control of the practice of medicine, was often enacted under the umbrella term "state medical practice act." See *infra* note 38 (describing the use of the term "state medical practice act"). The United States Supreme Court approved the legitimacy of state medical licensing requirements in 1889. *Dent v. West Virginia*, 129 U.S. 114 (1889). Per the Court's unanimous opinion, states have the power to regulate entry in the practice of medicine so long as such regulation is not applied arbitrarily and its purpose is the protection of public welfare. *Id.* at 122-24.

38. The term "state medical practice act(s)" or "medical practice act(s)" is used herein to connote the various statutory and regulatory schemes enacted by the states to codify the lawful practice of medicine by licensed individuals.

39. Each state varied on the scope of their respective state medical practice acts. However, generally speaking, the state medical practice acts evolved around the common concept of creating a rulemaking authority responsible for regulating the medical profession, delineating licensing qualifications, and prohibiting the unlicensed practice of medicine.

40. Huberfeld, *supra* note 2, at 249-50.

41. See Freiman, *supra* note 7, at 700-01; Huberfeld, *supra* note 2, at 249.

42. See generally STARR, *supra* note 14, at 117; Freiman, *supra* note 7, at 700-01; Huberfeld, *supra* note 2, at 249.

43. See *supra* note 38 (regarding state medical practice acts).

44. See STARR, *supra* note 14, at 117.

of mandatory licensing requirements.⁴⁵ For example, as enacted in 1887, the statutory origin of Idaho's Medical Practice Act provided that no "person" could practice medicine in the territory of Idaho without a medical education and diploma from a chartered medical school.⁴⁶ Shortly thereafter in 1899, the Idaho State Board of Medical Examiners was created by statute and vested with the power to administer licenses to practice medicine.⁴⁷

Its success in lobbying states to enact medical practice acts was viewed by the AMA as an encouraging sign, especially where such requirements resulted in the elimination of many potential physicians from the future practice of medicine, and thus a corresponding reduction in the competition within the medical profession.⁴⁸ In fact, it is likely that this early lobbying success was a catalyst for the AMA's continued focus of its resources during the early twentieth century on state lobbying efforts, especially in briefs submitted to state courts tasked with interpreting the scope of state medical practice acts, designed to increase control of competition within the medical profession, including the rising threat posed by corporations.⁴⁹

III. THE EMERGENCE OF THE CORPORATE PRACTICE OF MEDICINE AND THE AMA'S EFFORTS TO PROHIBIT IT

Whereas in the late nineteenth century and early twentieth century the AMA focused on improving the preeminence of the medical profession, improving physicians' livelihood, and limiting the competitive threat posed by "irregulars" and their commercialistic enterprises, in the twentieth century the AMA targeted a new economic threat to its

45. See Chase-Lubitz, *supra* note 7, at 451. "By 1905 all but three states required candidates not only to hold an acceptable diploma, but also to pass an independent state examination." *Id.* In fact, licensing legislation found its genesis much earlier. According to Konold, physicians were successful in causing the states to enact licensing statutes as early as the beginning of the nineteenth century; however, as physicians continued to struggle with sects of "irregulars" throughout the nineteenth century and the public's poor perception of the professionalism of the practice of medicine, those statutes were eventually abolished. See KONOLD, *supra* note 10, at 3-7; see also Chase-Lubitz, *supra* note 7, at 449-50. This resulted in the regeneration of state licensing legislative efforts at the beginning of the twentieth century. Chase-Lubitz, *supra* note 7, at 451.

46. Idaho Territory Rev. Stat. tit. VII, ch. XIII, § 1298 (1887).

47. Act of Mar. 3, 1899, § 1, 1899 Idaho Sess. Laws 345 (regulating the practice of medicine and surgery within the State of Idaho).

48. See CHAPMAN, *supra* note 10, at 113; Chase-Lubitz, *supra* note 7, at 452, nn.45-46 (citing KONOLD, *supra* note 10, at 30-31). For example, in 1877 Illinois passed a statute allowing a state board of medical examiners to withhold licenses to practice medicine from those graduating from disreputable medical colleges unless they also passed a state licensing examination, whereas those graduating from larger medical colleges received their licenses automatically. Chase-Lubitz, *supra* note 7, at 451 n.38 (citing STARR, *supra* note 14, at 104). That same year, approximately 3,600 nongraduate physicians were practicing medicine in the state. *Id.* Within ten years, 3,000 had been forced to stop practicing medicine. *Id.*

49. See Chase-Lubitz, *supra* note 7, at 452 (citing CHAPMAN, *supra* note 10, at 113; KONOLD, *supra* note 10, at 30-31).

member physicians and their control of the medical profession—the ever-increasing rate of corporate involvement in the practice of medicine.⁵⁰

In the post-industrialization period following the Civil War, the railroad, mining, and lumber industries, faced with increasing rates of employee workplace accidents, began to employ physicians to provide medical services to their employees.⁵¹ The passage of workers' compensation laws during this time further promoted corporate involvement in the practice of medicine, as businesses became concerned with liability and health insurance costs.⁵² Initially tolerant of the corporate practice of medicine,⁵³ as corporate presence in the medical profession increased and the market competition faced by physicians increased as a result, the AMA's membership became concerned and began to publicly complain that corporations were threatening physician autonomy and, consequently, physicians would lose their newly-won control of the medical profession.⁵⁴

A. Types of Corporate Involvement in the Practice of Medicine

In general, during the twentieth century corporate involvement in the practice of medicine took one of the following two forms: “contract practice” and “corporate practice.”⁵⁵ In the first form, the “contract practice,”⁵⁶ large corporations would hire physicians to provide full-time

50. See STARR, *supra* note 14, at 200–02.

51. *Id.* By 1900, railroad companies employed more than 6,000 surgeons. *Id.* at 201. Furthermore, it is estimated that by 1930, more than 530,000 railway employees, as well as their dependents, were covered by their employer's industrial health program. *Id.* at 202. It is also believed that the passage of workers' compensation laws at this time further promoted corporate involvement in the practice of medicine, as businesses became concerned with liability and health insurance costs. *Id.* at 200.

52. See *id.* at 200.

53. See Chase-Lubitz, *supra* note 7, at 455 n.66 (discussing an earlier, and allowed, form of corporate involvement in the practice of medicine, whereby the AMA allowed physicians to engage in corporate contract work without being disciplined for participating in such schemes).

54. Huberfeld, *supra* note 2, at 248–49; see also HALLER, *supra* note 22, at 245–47.

55. Additionally, many members of the AMA also resented the development of health department clinics, pay clinics, group practice, and health insurance. ROSEN, *supra* note 35, at 36. For simplistic purposes, the various forms of the practice of medicine involving unlicensed professionals and business entities is discussed herein initially under the terms “contract practice” and “corporate practice,” and later under the commonly-used rubric “the corporate practice of medicine.”

56. Alternatively, the AMA in its 1934 amendments to the AMA Principles of Medical Ethics broadly defines “contract practice” as “an agreement between a physician or a group of physicians . . . and a corporation, organization, political subdivision or individual, to furnish partial or full medical services . . . on the basis of a fee schedule or for a salary or a fixed rate per capita.” Joseph Laufer, *Ethical and Legal Restrictions on Contract and Corporate Practice of Medicine*, 6 L. & CONTEMP. PROBS. 516, 519 (1939) (quoting AMA 1934 AMENDMENTS TO THE AM. MED. ASS'N. PRINCIPLES OF MEDICAL ETHICS [hereinafter 1934 AMA AMENDMENTS]). For more information on the AMA's amendments of its ethical rules to address the corporate practice of medicine, see *infra* Part III.C.

medical care for their employees.⁵⁷ In exchange, physicians were compensated based upon either a predetermined salary or a monthly per-employee rate.⁵⁸ To cover the costs of medical services, an amount would be deducted from each worker's paycheck, similar to the cafeteria plan deductions that are commonplace today.⁵⁹ In the second form, which the authors would designate as "corporate practice,"⁶⁰ corporations would independently contract with physician organizations to market and provide medical services to the general public.⁶¹ In exchange, both entities would receive a portion of the medical services fees generated.⁶² Originally, these arrangements were dominated by the physicians themselves,⁶³ but eventually the terms were primarily dictated by laypersons.⁶⁴ In the most extreme cases, laypersons would even dictate the length of hospital stays and the schedule of fees-for-services.⁶⁵ In addressing the increase of corporate involvement in the practice of medicine, the AMA would later combine these two concepts under rubric "the corporate practice of medicine."⁶⁶

B. AMA's Concerns Against the Early Corporate Practice of Medicine

Understandably, after having successfully fought for control of the medical profession, the increasing involvement of corporations in the practice of medicine raised several additional concerns for the AMA and its member physicians. The AMA articulated a general ethical concern that corporations practicing medicine threatens physician autonomy.⁶⁷ For example, the AMA argued that the corporate practice of medicine would result in physician loss of control over (i) income, (ii) fee-for-service compensation structure, (iii) patient loads, (iv) methods of treatment and diagnosis, and (v) patient relationships.⁶⁸ Furthermore,

57. Freiman, *supra* note 7, at 701; Huberfeld, *supra* note 2, at 247.

58. *Id.*

59. See HALLER, *supra* note 22, at 246.

60. Alternatively, the AMA in its 1934 amendments to the AMA Principles of Medical Ethics broadly defined "corporate practice" as "Direct Profits to Lay Groups," or "any contractual arrangement by which a lay entity directly profits from the provision of medical services by physicians." See Laufer, *supra* note 56, at 519 (quoting 1934 AMA AMENDMENTS). For more information on the AMA's amendments of its ethical rules to address the corporate practice of medicine, see *infra* Part III.C.

