

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-I-13

Subject: The Corporate Practice of Medicine

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Referred to: Reference Committee J  
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1 At the 2012 Interim Meeting, the House of Delegates adopted Resolution 2, which established  
2 Policy D-215.993[4]. This policy calls for our American Medical Association (AMA) to study the  
3 evolving “corporate practice of medicine” with respect to its effect on the patient-physician  
4 relationship, financial conflicts of interest, patient-centered care and other relevant issues, and  
5 report back to the House at the 2013 Interim Meeting.

6  
7 This report provides background on the corporate practice of medicine, highlights the AMA’s  
8 physician satisfaction strategic focus area, summarizes relevant AMA policy, describes helpful  
9 AMA resources and presents policy recommendations.

10  
11 **BACKGROUND**

12  
13 The corporate practice of medicine concept dates to the 19<sup>th</sup> century and was integral to elevating  
14 the medical profession, ensuring the autonomy of physicians and providing an ethical basis for the  
15 practice of medicine. Most physicians practiced independently until mining, railroad and  
16 manufacturing industries began hiring physicians to provide medical care to their employees. State  
17 prohibitions against the corporate practice of medicine emerged out of concerns that these  
18 companies and other non-physician entities were influencing and profiting from the work of  
19 physicians. Iterations of the AMA’s Principles of Medical Ethics from the Depression era reflect  
20 physician unease with lay control over medical practices and interference with physician decision-  
21 making.<sup>1</sup>

22  
23 Early state medical practice acts indirectly addressed corporate practice of medicine concerns by  
24 codifying the requirements necessary for individuals to practice medicine and making it illegal to  
25 practice without a medical license. Unable to obtain medical licenses, corporations were thus  
26 precluded from practicing medicine. Many of these statutes were subsequently interpreted by  
27 courts, state attorneys general and medical boards to prohibit corporations from employing  
28 physicians or splitting fees with them. Policy concerns regarding the commercialization of medical  
29 practice, corporate interference with physicians’ independent medical judgments, and the integrity  
30 of patient-physician relationships were the primary motives behind the state bans. Generally  
31 speaking, the fundamental purposes of corporate practice of medicine prohibitions are to preserve  
32 physician autonomy and ensure the best interests of patients.

33  
34 As delivery systems and physician employment arrangements have evolved over the years, so too  
35 has the corporate practice of medicine doctrine. The health care environment is shifting toward  
36 increased coordination and integration of care, with growth in both the number of employed  
37 physicians and hospital acquisitions of physician practices. These trends have led to formalized

1 employment relationships between physicians and non-physician entities, arrangements that in  
2 certain states may run afoul of corporate practice of medicine policies.

3  
4 The doctrine is currently perceived within the context of corporate health care structures that did  
5 not exist a century ago, including large medical groups, retail health clinics, integrated health care  
6 systems and health insurers. The corporate practice of medicine concept is addressed broadly in  
7 Resolution 2-I-12, without specifying what, in the authors' view, constitutes violations of the  
8 doctrine. The term "corporate practice of medicine" encompasses complex legal issues that may  
9 mean different things to different people and vary widely by state. An AMA issue brief on the  
10 subject defines the corporate practice of medicine as "prohibiting corporations from practicing  
11 medicine or employing a physician to provide professional medical services."<sup>2</sup> Current discussions  
12 of the doctrine most frequently focus on the employment of physicians by hospitals and integrated  
13 delivery systems as well as billing arrangements between physicians and non-physician entities.

14  
15 Evidence-based findings delineating the effects of the corporate practice of medicine on patient-  
16 physician relationships, financial conflicts of interest and patient-centered care are not readily  
17 available. However, research underway within an AMA strategic focus area is intended to identify  
18 health care delivery models that support physician satisfaction and may provide relevant guidance  
19 in the future.

## 20 21 STATE APPROACHES

22  
23 The AMA issue brief explains that, "While most states prohibit the corporate practice of medicine,  
24 almost every state has broad exceptions, such as for professional corporations and employment of  
25 physicians by certain health care entities."<sup>3</sup> Though state policies vary, it can be argued that,  
26 overall, the exceptions to corporate practice of medicine bans have become the rule over time. All  
27 states exclude professional service corporations from the bans; however, in many states the  
28 ownership, or a majority of the professional corporation's shareholders, must be licensed  
29 practitioners of that particular profession. Many states permit physicians to be employed by  
30 hospitals, or certain categories of hospitals such as public, teaching or rural institutions. Hospital  
31 employment of physicians, when allowable, is subject to physician autonomy protections intended  
32 to preserve the independent medical judgment of physicians and the inviolability of patient-  
33 physician relationships. For example, in Louisiana, a "Statement of Position" by the Louisiana  
34 Board of Medical Examiners maintains that hospital employment of physicians is not prohibited  
35 unless it undermines the patient-physician relationship, specifying that:

36  
37 If a corporate employer seeks to impose or substitute its judgment for that of the physician ...  
38 or the employment is otherwise structured so as to undermine the essential incidents of the  
39 physician patient relationship, the Medical Practice Act will have been violated. But if a  
40 physician employment relationship is so established and maintained as to avoid such intrusion,  
41 it will not run afoul of the Medical Practice Act.<sup>4</sup>

42  
43 Some states exclude nonprofit health corporations, health maintenance organizations and federally  
44 qualified health centers from their corporate practice of medicine laws, again provided they do not  
45 interfere with physician autonomy or patient-physician relationships.

46  
47 In California, which maintains one of the strictest prohibitions on the corporate practice of  
48 medicine in the country, teaching hospitals and certain clinics are permitted to employ physicians  
49 "as long as the clinic or hospital does not interfere with, control, or otherwise direct the  
50 professional judgment of a physician or surgeon."<sup>5</sup> Texas, which also has strong history of

1 outlawing the corporate practice of medicine, now allows critical access hospitals, sole community  
2 hospitals and hospitals in counties with populations of 50,000 or less to employ physicians. The  
3 Texas statute also specifies that physicians “retain independent medical judgment in providing care  
4 to patients at the hospital and other health care facilities owned or operated by the hospital and may  
5 not be disciplined for reasonably advocating for patient care.”<sup>6</sup> Even with these exceptions, many  
6 hospitals in Texas cannot lawfully hire physicians.

7  
8 At the other end of the spectrum is Ohio, where the corporate practice of medicine is no longer  
9 prohibited. In 2012, the State Medical Board of Ohio qualified the state’s position by affirming that  
10 “the corporation shall not control the professional clinical judgment of the doctor of medicine and  
11 surgery.”<sup>7</sup>

12  
13 Where the corporate practice of medicine is prohibited, foundations and independent contracting  
14 relationships are frequently established to facilitate physician employment within the confines of  
15 the law. Some exceptions to the bans have been made to address physician shortages in areas of  
16 need, such as public and rural hospitals. In those states that permit the corporate practice of  
17 medicine, non-physician led entities are explicitly prohibited from undermining patient-physician  
18 relationships or interfering in any way with the independent medical judgment of physicians.

#### 19 20 AMA ACTIVITY

21  
22 The AMA has developed several resources related to the corporate practice of medicine, including  
23 the aforementioned issue brief and model state legislation to provide for the autonomy of hospital  
24 medical staffs, which was crafted in response to Policy D-215.993. Policy D-215.993 further  
25 directs the AMA provide guidance and consultation to state medical societies concerned that  
26 physician employment by non-physician entities is interfering in medical practice matters. Notably,  
27 the AMA continues to offer assistance to physicians on their relationships with hospitals, health  
28 systems and other corporate employers. AMA members can consult with AMA staff on any  
29 number of issues, including contracting, hospital medical staff governance, utilization review and  
30 peer review. Physicians concerned that an employer is violating state corporate practice of  
31 medicine policy can contact the AMA for assistance as well as legal staff at their state medical  
32 associations.

33  
34 The sanctity of the patient-physician relationship is a core priority for the AMA. Recognizing that  
35 physicians are increasingly becoming employed by hospitals and health systems, the AMA has  
36 developed the Annotated Model Physician-Hospital Employment Agreement and the Annotated  
37 Model Physician-Group Practice Employment Agreement to assist in the negotiation of  
38 employment contracts. AMA Principles for Physician Employment address some of the more  
39 complex issues related to employer-employee relationships. Conflicts of interest, advocacy for  
40 patients and hospital/medical staff relations are some of the topics addressed in these principles.  
41 Further guidance on conflicts of interest can also be found in Conflict of Interest Guidelines for  
42 Organized Medical Staffs and the AMA *Code of Medical Ethics*. Through these resources, the  
43 AMA is well-positioned to help employed physicians and those considering employment by  
44 hospitals or other corporations to preserve independent decision-making, avoid conflicts of interest  
45 and protect patient relationships.