61. Chase-Lubitz, *supra* note 7, at 456.

62. See Freiman, *supra* note 7, at 701; Huberfeld, *supra* note 2, at 249.

63. See Freiman, *supra* note 7, at 701.

64. *See id.*

65. *See id.*

66. See, e.g., *Proceedings of the Detroit Session*, 94 JAMA 2069, 2072 (1930).

67. Huberfeld, *supra* note 2, at 248-49.

68. *Id.* Nowhere was the AMA more passionate in arguing for a prohibition on the corporate practice of medicine than when it came to characterizing the importance of the physician-patient relationship. In interpreting the AMA's 1912 amendments to the AMA Principles of Medical Ethics, the AMA's judicial council harangued:

It was decided long ago that the practice of law by a corporation was against public policy and the same has been prohibited in many states. The relations be-

the AMA argued that the corporate practice of medicine would be harmful to the health of the general public, as it would (i) divide physician loyalty between corporate employers and patients, (ii) introduce non-professional control over medical decision-making, (iii) and sacrifice quality medical care for the sake of for-profit considerations.⁶⁹

However, the AMA's concerns regarding the corporate practice of medicine were not solely based on concerns for ethical safeguards and the safety of the general public. In fact, the AMA aggressively promoted a series of concerns that were based on a general fear of losing market control of the medical profession to larger, more powerful corporations.⁷⁰ For example, the AMA unabashedly admitted that its chief concerns were that the corporate practice of medicine meant (i) physicians were less able to control their income, (ii) increased competition among physicians, who were forced to bid against each other for contracts to provide medical services, and (iii) limiting the monopoly of the medical profession the organization had just created for its membership.⁷¹

C. The Development of AMA Ethical Standards to Address the Corporate Practice of Medicine

As early as 1890, the AMA publicly spoke out against the corporate practice of medicine by adopting an official statement that argued that corporate involvement in the practice of medicine had brought an excessive "spirit of trade" into the profession and urged physicians to resist further entrance of corporations into the medical profession.⁷²

Then, in 1912, the AMA amended its ethical standards for the first time to affirmatively address the corporate practice of medicine.⁷³ The AMA Principles of Medical Ethics of 1912 condemned as unprofessional conduct a physician entering into any contract which interfered with the

tween patient and physician are more intimate than are those between client and attorney. It is impossible for that intimacy of relationship to exist between and [sic] individual and a corporation, and if it is against public policy for a corporation to practice law, how much more so must it be for a corporation to practice medicine.

Id. at 246 n.7.

69. *Id.* at 251–52; *see also* Freiman, *supra* note 7, at 702.

70. With their history of fighting to reduce competition within the professional practice of medicine, it is not surprising that the AMA and its member physicians also viewed the corporate practice of medicine as threatening their newly-won control of the marketplace. *See* Huberfeld, *supra* note 2, at 248–49; *see also supra* Part II.A (discussing the AMA's efforts to reduce market competition within the medical profession as among medical colleges, licensed physicians, and so-called "irregulars").

71. Freiman, *supra* note 7, at 702.

72. *E.g.*, *In re Am. Med. Ass'n*, 94 F.T.C. 701, 898 (1979) (quoting an AMA Internal Report).

73. *See* Laufer, *supra* note 56, at 518 (citing AM. MED. ASS'N PRINCIPLES OF MEDICAL ETHICS, ch. II, art. V, § 2 (1912)).

provision of adequate medical care or with reasonable competition among physicians.⁷⁴

In 1934, the AMA undertook a much more substantive effort to revise its ethical standards to (i) identify the types of corporate practice of medicine, and (ii) identify the circumstances under which they should be prohibited.⁷⁵ The AMA Principles of Medical Ethics of 1934 defined the “contract practice” of medicine as any “agreement between a physician or a group of physicians . . . and a corporation, organization, political subdivision or individual, to furnish partial or full medical services . . . on the basis of a fee schedule or for a salary or a fixed rate per capita”;⁷⁶ and defined the corporate practice of medicine as any contractual arrangement by which a lay entity directly profits from the provision of medical services by physicians.⁷⁷

The AMA Principles of Medical Ethics of 1934 went on to prohibit both the contract practice and corporate practice of medicine, but in different manners. On one hand, any form of “corporate practice” was broadly prohibited as “beneath the dignity of professional practice . . . unfair competition with the profession at large . . . harmful alike to the profession of medicine and the welfare of the people [and] against sound public policy.”⁷⁸ This objective, bright-line prohibition of the corporate practice of medicine reflected the AMA’s primary concerns for buttressing the preeminence of the medical profession and solidifying physicians’ monopoly of the medical profession. On the other hand, a more pragmatic and practical approach was taken in prohibiting the “contract practice,” and instead, under the AMA Principles of Medical Ethics of 1934, each contractual arrangement was to be examined separately for the presence or absence of a series of ethical “red flags,” including whether (i) there is a direct or indirect solicitation of patients, (ii) “there is underbidding [by physicians] to secure the contract,” (iii) “the compensation is inadequate to assure good medical service,” (iv) “there is interference with reasonable competition in [the] community,” (v) the arrangement prevents physicians’ freedom to choose—“free choice of a position,” (vi) there are conditions of employment that “make it impossible to render adequate service to the patients,” or (vii) the arrangement is “contrary to sound public policy.”⁷⁹ This subjective, case-by-case basis is more reflective of a concern for monitoring the actual ethical standards upheld by physicians entering into contractual arrangements with corporations.

Thus, when it came to the “corporate practice,” the AMA directed a blanket prohibition designed to protect the economic interests of its member physicians; however, when it came to the “contract practice,”

74. *See id.*

75. *See generally id.*

76. *Id.* at 519 (quoting 1934 AMA AMENDMENTS).

77. Chase-Lubitz, *supra* note 7, at 461.

78. Laufer, *supra* note 56, at 519.

79. *Id.* at 519.

the AMA did focus on certain ethical concerns raised by corporate presence in the medical profession.

D. State-by-State Creation of the Corporate Practice of Medicine Doctrine

As experienced during the AMA's earlier efforts to lobby the states to enact state medical practice acts and implement mandatory licensing requirements, the AMA knew the most effective way to prohibit the corporate practice of medicine was to establish anti-corporate practice of medicine law at the state level. State judiciaries and attorney general offices, heavily influenced by the AMA's articulation of the public policy concerns with the corporate practice of medicine,⁸⁰ soon established corporate practice of medicine doctrines by expansively interpreting state medical practice acts as prohibiting the corporate practice of medicine.⁸¹

As a starting point for explaining the state-by-state development of the corporate practice of medicine doctrine, it is important to note that, for the most part,⁸² state medical practice acts do not expressly prohibit the corporate practice of medicine.⁸³ Instead, state medical practice acts generally provide two rules: (i) the qualifications for obtaining a license

80. The AMA's success at indoctrinating state courts with the AMA's articulation of the public policy arguments against the corporate practice of medicine, and the role of such indoctrination in establishing a prohibition of the corporate practice of medicine through judicial interpretation of state medical practice acts, cannot be overstated. See Huberfeld, *supra* note 2, at 251–52. The language used in the state court opinions supporting the prohibition of the corporate practice of medicine is strikingly similar to the language invoked by the AMA in their public criticisms of the corporate practice of medicine. See Alanson W. Willcox, *Hospitals and the Corporate Practice of Medicine*, 45 CORNELL L.Q. 432, 442–43 (1960); see also Chase-Lubitz, *supra* note 7, at 466–67. For example, the South Carolina Supreme Court reasoned that if the corporate practice of medicine were permitted, “professional standards would be practically destroyed, and professions requiring special training would be commercialized, to the public detriment.” *Ezell v. Ritholz*, 198 S.E. 419, 424 (S.C. 1938); see also *Bartron v. Codrington Cnty.*, 2 N.W.2d 337, 346 (S.D. 1942).

81. NAT'L HEALTH LAWYERS ASS'N & AM. ACAD. OF HEALTHCARE ATTORNEYS, PATIENT CARE AND PROFESSIONAL RESPONSIBILITY: IMPACT OF THE CORPORATE PRACTICE OF MEDICINE DOCTRINE AND RELATED LAWS AND REGULATIONS 6 (1997) [hereinafter NHLA/AAHA REPORT] (noting that state courts and attorneys generally rely on a mixture of licensing statutes, medical practice acts, and public policy to determine when and where the doctrine was violated); see also Huberfeld, *supra* note 2, at 248–49 (arguing that the AMA Principles of Medical Ethics of 1934 and the AMA's efforts to lobby state governments, all in an attempt to identify the corporate practice of medicine as an attack on the medical profession and a potential source of unethical medical care, heavily influenced state creation of prohibitions on the corporate practice of medicine).

82. At least the state medical practice acts of California, Colorado and Ohio include express statutory prohibitions on the corporate practice of medicine. See Huberfeld, *supra* note 2, at 250 n.29.

83. For example, Idaho's medical practice act contains no express statement praising, endorsing, limiting, cautioning against, casually mentioning, prohibiting, or otherwise mentioning the corporate practice of medicine. See generally IDAHO CODE ANN. §§ 54-1801 to -1841 (2010).

to practice medicine, and (ii) a prohibition of persons practicing medicine without a license.⁸⁴ From these two seemingly simple rules, state courts and offices of attorneys general artfully found support for a doctrine prohibiting the corporate practice of medicine. This was primarily accomplished by “interpreting the word ‘person’ as used in state medical practice acts to connote ‘human being,’ [and] thus finding a legislative intent to prohibit corporations from qualifying for [and receiving]” a license and thereby lawfully practicing medicine.⁸⁵ Essentially, because corporations are unable to satisfy the qualifications for receiving a license, including the implied qualification of being a human being, corporations could not receive a license and therefore could not lawfully practice medicine.⁸⁶ Courts theorized that corporations did not have the same characteristics of human beings regarding the ability to practice medicine, in that they could not attend medical school, obtain licenses, or treat patients, and, therefore, state legislatures must have intended to prevent corporations from obtaining a license to practice medicine.⁸⁷

However, there are two flaws in this reasoning. First, this reasoning ignores the historical evidence available that shows the AMA’s intent in causing states to implement mandatory licensing requirements was to outlaw the practice of medicine by “irregulars,” and not corporations.⁸⁸ Thus, the legislative intent behind the use of the term “persons” in state medical practice acts was to address the unlicensed practice of medicine by natural persons, and not corporations. Second, as at least one commentator has noted, where state medical practice acts expressly prohibit the practice of medicine by unlicensed “persons,” and where that term is interpreted to mean “human being,” then it would seem logical that the prohibition against “persons” practicing medicine without a license would also only apply to “human beings” and therefore state medical practice acts actually do not address the corporate practice of

84. Of course, each state’s medical practice act may include additional restrictions, but these are not uniform across the United States. For example, California’s state medical practice act also includes an affirmative statement that corporations shall have no professional rights to practice medicine. See CAL. BUS. & PROF. CODE § 2400 (West 2003). Another example is that many state medical practice acts prohibit the splitting of fees between licensed medical professionals and non-licensed persons or entities. See Charles D. Weller, “Free Choice” as a Restraint of Trade in American Health Care Delivery and Insurance, 69 IOWA L. REV. 1351, 1356 (1984) (quoting AMA, ORGANIZED PAYMENTS FOR MEDICAL SERVICES 142 (1939)). See NHLA/AAHA REPORT, *supra* note 81, at 5. In Idaho, the corporate practice of medicine is expressly prohibited in veterinary medicine, but not in human medicine. See *infra* Part V.A.

85. Freiman, *supra* note 7, at 704. For more information on other states’ judicial interpretation of their state medical practice acts as prohibiting the corporate practice of medicine, see *id.* at 704 & nn. 42–46. For more information on Idaho’s judicial interpretation of its state medical practice act as prohibiting the corporate practice of medicine, or rather the lack thereof, see *infra* Part V.B.

86. See Freiman, *supra* note 7, at 704; see also Huberfeld, *supra* note 2, at 249–50.

87. Huberfeld, *supra* note 2, at 251.

88. See *supra* Part II.A.

medicine at all.⁸⁹ Absent two distinct meanings of the term “person” within the state medical practice acts, it can be argued that corporations simply were not contemplated in the drafting of these medical practice acts.⁹⁰

State courts and offices of attorneys general also reasoned that because the acts of a corporation’s employees are attributed to the corporation, the employment by a corporation of a licensed physician to practice medicine nevertheless violated the prohibition.⁹¹ Essentially, corporations were prevented from circumventing state medical licensing restrictions by hiring or contracting with licensed physicians to provide medical services on their behalf.⁹² Furthermore, corporations were also prevented from circumventing the prohibition by including licensed physicians in the ownership or management of the corporation—in other words, a corporation was treated as a corporation for purposes of the corporate practice of medicine doctrine so long as at least one lay person or entity held an ownership or management interest in the employer of licensed physicians.⁹³

The AMA, having articulated their public policy concerns regarding the corporate practice of medicine to the states, and having convinced the states to expansively interpret their state medical practice acts, successfully indoctrinated a state-law based prohibition on the corporate practice of medicine during the twentieth century, commonly referred to as the “corporate practice of medicine doctrine.”

89. See Willcox, *supra* note 80, at 441; see also *State Electro-Med. Inst. v. State*, 103 N.W. 1078, 1079 (Neb. 1905) (Supreme Court of Nebraska holding that Nebraska’s medical licensure statutes do not apply to corporations, as a corporation is incapable of practicing medicine because an impersonal entity cannot diagnose or treat a disease).

90. See generally Willcox, *supra* note 80, at 441 (noting statutory word choice indicates that legislatures did not intend to permit corporations to practice law); see generally Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 512–13 (outlining argument of courts who have held that medical practice statutes prevent corporations from practicing medicine).

91. See Hall, *supra* note 90, at 512–13. For example, in 1936 the Illinois Supreme Court interpreted that state’s medical practice act as preventing a “for-profit corporation from providing medical services through [an affiliated] clinic” because such entities could not qualify to obtain a license to practice medicine and the medical practice act barred the unlicensed practice of medicine. NHLA/AAHA REPORT, *supra* note 81, at 5; *People v. United Med. Serv.*, 200 N.E. 157 (Ill. 1936). The court rejected United Medical Service’s argument that it was not practicing medicine but was only employing physicians to provide medical services on its behalf. *United Med. Serv.*, 200 N.E. at 162–64; see also *People v. Painless Parker Dentist*, 275 P. 928, 930–31 (Colo. 1929) (engaging in the same judicial interpretation as applied to California’s medical practice act).

92. See Huberfeld, *supra* note 2, at 250.

93. See generally *id.* at 244 (noting that one of the tenets of the corporate practice doctrine was that a non-licensed person or entity could not own an entity that provided medical services).

IV. THE CORPORATE PRACTICE OF MEDICINE DOCTRINE BECOMES UNLAWFUL, UNENFORCED, AND OBSOLETE

The fact that the principal purpose of the corporate practice of medicine doctrine is to restrain competition within the medical profession is demonstrated by the efforts of the Federal Trade Commission (FTC) to fight the AMA's implementation of the doctrine.

A. *FTC v. AMA*: The Corporate Practice of Medicine Doctrine as an Unreasonable Restraint on Trade

In 1975, the FTC filed an administrative complaint⁹⁴ charging the AMA and two Connecticut medical societies⁹⁵ with violations of Section 5 of the Federal Trade Commission Act (FTC Act).⁹⁶ The FTC complaint took issue with the Judicial Council's 1971 opinion that "[a] physician should not dispose of his professional attainments or services to any hospital, corporation, or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee"⁹⁷ and asserted that the AMA's Principles of Medical Ethics of 1934,⁹⁸ as interpreted by the 1971 opinion, illegally (i) restricted members' ability to advertise, (ii) restricted members' ability to solicit patients, (iii) restricted members' ability to engage in contractual relationships with non-physicians, (iv) restrained competition by "group health plans, hospitals, and similar organizations," and (v) restricted "physicians from developing business structures of their own choice."⁹⁹

In response, the AMA argued that its Judicial Council opinions were merely advisory and that the AMA had actually not taken any ac-

94. *In re Am. Med. Ass'n*, 94 F.T.C. 701, 701 (1979).

95. Although the FTC's action was based on the AMA's Principles of Medical Ethics of 1934, the FTC also included in its complaint the Connecticut medical societies because the AMA believed that state and local medical societies "follow the lead of [the] AMA and because the FTC believed that there was a conspiracy between [the] AMA and the state societies and local associations to restrict [the] competition among physicians through ethical limitations on advertising, solicitation, and contractual relationships." *Am. Med. Ass'n v. Fed. Trade Comm'n*, 638 F.2d 443, 447 (2d Cir. 1980).

96. In its 1975 version, Section 5 of the FTC Act provided as a general rule that "unfair methods of competition in commerce, and unfair or deceptive acts or practices in commerce, are declared unlawful." 15 U.S.C. § 45(a)(1) (1970), *amended by* Magnuson-Moss Warranty-Federal Trade Commission Improvement Act, Pub. L. No. 93-637, 88 Stat. 2183 (1975). The present day rule has been reworded to provide that "unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce, are hereby declared unlawful." 15 U.S.C. § 45(a)(1) (2006).

97. *In re Am. Med. Ass'n*, 94 F.T.C. at 896-97.

98. The actual underlying ethical standard which was interpreted by the AMA's Judicial Council and led to the FTC's action against the AMA provided that "[i]t is unprofessional for a physician to dispose of his services under conditions . . . which interfere with reasonable competition among physicians of a community. *Id.* at 1011 n.59.

99. *See Am. Med. Ass'n v. Fed. Trade Comm'n*, 638 F.2d. at 445-48.

that gave birth to the corporate practice of medicine doctrine.¹⁰⁶ However, the FTC's action against the AMA did not invalidate the state medical practice acts or the state case law and attorney general opinions interpreting the state medical practice acts as impliedly prohibiting the corporate practice of medicine.¹⁰⁷ Nevertheless, the foundation upon which the corporate practice of medicine doctrine was built, already shaky at best prior to *Am. Med. Ass'n v. Fed. Trade Comm'n*, was now completely in shambles. This has prompted at least one commentator to warn "[h]ealth care professionals must be quite careful in limiting medical staff and clinical physicians and other health care practitioners because of future antitrust suits."¹⁰⁸

B. The Aftermath of *Am. Med. Ass'n v. Fed. Trade Comm'n*

Despite the Second Circuit's affirmation in *Am. Med. Ass'n v. Fed. Trade Comm'n*, some states have nevertheless continued to enforce the corporate practice of medicine doctrine, albeit to varied effect and intensity, and with several exceptions. In a handful of states, the corporate practice of medicine doctrine continues to be enforced pursuant to either (i) express statutory prohibitions or case law and/or (ii) attorney general opinions interpreting state medical practice acts and finding legislative intent prohibiting the corporate practice of medicine.¹⁰⁹ In these states, the realities of the modern practice of medicine and the corresponding emergence of managed care have forced the legislatures, regulators, courts, and attorney generals to develop multiple exceptions and modifications to the corporate practice of medicine doctrine.¹¹⁰ For example, although the Colorado Legislature expressly reinstated the corporate practice of medicine doctrine in 2003,¹¹¹ Colorado still has statutory exceptions for hospitals and professional corporations owned by physicians to employ physicians.¹¹² Yet, these legal relationships do not expose hos-

106. See Chase-Lubitz, *supra* note 7, at 478 (noting that given the changes in the AMA's ethical standards, as required by the FTC, it is not surprising that some argue that the FTC order "weakens the foundation upon which the corporate practice of medicine doctrine was built"); see also Huberfeld, *supra* note 2, at 255-57.