46  
47 The AMA also has dedicated one of the organization’s three strategic focus areas to helping  
48 physicians ensure sustainable practices that lead to improved health outcomes for patients and  
49 greater professional satisfaction for physicians. Research is underway to identify payment and  
50 delivery models that promote physician satisfaction and sustainability in a variety of practice

1 settings. The results of this research will inform future AMA policy and help physicians  
2 successfully navigate the evolving health care environment while maintaining their clinical  
3 autonomy.

4  
5 RELEVANT AMA POLICY

6  
7 The AMA has substantial policy emphasizing physician independent decision-making, patient-  
8 physician relationships and financial conflicts of interest; however, the corporate practice of  
9 medicine is not explicitly prohibited. On the contrary, AMA policy presumes that a significant  
10 proportion of practicing physicians is employed by lay organizations, including corporations.  
11 Policy H-285.951[2] states that physicians should have the right to enter into whatever contractual  
12 arrangements with health care systems, plans, groups or hospital departments they deem desirable  
13 and necessary, but they should be aware of the potential for some types of systems, plans, group  
14 and hospital departments to create conflicts of interest, due to the use of financial incentives in the  
15 management of medical care. The freedom to choose the environment in which to provide care is  
16 also affirmed by the AMA *Code of Medical Ethics*.

17  
18 Although AMA policy does not prohibit the corporate practice of medicine, it opposes federal  
19 attempts to preempt state prohibitions (Policy H-215.981). Furthermore, Policy H-275.937  
20 acknowledges that certain practice models may result in an inappropriate restriction of the  
21 physician's ability to practice quality medicine.

22  
23 Policy D-215.993 directs the AMA to: (1) provide guidance and consultation in drafting state  
24 legislation to medical societies which are concerned that physician employment by non-physician  
25 organizations may be interfering in professional medical matters; (2) revise its economic  
26 credentialing model legislation; (3) develop model legislation to protect medical staffs from board  
27 interference; and (4) study of the evolving corporate practice of medicine with respect to its effect  
28 on the patient-physician relationship, financial conflicts of interest, patient-centered care and other  
29 relevant issues.

30  
31 Policy D-225.977 directs the AMA to continue to assess the needs of employed physicians,  
32 ensuring autonomy in clinical decision-making and self-governance; and promote physician  
33 collaboration, teamwork, partnership, and leadership in emerging health care organizational  
34 structures, including but not limited to hospitals, health care systems, medical groups, insurance  
35 company networks and accountable-care organizations. Furthermore, Policy H-285.954 states that  
36 certain professional decisions critical to high quality patient care should always be the ultimate  
37 responsibility of the physician regardless of the practice setting. Policy H-285.910 endorses the  
38 insertion into physician employment agreements of language guaranteeing physician independence.

39  
40 Conflicts of interest are addressed in AMA's Principles for Physician Employment (Policy  
41 H-225.950), which makes it clear that patient welfare must always take priority over an employer's  
42 economic interests. Policy H-140.978 states that physicians must not deny their patients access to  
43 appropriate medical services based upon the promise of personal financial reward, or the avoidance  
44 of financial penalties.

45  
46 The inviolability of the patient-physician relationship is a recurrent theme throughout the AMA  
47 *Code of Medical Ethics*. It is the policy of the AMA to strongly condemn any interference by  
48 outside parties that causes a physician to compromise his or her medical judgment (Policy  
49 H-5.989). Policies H-285.910 and H-285.951 promote independent patient advocacy as  
50 fundamental to the patient-physician relationship and thereby free from interference. Protecting the

1 patient-physician relationship was also the subject of Council Report 4-A-10, which established  
2 policy supporting these relationships in myriad emerging practice arrangements (Policy  
3 H-225.950). The AMA has equally strong policy on organized medical staff affairs (e.g. Policies  
4 H-225.963, H-235.963, H-235.990, H-235.992, H-235.999), including a physician's right to  
5 exercise independent judgment in all matters regarding patient care, the profession, health care in  
6 the community and medical staff matters, and to incorporate the independent exercise of medical  
7 judgment into physician employment and contracting agreements (Policy D-225.978). Policy  
8 H-225.957 outlines principles for strengthening physician-hospital relationships. Accountable Care  
9 Organizations must be physician-led to ensure that physicians' medical decisions are based on  
10 professional medical judgments rather than commercial interests (Policy H-160.915). Finally,  
11 AMA Policy H-285.983 supports the establishment of self-governing medical staffs in other health  
12 care delivery systems, similar to those that exist in hospitals.