107. See *supra* note 104 (regarding the precedential effect of the Supreme Court's affirmation of the FTC's cease and desist order against the AMA).

108. Arthur J. Marinelli, *The Role of Antitrust Laws in the Health Care Field*, 1984 DETROIT C. L. REV. 687, 701 (1984).

109. See Huberfeld, *supra* note 2, at 253-54.

110. See *id.* For example, exceptions are necessary to authorize the practice of medicine by hospitals, clinics, professional corporations, and managed care entities. See *infra* Part VI (discussing the plethora of exceptions to the corporate practice of medicine doctrine made necessary by the modern development of the medical profession).

111. 2003 Colo. Sess. Laws 1598. "[T]he purpose of enacting HB03-1012 is to state clearly and unequivocally the legislative intent of the general assembly to restore and reinstate the corporate practice of medicine doctrine in this state so that no individual or entity, other than a patient's physician, may be held liable or vicariously liable in any action for the physician's professional negligence or other tortious conduct." *Id.* § 1.

112. See COLO. REV. STAT. §§ 25-3-103.7(2), 12-36-134 (2005).

pitals and professional corporations to vicarious liability for the negligent acts of their medical professionals.¹¹³

Yet, other states are no longer enforcing the doctrine¹¹⁴ despite the fact that the language of the state medical practice acts and/or the case law supporting the presence of the corporate practice of medicine doctrine still remain. In these states, the state legislatures and regulators have determined that the corporate practice of medicine doctrine is dysfunctional, arcane, obsolete, or unlawful, and have therefore made the conscious decision to refrain from enforcing the doctrine's prohibitions, either partially or wholly, even though state medical practice acts remain and/or the existing case law in favor of the corporate practice of medicine doctrine has not necessarily been overturned.¹¹⁵ In other words, in these states "it became the established custom not to enforce it . . ."¹¹⁶ For example, a Statement of Position by the Louisiana Board of Medical Examiners dated September 24, 1992, concluded that "a physician's employment by a corporation other than a professional medical corporation is not *per se* unlawful under the Louisiana Medical Practice Act."¹¹⁷ According to the Louisiana Board of Medical Examiners, the focus of such inquiries should be on the amount of control the corporation is allowed to exercise over the physician.¹¹⁸

113. *Id.* § 25-3-103.7(3) ("Nothing in this section shall be construed to allow any hospital which employs a physician to limit or otherwise exercise control over the physician's independent professional judgment . . ."); *id.* § 12-36-134(1)(f) ("Nothing in this article shall be construed to cause a professional service corporation to be vicariously liable to a patient or third person for the professional negligence or other tortious conduct of a physician who is a shareholder or employee of a professional service corporation.")

114. A recent study indicates that approximately thirty-seven states have some form of statutory or common law corporate practice of medicine doctrine, or at least authority implying the same. Edward S. Kornreich, *Health Care M & A: Commercialization of the Medical Industry*, in HEALTH CARE M & A: COMMERCIALIZATION OF THE MEDICAL INDUSTRY 329, 375 (PLI Commercial Law & Practice, Course Handbook Ser. No. A-741, 1996). However, another study completed around the same time found that approximately thirty states lack specific corporate practice of medicine laws or regulations. NHLA/AAHA REPORT, *supra* note 81, at 5 (citing a 1996 survey conducted by the NHLA). In any event, enforcement of the corporate practice of medicine amongst the states is sporadic. See Freiman, *supra* note 7, at 713 n.97.

115. See Huberfeld, *supra* note 2, at 253–54.

116. Linda Punch, *Freestanding Center's Growth Raises Questions about Corporate Practice Law*, MODERN HEALTHCARE, May 15, 1984, at 32.

117. LA. STATE BD. OF MED. EXAM'RS, STATEMENT OF POSITION ON EMPLOYMENT OF PHYSICIAN BY CORPORATION OTHER THAN A PROFESSIONAL MEDICAL CORPORATION (Sept. 24, 1992); see also LA. REV. STAT. ANN. § 37:1271 (2006).

118. LA. STATE BD. OF MED. EXAM'RS, STATEMENT OF POSITION ON EMPLOYMENT OF PHYSICIAN BY CORPORATION OTHER THAN A PROFESSIONAL MEDICAL CORPORATION (Sept. 24, 1992). The position statement explains:

It is our opinion, that is, that a corporation may not necessarily be said, by the mere fact of employing a physician to practice medicine, and by the fact alone, to be itself practicing medicine. As contemplated by the Medical Practice Act, and as frequently reiterated herein, the essence of the practice of medicine is the exercise of independent medical judgment in the diagnosing, treating, curing or re-

Finally, in a third category of states, the corporate practice of medicine doctrine has been either partially or wholly eradicated by state legislatures, regulators, or courts.¹¹⁹ For example, the Tennessee Legislature amended the Tennessee Medical Practice Act to expressly allow for contract practice.¹²⁰ Tennessee Code Section 63-6-204, which defines the “practice of medicine” provides:

Nothing in this section shall be construed to prohibit a person, corporation, organization or other entity from employing a physician to treat only the entity's full-time, part-time and contract employees, the entity's retirees and dependents of the entity's employees or retirees; provided, however, that the employment relationship between the physician and the person, corporation, organization or other entity is evidenced by a written contract, job description or documentation, containing language which does not restrict the physician from exercising independent medical judgment in diagnosing and treating patients. Under this section, such person, corporation, organization or other entity shall not be deemed to be engaged in the practice of medicine.¹²¹

The South Dakota Legislature went a step further and passed a statute in 1993, allowing for both contract and corporate practice of medicine. South Dakota Codified Laws Section 36-4-8.1 states:

Except as provided in chapter 47-11 [medical corporations], it is the public policy of this state that a corporation may not practice medicine or osteopathy. A corporation is not engaged in the practice of medicine or osteopathy and is not in violation of § 36-4-8 by entering into an employment agreement with a physician licensed pursuant to this chapter if the agreement or the relationship it creates does not:

(1) In any manner, directly or indirectly, supplant, diminish or regulate the physician's independent judgment concerning the practice of medicine or the diagnosis and treatment of any patient;

lieving of any bodily or mental disease, condition, infirmity, deformity, defect, ailment, or injury in any human being If a corporate employer seeks to impose or substitute its judgment for that of the physician in any of these functions, or the employment is otherwise structured so as to undermine the essential incidents of the physician patient relationship, the Medical Practice Act will have been violated. But if a physician employment relationship is so established and maintained as to avoid such intrusions, it will not run afoul of the Medical Practice Act.

Id.

119. See Huberfeld, *supra* note 2, at 253–54.

120. TENN. CODE ANN. § 63-6-204(c) (2010).

121. *Id.*

A. The Idaho Medical Practice Act

The Idaho Medical Practice Act can be traced back to an 1887 statute that provided no “person” could practice medicine or surgery in the Idaho Territory without a medical education and a diploma from a chartered medical school.¹²⁷ Any person found to be practicing medicine or surgery without complying with the provisions of the Act was guilty of a misdemeanor.¹²⁸ Thus, in line with the AMA’s early efforts to enact state medical practice acts that would implement mandatory licensing requirements for individuals,¹²⁹ the initial Act focused on proscribing individuals from practicing unlicensed medicine rather than prohibiting corporations from practicing medicine.

A few years later in 1899, the Idaho legislature established the Idaho State Board of Medical Examiners (hereinafter the Board), which was charged with administering examinations and licenses to practice medicine for individuals.¹³⁰ Accordingly, the Act provided “[n]o applicant for license shall be allowed to practice medicine and surgery or either of them until such license shall have been granted.”¹³¹ Any person found to be practicing medicine or surgery without a license was guilty of a misdemeanor.¹³² The Act further provided that the Board may refuse a license for unprofessional or dishonorable conduct.¹³³ Yet none of these provisions implemented the corporate practice of medicine doctrine. In

127. Idaho Territory Rev. Stat. tit. VII, ch. XIII § 1298 (1887).

128. *Id.* § 1298c.

129. *See supra* Part II.A.

130. Act of Mar. 3, 1899, §§ 1, 6, 1899 Idaho Sess. Laws 345, 347 (regulating the practice of medicine and surgery within the State of Idaho).

131. *Id.* § 6, 1899 Idaho Sess. Laws at 347.

132. *Id.* § 10, 1899 Idaho Sess. Laws at 349.

133. *Id.* §§ 6–7, 1899 Idaho Sess. Laws at 347–48. Unprofessional or dishonorable conduct was defined as follows:

FIRST. The procuring or aiding or abetting in procuring a criminal abortion.

SECOND. The employment of what are popularly known as “cappers” or “steerers” in procuring practice.

THIRD. The obtaining of a fee on the assurance that a manifestly incurable disease can be permanent cured.

FOURTH. A willful betrayal of the professional secret to the detriment of a patient.

FIFTH. All advertisements of medical business in which untruthful and improbable statements are made.

SIXTH. All advertisements of any kind, of any medicine or means whereby the monthly periods of women can be regulated or the menses can be re-established if suppressed.

SEVENTH. Conviction of any offense involving moral turpitude.

EIGHTH. Habitual intemperance in the use of ardent spirits, narcotics, or stimulants.

Id. § 7, 1899 Idaho Sess. Laws at 348.

fact, the Act specifically excluded “railway surgeons in the discharge of official duties,” thus evidencing that in 1899 corporations were allowed to employ physicians in the state, and the Idaho legislature, at least tacitly, supported such a practice.¹³⁴

In 1948, the Idaho legislature amended the statute to provide, in part, grounds for revocation or suspension of a license, which included the following:

Practicing medicine and surgery, or any branch thereof, under a false or assumed name, or practicing or advertising as practicing medicine and surgery or any branch thereof, under the name of a company, association, corporation, trade name or business name, *unless* such name shall contain the names of all persons licensed to practice under this chapter and no other name or names. . . .¹³⁵ Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of a financial profit as personal compensation, or as a compensation charge, profit, or gain *for an employer* or for other person or persons, on the fraudulent representations that a manifestly incurable condition or sickness, disease or injury or any person can be permanently cured.¹³⁶

The 1948 version of the Act did not expressly prohibit corporations from employing physicians. Rather, the above quoted statutory language appears to have endorsed the corporate practice of medicine.¹³⁷

A year later in 1949, the Idaho legislature passed House Bill No. 34 to enact definitions of key terms used in the Act.¹³⁸ Although the Act proscribed the “practice of medicine or surgery” by a “person” without a license, the Act had not yet defined those terms.¹³⁹ The practice of medicine was broadly defined to include essentially any type of medical care, “whether or not such person receives therefor, either directly or indirectly, any fee, gift or compensation of any kind whatsoever or in any manner whatsoever”¹⁴⁰ And the term “person” was narrowly defined to mean “natural person.”¹⁴¹ Although the grounds for revocation or suspension of a license remained relatively the same, the reference to practicing medicine under the name of a company, association, corporation, trade name or business name in Subsection (3) was removed and short-

134. *Id.* § 16, 1899 Idaho Sess. Laws at 350.

135. IDAHO CODE ANN. § 54-1807(3) (1948) (emphasis added).

136. *Id.* § 54-1807(8) (1948) (emphasis added).

137. *See generally id.* Railroad surgeons were no longer excluded from the 1948 version of the Act.

138. Act of Feb. 3, 1949, ch. 23, 1949 Idaho Sess. Laws 27 (regulating the practice of medicine and surgery).

139. *Id.* § 2, 1949 Idaho Sess. Laws at 29.

140. *Id.*

141. *Id.*

ened as follows: “[p]racticing medicine and surgery under a false or assumed name.”¹⁴² This marks the Act’s first potential departure from the notion that licensed persons could practice medicine by or through a corporation.

In 1977, the Idaho legislature adopted the modern Idaho Medical Practice Act, codified at Idaho Code sections 54-1801 to 54-1841.¹⁴³ The Act currently prohibits the “practice of medicine” by an unlicensed “person.”¹⁴⁴ The term “practice of medicine” is tailored to include the following activities:

- (a) To investigate, diagnose, treat, correct, or prescribe for any human disease, ailment, injury, infirmity, deformity, or other condition, physical or mental, by any means or instrumentality;
- (b) To apply principles or techniques of medical science in the prevention of any of the conditions listed in paragraph (a) of this section; or
- (c) To offer, undertake, attempt to do or hold oneself out as able to do any of the acts described in paragraphs (a) and (b) of this subsection.¹⁴⁵

The term “person” remains narrowly defined as any “natural person.”¹⁴⁶

Under the Act, it is a felony for a “person” to practice medicine in the State without a license.¹⁴⁷ The Board is required to report all known incidents of “persons” violating the Act to the appropriate prosecuting attorneys.¹⁴⁸ Further, the Board may maintain an action to enjoin any “person” found in violation of the Act.¹⁴⁹

Thus, in its current form, the Idaho Medical Practice Act expressly prohibits the unlicensed practice of medicine by natural persons, but the question remains whether that prohibition also prohibits, by negative inference, licensed persons from practicing medicine by or through corporations, which cannot, by definition, qualify for a license to practice medicine. The Board answers this question in the affirmative, but that position, for the reasons discussed below, is a dubious one. When corporations hire or contract with licensed persons to practice medicine, or when licensed persons collaborate to practice medicine through corporate entities, it is still the licensed persons, and not the corporations, that are practicing medicine. No violation of the Act is found by the mere existence of a corporation in the fact pattern. The licensed persons,

142. *Id.* § 10(c), 1949 Idaho Sess. Laws at 36.

143. Idaho Medical Practice Act, ch. 199, 1977 Idaho Sess. Laws 536.

144. IDAHO CODE ANN. § 54-1804(2) (2010).

145. *Id.* § 54-1803(1).

146. *Id.* § 54-1803(9).

147. *Id.* § 54-1804(2).

148. *Id.* § 54-1804(5).

149. *Id.* § 54-1815.

whether as the owners or agents of corporations, remain responsible for practicing medicine in compliance with the Act and under the Board's regulation. The only issue that remains is the extent of corporate control over the licensed persons' medical judgment, and that issue is appropriately addressed by (i) regulation and supervision of the licensed persons, (ii) contractual provisions ensuring the independence of the licensed persons' medical judgment, and (iii) tort law that imputes the malpractice liability of licensed persons to the corporations.

If the Idaho legislature intended to prohibit corporations from hiring physicians through limiting the definition of "person" to individuals, it stands to reason that the legislature would have also provided the Board and prosecuting attorneys with jurisdiction over corporations found in violation of the Act, which it did not. The lack of any enforcement mechanism renders the doctrine, if it exists in Idaho, toothless.

In contrast, the Idaho Veterinary Practice Act, codified at Idaho Code sections 54-2101 to 54-2121, goes a step further and actually expressly includes the corporate practice of medicine doctrine.¹⁵⁰ Furthermore, the Veterinary Practice Act broadly defines the term "person" to include corporations.¹⁵¹ As such, the State Board of Veterinary Medicine and prosecuting attorneys have jurisdiction over corporations found to be in violation of the Veterinary Practice Act.¹⁵² Presumably, with no implied corporate practice of medicine doctrine in Idaho, the legislature had to expressly add the doctrine for it to exist with respect to the practice of veterinary medicine.¹⁵³

The Board also cites to various grounds for medical discipline in the Act as further implied authority for the doctrine. Specifically, the Board cites the following types of unethical conduct prohibited by licensed persons:

(3) Practicing medicine under a false or assumed name in this or any other state.

....

(5) Knowingly aiding or abetting any person to practice medicine who is not authorized to practice medicine. . .

150. *Id.* § 54-2113. But even then, exemptions to the doctrine were expressly made for partnerships, professional corporations and non-profit corporations. *Id.*

151. *Id.* § 54-2103(32) ("Person" means any individual, firm, partnership, association, joint venture, cooperative and corporation, or any other group or combination acting in concert; and whether or not acting as principal, trustee, fiduciary, receiver, or as any other kind of legal or personal representative, or as the successor in interest, assignee, agent, factor, servant, employee, director, officer, or any other representative of such person.").

152. *See, e.g., id.* §§ 54-2114(3), -2118.

153. *But see* *Isles Wellness, Inc. v. Progressive N. Ins. Co.*, 703 N.W.2d 513, 521 (Minn. 2005). The Minnesota Supreme Court rejected the clinic's argument that there was no corporate practice of medicine doctrine in Minnesota beyond the statutory prohibitions on the corporate practice of dentistry and veterinary medicine. *Id.*

....

(8) Division of fees or gifts or agreement to split or divide fees or gifts received for professional services with any person, institution or corporation in exchange for referral.

(9) Giving or receiving or aiding or abetting the giving or receiving of rebates, either directly or indirectly.¹⁵⁴

The Board cites to *Miller v. Haller*¹⁵⁵ as indirectly interpreting the fee splitting statute and providing implied authority for the doctrine.¹⁵⁶ In *Miller*, a surgeon, who had previously been a partner in a medical clinic, sued his former partners for breach of an alleged oral contract under which the physicians would continue to refer patients to the surgeon if the surgeon left the partnership.¹⁵⁷ The former partners asserted that the referral agreement was illegal and void against public policy.¹⁵⁸ In addressing Idaho Code section 54-1814(8), the Idaho Supreme Court acknowledged that contracts between health care professionals in which some form of consideration is given in exchange for referrals are void.¹⁵⁹ However, the court determined that the alleged oral contract at issue did not contemplate a “division or agreement to divide fees or gifts, nor [was] there a giving or receiving of any remuneration in exchange for referrals.”¹⁶⁰ Because the form of consideration contemplated by the alleged oral contract was not strictly proscribed by the statute, the court held that the oral contract was not void as a matter of law.¹⁶¹ Notably, *Miller* does not address the corporate practice of medicine.

Fee splitting arose as an issue in response to the early practice of surgeons paying family practice physicians for patient referrals.¹⁶² The AMA’s ethical prohibition against fee splitting in this context was the driving force behind state laws rendering fee splitting illegal.¹⁶³ However, the distinction between corporate practice of medicine and traditional fee splitting is critical—it is the difference between legitimate fee allocations versus improper financial inducements. Indeed, the federal government has recognized this distinction in the federal Anti-Kickback Statute¹⁶⁴ and provides a safe harbor for employment contracts that meet regulatory requirements.¹⁶⁵

154. IDAHO CODE ANN. § 54-1814 (2010).

155. 129 Idaho 345, 924 P.2d 607 (1996).

156. See, e.g., Memorandum to Idaho State Board of Medicine, *supra* note 4, at 11.

157. *Miller*, 129 Idaho at 348, 924 P.2d at 609.

158. *Id.* at 351, 924 P.2d at 613.

159. *Id.*

160. *Id.* at 352, 924 P.2d at 614.

161. *Id.*

162. Richard Jacobs & Elizabeth Goodman, *Splitting Fees or Splitting Hairs? Fee Splitting and Health Care—The Florida Experience*, 8 ANNALS HEALTH L. 239, 241 (1999) (citing MARC RODWIN, MEDICINE MONEY & MORALS 22 (1995)).