#### 13 14 DISCUSSION

15  
16 The corporate practice of medicine doctrine and state prohibitions against the practice were  
17 developed in the context of a health care environment that did not encourage delivery system  
18 integration. Corporate practice of medicine bans are regarded by some physicians as barriers to  
19 clinical integration and delivery system innovation. Resolution 2-I-12, on the other hand, presents  
20 concerns that the prohibitions have been diluted over time and have the potential to infringe on the  
21 independent medical judgment of physicians. The Council takes these concerns seriously and  
22 believes the AMA should maintain balanced policy on the corporate practice of medicine.  
23 Accordingly, the Council recommends modifying Policy H-215.981 to ensure that the AMA  
24 provides guidance and consultation to states that request assistance with corporate practice of  
25 medicine matters. The Council further recommends changing the title of Policy H-215.981 to  
26 reflect its corporate practice of medicine focus.

27  
28 The Council believes that potentially detrimental effects of the corporate practice of medicine can  
29 be mitigated by having strong policies in place to protect the independent medical judgment of  
30 physicians and patient-physician relationships. The AMA has an extensive policy base that  
31 includes the *Code of Medical Ethics*, and addresses these inviolable issues as well as maintaining  
32 clinical autonomy under a variety of physician employment arrangements. Furthermore, the  
33 Council finds that states permitting corporate employment of physicians explicitly prohibit non-  
34 physician entities from undermining physician decision making. The Council, therefore,  
35 recommends reaffirmation of the following policies: Policy H-225.950, which outlines AMA  
36 Principles for Physician Employment and address conflicts of interest; Policy H-225.957, which  
37 defines AMA Principles for Strengthening the Physician-Hospital Relationship; and Policy  
38 H-160.915, which delineates Accountable Care Organization Principles.

39  
40 The Council also recommends rescinding Policy D-215.993, which has been accomplished by the  
41 development of model state legislation providing for the autonomy of hospital medical staffs,  
42 revisions to the AMA's model legislation on economic credentialing, and the development of this  
43 Council report.

1 RECOMMENDATIONS

2

3 The Council on Medical Service recommends that the following be adopted and the remainder of  
4 the report be filed:

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6 1. That our American Medical Association (AMA) amend Policy H-215.981 and its title by  
7 addition and deletion to read as follows:

8

9 H-215.981 ~~Hospital Employed Physicians~~ Corporate Practice of Medicine

10 (1) Our AMA vigorously opposes any effort to pass federal legislation preempting state  
11 laws prohibiting the corporate practice of medicine. (2) At the request of state medical  
12 associations, our AMA will provide guidance, consultation, and model legislation  
13 regarding the corporate practice of medicine, to ensure the autonomy of hospital medical  
14 staffs. (3) Our AMA will continue to monitor the evolving corporate practice of medicine  
15 with respect to its effect on the patient-physician relationship, financial conflicts of  
16 interest, patient-centered care and other relevant issues. (Modify HOD Policy)

17

18 2. That our AMA reaffirm Policy H-225.950, which outlines AMA Principles for Physician  
19 Employment; Policy H-225.957, which defines AMA Principles for Strengthening the  
20 Physician-Hospital Relationship; and Policy H-160.915, which delineates AMA  
21 Accountable Care Organization (ACO) Principles. (Reaffirm HOD Policy)

22

23 3. That our AMA rescind Policy D-215.993, which prompted the development of model state  
24 legislation to ensure the autonomy of hospital medical staffs, revisions to the AMA's  
25 economic credentialing model legislation and the development of this report. (Rescind  
26 HOD Policy)

Fiscal Note: Less than \$500 to implement.

## REFERENCES

<sup>1</sup> Ethics Timeline: 1847 to 1940. American Medical Association. Copyright 1995-2013. Available at: <http://www.ama-assn.org/ama/pub/about-ama/our-history/history-ama-ethics/ethics-timeline-1847-1940.page?>

<sup>2</sup> Issue Brief: Corporate practice of medicine. Advocacy Resource Center. American Medical Association. 2011. Available at: <http://www.ama-assn.org/resources/doc/arc/x-ama/corporate-practice-of-medicine-issue-brief.pdf>

<sup>3</sup> Ibid.

<sup>4</sup> Statement of Position: Employment of Physician by Corporation other than a Professional Medical Corporation. Louisiana Board of Medical Examiners. September 24,1992.

<sup>5</sup> Cal.Bus. & Prof. Code §2401(b) 2011

<sup>6</sup> Tex. Health and Safety Code § 311.063(G) 2011

<sup>7</sup> Statement on the Corporate Practice of Medicine. State Medical Board of Ohio. 2012.