163. See *id.*

164. 42 U.S.C. § 1320a-7b(1) (West, Westlaw through 2011). The federal Anti-Kickback Statute (AKS) prohibits anyone from knowingly and willfully soliciting, offering,

The Board also looks to one of its own administrative rules, which sets forth an additional ground for medical discipline, as providing further implied authority for the doctrine. The Act vests the Board with the power to establish rules governing the practice of medicine in Idaho.¹⁶⁶ Specifically, the Board cites to Idaho Administrative Code Rule 28.01.01.101.03(c), which provides that it is a violation of the community standard of care for a physician to allow another person or organization to use his or her license to practice medicine.¹⁶⁷ As discussed above, when a corporation hires a physician to provide patient care, the corporation is not practicing medicine, as it is impossible for the artificial person to investigate, diagnose, treat, correct, or prescribe patient care. Rather, the physician employee remains the licensed person using his or her license to practice medicine. The corporation does not use a physician's license to practice medicine when it employs physicians. Further, the community standard of care is implicated in medical malpractice suits against health care providers and has no place in the corporate practice of medicine doctrine. The applicable community standard of care is

- (a) the standard of care for the class of health care provider to which the defendant belonged and was functioning, taking into account the defendant's training, experience, and fields of medical specialization, if any; (b) as such standard existed at the time of the defendant's alleged negligence; and (c) as such standard existed at the place of the defendant's alleged negligence.¹⁶⁸

The Board is hard pressed to argue that by a physician allowing himself to be employed by a corporation, the physician has negligently failed to meet the applicable standard of care for his community.

B. *Worlton v. Davis*

In addition to the statutory argument, the Board also argued that the Idaho Supreme Court's reasoning in *Worlton v. Davis*¹⁶⁹ indicates that the court has considered the merits of the corporate practice of medicine doctrine and ruled, for public policy reasons, that as a matter of common law, Idaho has adopted the doctrine. In *Worlton*, the court considered the validity of an employment contract between a partner-

receiving, or paying any form of remuneration to induce referrals for any items or services for which payment may be made by any federal health care program. *Id.*

165. *Id.* § 1320a-7b(b)(3)(B).

166. IDAHO CODE ANN. § 54-1806(2) (2010).

167. IDAHO ADMIN. CODE r. 22.01.01.101.03(c) (2011).

168. *McDaniel v. Inland Nw. Renal Care Group, L.L.C.*, 144 Idaho 219, 222, 159 P.3d 856, 859 (2007) (quoting *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 164, 45 P.3d 816, 820 (2002)); *see* IDAHO CODE ANN. § 6-1012 (2007).

169. 73 Idaho 217, 249 P.2d 810 (1952).

ship, composed of licensed physicians and an unlicensed business manager, and a licensed physician employee, under which the unlicensed business manager had control over the licensed physician employee.¹⁷⁰ The court held that the employment contract was void as contrary to public policy.¹⁷¹ In making its decision, the court stated as follows:

It is well established that no unlicensed person or entity may engage in the practice of the medical profession through licensed employees; nor may a licensed physician practice as an employee of an unlicensed person or entity. Such practices are contrary to public policy.¹⁷²

The public policy at issue in *Worlton* was the ability of unlicensed persons to control the independent medical judgment of licensed medical professionals. The court took umbrage with that relationship between licensed and unlicensed persons, and specifically with the following language from the clinic's physician employment contract:

Second party agrees that he will, during the term of his employment hereunder, *work under the supervision and direction of first parties and obey first parties' orders and instructions* and that he will practice his said profession according to the best of his skill and knowledge, and not engage in any other business or practice for his own personal gain and benefit unless the consent of first parties be first obtained in writing.¹⁷³

The court concluded that given the power granted to the unlicensed business manager to control the practice of medicine by the licensed physician employees, the employment contract was void as a matter of public policy.¹⁷⁴

It is important to note that the court never undertook a statutory interpretation of the Idaho Medical Practice Act, and therefore never determined whether the Act itself contained an express or implied prohibition on the corporate practice of medicine. In fact, nowhere in the court's six page opinion is the "corporate practice of medicine doctrine" mentioned.¹⁷⁵ Instead, the court invalidates the employment contract as violating a public policy against unlicensed persons controlling the independent medical judgment of licensed persons.¹⁷⁶ In citing the court's opinion as authority for the doctrine, the Board goes too far.

170. *Id.* at 219, 249 P.2d at 811.

171. *Id.* at 221, 249 P.2d at 813.

172. *Id.* at 221, 249 P.2d at 813.

173. *Id.* at 222, 249 P.2d at 813 (emphasis added).

174. *Id.* at 221–23, 249 P.2d at 813–14.

175. *See id.*

176. *Id.* at 221, 249 P.2d at 813.

In support of its reasoning, the court cites to state court decisions in California, Colorado, Iowa, and Washington.¹⁷⁷ These cases, and *Worlton* itself, were all decided during a time when the AMA was spearheading efforts to convince state courts and attorney generals that, as a matter of public policy, unlicensed persons cannot own a business that provides medical services or employ licensed physicians because such an arrangement negatively impacts the physician's ability to exercise his independent medical judgment.¹⁷⁸ Yet since that time, the FTC has successfully stripped the AMA of its ability to make such public policy arguments for the reason that such arguments are in reality a tool used by the AMA to unlawfully restrain trade within the medical profession.

As a matter of public policy, the medical judgment of licensed persons should be protected from improper corporate influence. But that protection may be addressed by regulation and supervision of the conduct of the licensed persons. Contractual provisions which do not adequately protect the independence of licensed persons to practice medicine may be invalidated on a case-by-case basis. The public policy concern is not a sufficient basis for a doctrine that, as a bright-line rule, prohibits corporations from having any presence in the practice of medicine.

Moreover, the court's concern in *Worlton* is anachronistic. In the years following *Worlton*, advances in the medical profession and legal constructs have narrowed the control concerns articulated by the court in *Worlton*. For example, the modern practice of medicine is dominated by large organizations, such as hospitals and health maintenance organizations (HMOs), which have the legal ability to employ and contract with physicians to provide medical services, notwithstanding their potential control by unlicensed persons.¹⁷⁹ In these arrangements, the protection of physicians' independent medical judgment is handled through

177. *Id.* (citing *Painless Parker v. Bd. of Dental Exam'rs of State of Cal.*, 14 P.2d 67 (Cal. 1932); *Pac. Emp'rs Ins. Co. v. Carpenter*, 52 P.2d 992 (Cal. Ct. App. 1935); *People v. Painless Parker Dentist*, 275 P. 928 (Colo. 1929); *Bebber v. Fisher*, 102 P.2d 741 (Colo. 1940); *State v. Bailey Dental Co.*, 234 N.W. 260 (Iowa 1931); *State v. Boren*, 219 P.2d 566 (Wash. 1950)).

178. *See generally* Huberfeld, *supra* note 2, at 243 (explaining that the AMA created the corporate practice as an ethical constraint and that it was later codified through state law and adopted by the courts).

179. *See id.*

contractual provisions,¹⁸⁰ ethical oversight,¹⁸¹ and medical malpractice tort law,¹⁸² rather than an outright prohibition on corporate formats.¹⁸³

Worlton has been largely ignored since its issuance. In fact, *City of McCall v. Buxton*¹⁸⁴ is one of the few Idaho cases that cites *Worlton*. In *City of McCall*, the Idaho Supreme Court reiterated that the employment contract in *Worlton* was void against public policy because it enabled a layperson to practice medicine without a license;¹⁸⁵ however, the Court made no reference to the corporate practice of medicine doctrine. Accordingly, in the fifty-eight years that have passed since the Court's holding in *Worlton*, the case has never been cited by any court as establishing the doctrine in Idaho.

VI. MODERN STATUTORY EXAMPLES OF THE CORPORATE PRACTICE OF MEDICINE IN IDAHO

As discussed above, the Board has historically taken the position that Idaho has adopted the corporate practice of medicine based on implied authority in the Idaho Medical Practice Act and the Board's administrative rules. The above analysis demonstrates that the Board's position is dubious for several reasons. The following section discusses several modern statutory examples that further undermine the Board's position.

Idaho law currently allows corporations to be involved in the practice of medicine through various structures. The Board argues that if the Idaho legislature intended to allow the corporate practice of medicine doctrine, it would have expressly provided so in the exceptions to

180. Employment and other physician services contracts generally contain terms that expressly prohibit the employer from interfering with the physician's independent exercise of medical judgment.

181. See, e.g., AM. MED. ASS'N, CODE OF MEDICAL ETHICS, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.shtml> (last visited Apr. 19, 2011).

182. Huberfeld, *supra* note 2, at 272 ("Tort law has been evolving in a manner that also suggests increased integration of the delivery of health care and that ties physician services to the corporate control of hospitals and other entities."); see, e.g., IDAHO CODE ANN. § 6-1012 (2010) (establishing that medical malpractice suits can be instituted against providers of health care, including hospitals or nursing homes, or any person vicariously liable for the negligence of any provider of health care); see also *Jones v. Healthsouth Treasure Valley Hosp.*, 147 Idaho 109, 116, 206 P.3d 473, 480 (2009) (recent Idaho Supreme Court decision expanding hospital vicarious liability under the doctrine of apparent authority to the negligence of independent personnel assigned by the hospital to perform support services). For more information on *Jones*, see Thomas Mortell, *Liability of Health Care Providers in Idaho—Apparent Authority and Negligent Credentialing*, *ADVOC.*, Oct. 2010, at 37, 37.

183. "Only mythological demons can long be exorcised with hocus pocus." Grace Giesel, *Corporations Practicing Law Through Lawyers: Why the Unauthorized Practice of Law Doctrine Should Not Apply*, 65 MO. L. REV. 151, 205 (2000) (quoting H.H. Walker Lewis for the proposition that the Model Rules protect more directly against the evils feared if corporations can practice law via attorneys than does the "hocus pocus" of the corporate practice of law doctrine).

184. 146 Idaho 656, 201 P.3d 629 (2009).

185. *Id.* at 666, 201 P.3d at 639.

sionals to render professional services.¹⁹⁰ Accordingly, both the Professional Corporation Act and the LLC Act expressly contemplate that professional services, including the provision of medical services, may be rendered by licensed professionals, such as physicians, who are employed by or independently contract with the professional entity. Further, the express provisions of the Acts effectively nullify any contrary provision in the Idaho Medical Practice Act. Both Acts similarly provide that its provisions shall not be considered as repealing, modifying or restricting the applicable provisions of law regulating the several professions unless such laws conflict with the provisions of the Act.¹⁹¹ Because all stockholders or members of a professional entity are licensed, and because the professional entity provides professional services through only its licensed officers, agents, and employees, the professional entity is licensed for all intents and purposes.

B. County and Private Hospitals

Idaho statutes and administrative rules permit county and private hospitals to employ physicians. Idaho Code Section 31-3521 provides that “county commissioners may employ a physician to attend, when necessary, the patients of the county hospital, provided however, that the county commissioners may enter into contracts with groups of licensed physicians for medical attendance upon patients of the county hospital or other persons receiving medical attendance at county expense.”¹⁹² In addition, Idaho Code Section 39-1301 and Idaho Administrative Rule 16.03.14.16(a) define “hospital” as a facility primarily engaged in the provision of defined medical services¹⁹³ “by or under the

190. The Professional Corporation Act sets forth that a professional corporation will render professional services to the public through its officers, employees, and agents who are duly licensed to render such professional services. IDAHO CODE ANN. § 30-1305 (2010). Similarly, in almost identical language, the LLC Act expressly provides that professional limited liability companies will render professional services to the public through their managers, members, employees, and agents, with the professionals being personally liable for their actions. IDAHO CODE ANN. § 53-615(2), (3) (2009), *repealed by* Idaho Uniform Limited Liability Company Act, IDAHO CODE ANN. §§ 30-6-101 to -1104 (2010).

191. IDAHO CODE ANN. § 30-1313 (2010) (professional corporations); IDAHO CODE ANN. § 53-615(7) (2009) (professional LLCs), *repealed by* Idaho Uniform Limited Liability Company Act, IDAHO CODE ANN. §§ 30-6-101 to -1104 (2010).

192. *Id.* § 31-3521.

193. IDAHO CODE § 39-1301 and IDAHO ADMIN. CODE r. 16.03.14.16(a) set forth that a “hospital” is primarily engaged in providing the following services, under the daily supervision of physicians:

Concentrated medical and nursing care on a twenty-four (24) hour basis to inpatients experiencing acute illness; or . . . [d]iagnostic and therapeutic services for medical diagnosis and treatment, psychiatric diagnosis and treatment, and care of injured, disabled, or sick persons; or . . . [r]ehabilitation services for injured, disabled, or sick persons; or . . . [o]bstetrical care.

IDAHO ADMIN. CODE r. 16.03.14.16(a)(i)-(iv) (2009).

their district health departments provide basic health care services, including, without limitation, public health education, physical health, environmental health and public health administration.²⁰⁵ Idaho Code Section 39-409 provides that each district “shall have a doctor of medicine licensed in Idaho as a staff member or as a regular consultant.”²⁰⁶ Idaho Code Section 39-413 further provides that the district board of health for each public health district has the authority to prescribe the positions and qualifications for all personnel and fix the rate of pay for its employees.²⁰⁷ Although public health districts are not licensed health care providers, the Board has approved of public health districts providing medical services by hiring licensed physicians.²⁰⁸

E. County Jails and Private Prison Facilities

The Idaho Legislature has also carved out statutory exceptions for county jails and private prison facilities. Idaho Code Section 20-619 provides that county jails may charge nonindigent inmates a nominal fee for “the purpose of seeing the jail provided doctor or nurse for a medical complaint.”²⁰⁹ In addition, Idaho Code Sections 20-805 and -807 provide that private prison facilities must provide medical services to prisoners and may employ a licensed physician to render the same.²¹⁰ Neither county jails nor private prison facilities are licensed health care providers.

F. Skilled Nursing Facilities and Independent Care Facilities

Skilled Nursing Facilities (SNFs) and Independent Care Facilities (ICFs) may also employ physicians. A SNF is:

[A] facility whose design and function shall provide area, space and equipment to meet the health needs of two (2) or more individuals who, at a minimum, require inpatient care and services for twenty-four (24) or more consecutive hours for unstable chronic health problems requiring daily professional nursing supervision and licensed nursing care on a twenty-four (24) hour basis, restorative, rehabilitative care, and assistance in meeting daily living needs.²¹¹

For SNFs, “medical supervision is necessary on a regular, but not daily, basis.”²¹²

ICF Nursing Homes are defined as:

205. *Id.* § 39-409.

206. *Id.*

207. *Id.* § 39-413.

208. Memorandum to Idaho State Board of Medicine, *supra* note 4, at 7.

209. IDAHO CODE ANN. § 20-619(1) (2010).

210. *See id.* §§ 20-805(3)(d); 20-807(2)(e).

211. *Id.* § 39-1301(b) (2010); IDAHO ADMIN. CODE r. 16.03.02.002.33 (2009).

212. IDAHO ADMIN. CODE r. 16.03.02.002.33.

[A] facility that is (a) [d]esigned to provide area, space and equipment to meet the restorative, rehabilitative, recreational, intermittent health needs, and daily living needs of two (2) or more individuals who require in-residence care and services for twenty-four (24) or more consecutive hours”²¹³

ICF Nursing Homes are “[d]esigned to provide for regular but less than daily medical and skilled nursing care.”²¹⁴

An ICF for people with intellectual disabilities (ICF/ID) is a “nursing home facility, designed and operated to meet the unique educational, training, habilitative and medical needs of the developmentally disabled through the provision of active treatment.”²¹⁵

SNFs, ICF Nursing Homes, and ICFs/ID all provide medical services by definition and, therefore, must hire or independently contract with physicians to provide patient care. The Board has approved SNFs and ICFs employing physicians since they are both licensed health care providers.²¹⁶

G. Home Health Agencies

Home health agencies, which are business entities that provide skilled nursing services by licensed nurses and at least one other health care service to individuals in the individual’s place of residence,²¹⁷ are also permitted to employ physicians. “Health care services” include medical/social services.²¹⁸ The Board has determined that home health agencies may hire physicians to provide medical care because they are licensed.²¹⁹

H. Non-Hospital, Medically-Monitored Detox/Mental Health Diversion Units

The Idaho Department of Health and Welfare has proscribed administrative rules governing the minimum standards for non-hospital, medically-monitored detox/mental health diversion units (detox/mental health diversion units).²²⁰ Detox/mental health diversion units provide “evaluation; observation; monitoring; care; and treatment; twenty-four (24) hours per day, seven (7) days per week, to individuals suffering

213. IDAHO ADMIN. CODE r. 16.03.02.02.16(a) (1988).

214. *Id.* r. 16.03.02.02.16(b) (1988).

215. IDAHO CODE ANN. § 39-1301(c) (2010); *see also* IDAHO ADMIN. CODE r. 16.03.11.004.18. (2009).

216. Memorandum to Idaho State Board of Medicine, *supra* note 4, at 6; IDAHO CODE ANN. § 39-1303 (2010).

217. IDAHO CODE ANN. § 39-2402(5) (2010).

218. *Id.* § 39-2402(4).

219. Memorandum to Idaho State Board of Medicine, *supra* note 4, at 6; *see* IDAHO CODE ANN. § 39-2403 (2010).

220. IDAHO ADMIN. CODE r. 16.07.50.001 (2009).

from a subacute psychiatric or alcohol/drug crisis.”²²¹ Detox/mental health diversion unit services are provided “in a residential setting under the supervision of a physician.”²²² Accordingly, these facilities may employ physicians.²²³ Detox/mental health diversion units operate under a certificate of approval issued by the Idaho Department of Health and Welfare.²²⁴

I. The Idaho Conrad J-1 Visa Waiver Program

In 2004, the Legislature enacted the Idaho Conrad J-1 Visa Waiver Program (Program).²²⁵ Under the Program, rural and underserved communities in Idaho are able to “apply for the placement of a foreign trained physician after demonstrating that they are unable to recruit an American physician and all other recruitment . . . possibilities have proven to be inaccessible.”²²⁶ The Program “authorizes the Idaho department of health and welfare to recommend up to thirty (30) foreign trained physicians per federal fiscal year to locate in communities that are federally designated as having a health workforce shortage.”²²⁷ The Program provides that “health care facilit[ies],” meaning “entit[ies] with an active Idaho taxpayer identification number doing business or proposing to do business in the practice location where the physician would be employed, whose stated purposes include the delivery of primary medical or mental health care,”²²⁸ can apply for J-1 Visa Waiver physicians.²²⁹ In order to apply, a health care facility need not be in existence at that time.²³⁰ The Program mandates that applicants must enter into an employment agreement with the physician.²³¹

Notably, the Idaho Legislature chose to define “health care facility” very broadly, to presumably encompass unlicensed business entities providing medical care through licensed physicians practicing medicine. Tennessee, on the other hand, chose to define “health care facilities” for its J-1 Visa Waiver Program more narrowly as including only those “hospitals, primary care clinics, community health clinics, local health departments, or private physician offices which routinely accept TennCare and indigent patients.”²³² Washington also limited its definition of “health care facilities” to “entit[ies] with . . . active Washington

221. *Id.* r. 16.07.50.001.02.

222. *Id.*

223. *See id.* r. 16.07.50.272.03 (“Each medical director of a detox/mental health diversion unit must be a licensed physician by the Idaho Board of Medicine . . .”).

224. *Id.* r. 16.07.50.100.01.

225. IDAHO CODE ANN. § 39-6101 (Supp. 2010).

226. *Id.* § 39-6102.

227. *Id.* § 39-6102(1).

228. *Id.* § 39-6105(8).

229. *Id.* § 39-6108(1).

230. *Id.* §§ 39-6108(1)(b), 39-6110(2).

231. *Id.* §§ 39-6108(8), 39-6109.

232. TENN. COMP. R. & REGS. 1200-20-11-.02(18) (2006).

ly contract with management service organizations, which perform administrative and oversight functions to increase the efficiency of practices. These changes have effectively circumvented the [corporate practice of medicine] doctrine.”²³⁸

If Idaho were to take the Board’s position and hold on to any vestiges of the corporate practice of medicine doctrine, such would be at the cost of sacrificing the many advantages to modern health care.

A. The Doctrine Potentially Limits Access to Health Care in Rural Areas of Idaho

“Idaho is experiencing a scarcity of medical professionals.”²³⁹ In 2008, Idaho earned a “D” for the state’s overall support of its emergency patient care system from the American College of Emergency Physicians.²⁴⁰ Even more alarming, Idaho consistently ranks last in the country for the number of physicians per capita.²⁴¹ Physicians especially have a disincentive to practice in rural or remote areas, which inherently pose significant economic risks due to their size and disadvantaged status.²⁴² Corporations are more qualified to shoulder the economic risks by hiring physicians full-time.²⁴³ Idaho’s community hospitals have been extremely helpful in attracting and employing physicians and ensuring rural citizens have access to health care. A prohibition on the corporate practice of medicine limits the more efficient and economical forms in which a physician can practice in the state, effectively endangering rural access to health care. Commentators in other states that adhere to the corporate practice of medicine doctrine also note its adverse effects on access to health care in rural areas.²⁴⁴

B. The Doctrine Inhibits Health Care Development in Idaho

Proponents of the corporate practice of medicine doctrine assert that corporate influence will decrease the level of patient care. The fear is that the big bad corporation will place its profit margin above quality

238. ALLEGRA KIM, CAL. RESEARCH BUREAU, THE CORPORATE PRACTICE OF MEDICINE DOCTRINE, CRB 07-011 24 (2007).

239. AM. COLL. OF EMERGENCY PHYSICIANS, THE NATIONAL REPORT CARD ON THE STATE OF EMERGENCY MEDICINE: EVALUATING THE EMERGENCY CARE ENVIRONMENT STATE BY STATE 41 (2009).

240. *Id.*

241. S. Con. Res. 135, 59th Leg., 2d Reg. Sess. (Idaho 2008); U.S. CENSUS BUREAU, ACTIVE PHYSICIANS AND NURSES BY STATE: 2008 (2011), <http://www.census.gov/compendia/statab/2011/tables/11s0161.xls>; U.S. CENSUS BUREAU, ACTIVE PHYSICIANS AND NURSES BY STATE: 2007 (2010), <http://www.census.gov/compendia/statab/2010/tables/10s0159.xls>.

242. *See* KIM, *supra* note 238, at 7.

243. *Id.*

244. *See, e.g.*, Craig A. Conway, *Accountable Care Organizations Versus Texas’ Corporate Practice of Medicine Doctrine*, HEALTH LAW PERSPECTIVES, 3 (Oct. 19, 2010), <http://www.law.uh.edu/healthlaw/perspectives/2010/%28CC%29%20ACO.pdf>; KIM, *supra* note 238, at 7.

patient care. However, this fear is misplaced. The corporate practice of medicine doctrine stems from an era long before the corporate-managed care that now dominates the health care environment. Today's delivery of health care through increasingly complex and integrated systems actually promotes the effectiveness and efficiency of patient care. In fact, one commentator argues that "health care providers must work as a multidisciplinary unit, as part of a whole system, in order to effectuate change toward safer health care delivery."²⁴⁵ Adhering to the corporate practice of medicine doctrine would inhibit health care development in Idaho.

C. Physicians Are Still Influenced by Financial Gain in Solo Practice

Another fear behind the corporate practice of medicine doctrine is that unlicensed corporate employers may improperly interfere with a physician's independent medical judgment. Specifically, proponents of the doctrine are concerned about undue financial influence. Yet, it's naive to believe physicians are not influenced by financial incentives in solo practice. "Insisting on the fiscal purity of treatment decisions ignores the financial incentives inherent in the fee-for-service method of payment and the astonishing health care inflation those incentives have caused."²⁴⁶ In order to protect the integrity of the practice of medicine as well as the government health care budget, Congress has passed various statutes limiting arrangements between medical referral sources.²⁴⁷ These include the federal Anti-Kickback Statute,²⁴⁸ federal Stark law,²⁴⁹ and the civil monetary penalties law.²⁵⁰ Thus, prohibiting the corporate practice of medicine does not insulate physician practices from financial incentives.

245. Huberfeld, *supra* note 2, at 268.

246. Hall, *supra* note 90, at 516.

247. Kim C. Stanger, *What You Don't Know May Hurt You: Laws Affecting Health Care Transactions*, ADVOC., Oct. 2010, at 34, 34.

248. The federal Anti-Kickback Statute "prohibits anyone from knowingly and willfully soliciting, offering, receiving, or paying any form of remuneration to induce referrals for any items or services for which payment may be made by any federal health care program," unless the transaction fits within one of the statutory exceptions and regulatory safe harbor provisions. *Id.* at 34; *see also* 42 U.S.C. §§ 1320a-7b(b)(West, Westlaw current through 2011); 42 C.F.R. § 1001.952 (2011).

249. The federal Stark law "prohibits physicians from referring patients for certain designated health services to entities with which the physician (or a member of the physician's family) has a financial relationship unless the transaction fits within a regulatory safe harbor" provision. Stanger, *supra* note 247, at 34; *see also* 42 U.S.C. § 1395nn (2006); 42 C.F.R. § 411.351 (2011).

250. "The [civil monetary penalties law] prohibits certain transactions that have the effect of increasing utilization or costs to federally funded health care programs or improperly minimizing services to beneficiaries." Stanger, *supra* note 247, at 35.

D. The Doctrine May Actually Be Restraining the Form of Practice It Was Originally Intended to Protect

One often overlooked argument against the corporate practice of medicine doctrine is that the doctrine may actually be restraining the form of practice it was originally intended to protect. Due to the state of the economy, physicians are usually financially unable to support a solo practice right out of medical school, especially with the dual burdens of school loans and high costs of practice. New physicians may be quick to embrace employment by a large corporation as the best way to facilitate the early development of their practice. In fact, many new physicians actually prefer the predictability, in terms of hours, salary, and patient load, that employment brings. The physician has three main options for employment: physician-owned practices, hospitals, and managed care organizations. Of these three, two are more likely in today's modern health care landscape: hospitals and HMOs. Physician-owned practices, feeling the strain of the economy, are often unable to support a new physician. Thus, with his options limited, and considering the burden of student loan debt, the new physician usually goes to work for these larger, more integrated health care systems. Consequently, by preventing corporations from shouldering the economic burden of management for small to mid-size physician clinics, the corporate practice of medicine doctrine may actually be restraining forms of practice it was designed to protect.

VIII. PROPOSED AMENDMENT TO ELIMINATE ANY REMNANTS OF IDAHO'S CORPORATE PRACTICE OF MEDICINE DOCTRINE

If anything is clear from the above discussion, it is that Idaho has not clearly adopted or rejected the corporate practice of medicine doctrine. The Board's position that Idaho has clearly adopted the doctrine is dubious for several reasons. Moreover, even if there were some implied authority for the existence of the doctrine in Idaho, either under the Idaho Medical Practice Act or the court's opinion in *Worlton*, that implied authority is seriously undermined by the several examples of statutorily endorsed (or administratively ignored) corporate involvement in the practice of medicine and the realities of modern health care. This issue begs for clarification and the practice of medicine in Idaho would do well to have certainty as to the types of medical practice that are allowed. For these reasons, we encourage the Idaho legislature to amend the Act to expressly allow corporations to hire or contract with licensed persons to provide medical services. The amendment would be added to Idaho Code Section 54-1804 as a new subsection (6), and would provide as follows:

Notwithstanding the provisions of this Chapter, a corporation is not engaged in the practice of medicine and is not in violation of

this section by entering into an employment or independent contractor agreement with a physician licensed pursuant to this Chapter if the relationship it creates does not in any manner, directly or indirectly, supplant, diminish or regulate the physician's independent judgment concerning the practice of medicine.

This amendment is modeled after South Dakota's statute, which specifically allows corporations to employ licensed physicians to provide medical services.

The amendment is advantageous for three primary reasons. First, the amendment recognizes the critical distinction between the employment of physicians to provide medical services versus the actual practice of medicine and, in doing so, expressly eliminates the corporate practice of medicine doctrine. Second, the amendment promotes physician autonomy in rendering medical care and prevents lay control of the physicians' medical decisions, thereby doing away with any concerns articulated by the court in *Worlton*. Third, the amendment provides certainty to Idaho corporations and physicians in determining which arrangements are lawful. Certainty will in turn foster the growth of integrated delivery systems for health care, which will promote effectiveness and efficiency of medical care for the residents of Idaho.

Without legislative action, it is likely the Board will maintain the position that the corporate practice of medicine doctrine exists in Idaho, as it has done over the past two decades, and continue to disapprove of arrangements between corporations and licensed persons at the expense of health care in Idaho.

IX. CONCLUSION

The time has come to lay to rest the argument over whether Idaho has adopted the corporate practice of medicine doctrine. While the Board cites to implied statutory or common law authority for the corporate practice of medicine doctrine, the overwhelming authority is that Idaho has never clearly adopted the doctrine. Rather, Idaho's health care industry continues to utilize the advantages of corporations, whether they be hospitals or physician-owned clinics, to deliver quality health care through economical arrangements. The industry has done this in the face of uncertainty as to whether Idaho law allows or prohibits these arrangements. Legislative action is needed to once and for all eliminate any doubt that in Idaho corporations may hire or contract with licensed persons to provide medical care.

